Our Home, Our Family, Our Life, Too.

Heritage Hall of Brookneal • 633 Cook Avenue • Brookneal, VA 24528 • (P) 434.376.3717

November 03, 2016

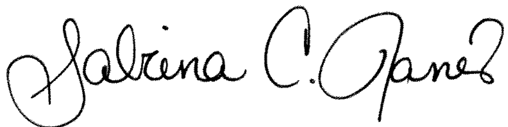
Office of Licensure and Certification
Division of Long Term Care Services
9960 Mayland Drive – Suite 401
Attn: Rodney Miller, Long Term Care Supervisor
Richmond, VA 23233-1463

Mr. Miller;

Attached to this cover letter you will find Heritage Hall–Brookneal's Plan of Correction and our credible allegation of compliance. The Plan of Correction addresses the corrective action, identification of deficient practices, systemic changes, and monitoring that will be implemented to address deficient practices identified during our annual survey.

If I can be of further assistance don't hesitate to contact me at (434) 376-3740.

Sincerely;



Sabrina Jones
Administrator

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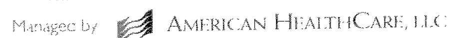
HERITAGE HALL
HEALTHCARE AND REHABILITATION CENTERS



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495242	A. BUILDING ______ B. WING ______	C 10/17/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HALL - BROOKNEAL	633 COOK AVENUE BROOKNEAL, VA 24528

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F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 10/12/16 through 10/17/16. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. The census in this 60 certified bed facility was 57 at the time of the survey. The survey sample consisted of 14 current Resident reviews (Resident #1 through Resident #13 and Resident #17) and 3 closed record reviews (Resident #14 through Resident #16).	F 000		
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a	F 157	**F-157** **Corrective Action(s)** The administrator has met with Resident #5's responsible party and discussed the room change and possible options to place in an alternate location to re-establish his prior routine prior to the room change. The RP has been educated on their rights regarding room changes and transfers. A Facility Incident & Accident Form has been completed for this incident.	11/30/16

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Sabrina C. Jones | TITLE: Administrator | (X6) DATE: 11/3/16

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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change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.

The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.

This REQUIREMENT is not met as evidenced by:
Based on observation, staff interview, family interview, and clinical record review, facility staff failed to notify the resident's responsible party prior to a room change for 1 of 17 resident's in the survey sample (Resident # 5).

Resident #5 was admitted to the facility on 6/9/16 with diagnoses including chronic kidney disease, hypertension, cognitive communication deficit, muscle weakness, and dementia with behavioral disturbance. On the quarterly minimum data assessment with assessment reference date 9/14/16, the resident scored 4/15 on the brief interview of mental status and exhibited symptoms of inattention, disorganized thinking, and daily wandering.

During initial tour on 10/12/16, the surveyor observed the resident walking in the halls and then sitting in a chair in an alcove near the resident's room. The nurse touring with the resident stated that the resident walked a lot and liked to sit in the alcove where there was a view out the doors at the end of the hall and of the nurse's station. The surveyor observed the resident frequently walking in the halls or sitting in

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Identification of Deficient Practices & Corrective Action(s):
All other residents that have had a room change may have potentially been affected. The Administrator and Social Service Director will review all resident room changes for the last 6 months to identify residents who may have not had their Responsible Party notified prior to the room change or were not allowed to exercise their right to refuse the room change. All negative findings will be corrected at time of discovery and an Incident & Accident form will be completed.

Systemic Change(s):
The facility policy and procedure has been reviewed and no changes are warranted at this time. The Administrator and the Social Service director will be inserviced by the Regional Nurse consultant and/or Clinical Services director on the Notification of Rights & Services and issued a copy of the regulation and the policy and procedure regarding resident rights. The inservice will include staff education on the timeliness of notification to responsible parties prior to making a resident room change and their right to refuse a room change.

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F 157	Continued From page 2 the chair in the alcove on 10/13 and 14. On 10/17/16 at 8:30 the surveyor found another resident in the room where the resident was observed the prior week. The resident was not in the dining room, the hall, or the alcove where he had been previously observed. The surveyor asked the nurse who had administered the resident's medications on 10/13/16 where the resident had gone. The nurse stated that there was a hospice resident in the room and he had probably been moved to give that resident privacy. The nurse was unable to say when the resident had moved. A second nurse said the resident had probably moved Friday or Saturday. The resident was observed in the new room sitting in a chair against the wall between the two beds with an overbed tray table and the resident's room mate in a wheelchair with his back to the resident between the resident and the door. The resident was in the chair with the tray table in front of him each of the 6 times the surveyor observed him on 10/17/16. The resident was not observed out of his room between 9 AM and 3 PM on 10/17/16. Clinical record review did not reveal documentation of the room change or the reason for the room change. The surveyor reviewed the resident's orders, nursing, and social service notes. None mentioned the resident changing rooms or the resident's responsible party (RP) being notified of the change. The surveyor interviewed the resident's responsible party by phone on 10/17/16 at 10:15 AM. The RP stated that she had been told the resident was moved. She stated she was not offered a choice. The RP felt the resident was confused by the move and thought he was not	F 157	**Monitoring:** The Administrator and Social Service director are responsible for maintaining compliance. The administrator and Social service director will review all room changes weekly to monitor compliance. Any/all negative findings will be corrected at time of discovery and appropriate disciplinary action taken as needed. Aggregate findings will be reported to the QA Committee for review, analysis and recommendation for changes in facility policy, procedure and/or practice. **Completion Date: 11/30/2016**	

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F 157	Continued From page 3 allowed to leave the room. She stated he just sat in the chair in the room now instead of going out and walking around the halls. The RP stated the new room "is like a jail to him". The RP felt the resident was not properly oriented to the change and that the resident did not know where he was anymore. She said it took months to acclimate him to the old room and establish a routine. The resident's comprehensive care plan (CCP) provided on 10/13/16 listed under problem/need: resident is at risk Dx dementia with goals 1- find own room with/without cueing 2- find bathroom with/without cueing 3- find dining room with/without cueing and approaches a- provide 24 hour reality orientation b- place calendar where resident has access c- observe fro changes in cognitive status, provide consistent caregiver d- approach resident warmly and positively and e-establish daily routine with resident. The administrator and director of nursing were notified of the concern. The administrator stated that the resident's RP had not objected to the move. After a call to the resident's RP, the administrator stated that the RP was for the move because the resident needed a room mate. The surveyor asked if the resident's care plan goals had been addressed with the move. The administrator offered to speak with the RP again concerning the move.	F 157		
F 272 SS=E	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.	F 272		11/30/16

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F 272	Continued From page 4 A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment. 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 ensure complete and accurate Care Area	F 272	**F272** **Corrective Action(s):** Resident #1, #2, #3, #4, #5, #6, #7, #8, #9 identified in the survey sample have had their Care Area Assessment Summary and Care Area worksheets revised to reflect the location of the of documentation to support the care plan decisions. **Identification of Deficient Practices & Corrective Action(s):** All other residents may have potentially affected. A 100% review of all resident's most current comprehensive MDS assessments and the Care Area Assessment Summary's will be completed by the RCC and/or designee to identify residents affected. All residents affected will have their Comprehensive MDS assessments and Care Area Assessment Summary's corrected at time of discover and their comprehensive care plans updated. **Systemic Change(s):** The facility policy and procedure was reviewed and no changes are warranted at this time. The regional nurse consultant will inservice the Resident Care Coordinator's and the interdisciplinary Care Plan Team on accurately completely the Care Area Assessment Summary. This will include accurate documentation indicating the date and location of documentation describing each resident's clinical status and other factors that impact care planning.	11/30/16

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Assessments (CAA's) for 9 of 17 Residents in the sample survey, Resident #1, Resident #2, Resident #3, Resident #4, Resident #5, Resident #6, Resident #7, Resident #8 and Resident #9.
The Findings Included:
1. For Resident #1 the facility staff failed to ensure a complete and accurate Care Area Assessment (CAA) on an Annual Minimum Data Set (MDS) assessment with an Assessment Reference Date (ARD) of 2/26/16.
Resident #1 was a 76 year old female who was admitted on 3/28/15. Admitting diagnoses included, but were not limited to: uterine Cancer, diabetes mellitus, dementia without behaviors and failure to thrive.
The most current MDS located in the clinical record was a Quarterly MDS assessment with an ARD of 8/9/16. The facility staff coded that Resident #1 had a Cognitive Summary Score of 4. The facility staff also coded that Resident #1 required extensive (3/2) to total nursing care (4/2) with Activities of Daily Living (ADL's).
On October 13, 2016 at 7:45 a.m. the surveyor reviewed Resident #1's clinical record. Review of the clinical record produced an Annual MDS assessment with an ARD of 2/26/16. The facility staff coded that Resident #1 had a Cognitive Summary Score of 4. The facility staff also coded that Resident #1 required limited (2/2) to total nursing care (4/2) with ADL's. In Section V. Care Area Assessment Summary (CAA's) Resident #1 triggered for the following care areas: Cognition, Vision, Urinary Incontinence, Psychosocial Well-Being, Mood State, Behavioral Symptoms, Activities, Falls, and Nutritional Status. In the column titled, "Location and Date of CAA documentation" the facility staff documented "Current Care Plan Continued ..." (sic) The column did not document the location and date of

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Monitoring:
The RCC is responsible for maintaining compliance. The RCC will complete the MDS audit tool weekly coinciding with the MDS calendar to monitor for compliance. Any/all negative findings will be reported to the RCC and the DON at the time of discovery for immediate correction. Aggregate findings will be reported to the Quality Assurance Committee for review, analysis, and recommendations for changes in policy, procedure, and/or facility practice.
Completion Date: 11/30/2016

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F 272	Continued From page 6 the supporting documentation for the care plan decision making for Cognition, Vision, Urinary Incontinence, Behavioral Symptoms and Falls. The surveyor continued to review the Annual MDS assessment with the ARD of 2/26/16. The surveyor reviewed the CAA summary worksheets. Review of the CAA summary worksheets did not document the date and/or location of the supporting documentation for the care planning decision making for Cognition, Vision, Urinary Incontinence, Behavioral Symptoms and Falls. On October 13, 2016 at 8:35 a.m. the surveyor notified the Director of Nursing (DON) that Resident #1's CAA's were not complete and accurate. The surveyor and DON reviewed Resident #1's Annual MDS assessment with the ARD of 2/26/16. The surveyor pointed out that Section V. CAA's and the CAA worksheets did not document the date and location of the supporting documentation for the decision making process regarding care plans. The DON stated that she would check with the MDS Nurse. On October 13, 2016 at 9:20 a.m. the DON approached the surveyor and informed the surveyor that the MDS Nurse stated that she was not aware that she needed to document the specific date and location of the supporting documentation for the care plan decision making process. On October 13, 2016 at 4:20 p.m. the survey team met with the Administrator (Adm), DON and Corporate Compliance Nurse (CCN). The surveyor notified the Administrative Team (AT) that the facility staff failed to ensure complete and accurate CAA's for Resident #1. The surveyor notified the AT that the facility staff failed to document the date and location of the supporting documentation regarding the care plan decision making.	F 272		

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F 272	Continued From page 7 No additional information was provided prior to exiting the facility as to why the facility staff failed to ensure complete and accurate CAA's for Resident #1. 2. For Resident #2 the facility staff failed to ensure a complete and accurate Care Area Assessment (CAA) on an Admission Minimum Data Set (MDS) assessment with an Assessment Reference Date (ARD) of 5/10/16. Resident #2 was an 84 year old male who was admitted on 4/28/16. Admitting diagnoses included, but were not limited to: chronic obstructive pulmonary disease, dysphagia, seizures, pneumonia, myocardial infarction, osteoporosis and hypothyroidism. 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 10/11/16. The facility staff coded that Resident #2 had short and long term memory impairment (1/1) and was severely impaired (3) with daily decision making regarding Activities of Daily Living (ADL's). The facility staff also coded that Resident #2 required total nursing care (4/2) with ADL's. On October14, 2016 at 7:45 a.m. the surveyor reviewed Resident #2's clinical record. Review of the clinical record produced an Admission MDS assessment with an ARD of 5/10/16. The facility staff coded that Resident #2 had short and long term memory impairment (1/1) and was severely impaired (3) with daily decision making regarding ADL's. The facility staff also coded that Resident #2 required extensive (3/2) to total nursing care (4/2) with ADL's. In Section V. Care Area Assessment Summary (CAA's), Resident #2 "triggered" for Cognitive Loss, Communication, Urinary Incontinence, Psychosocial Well-Being, Mood State, Activities, Falls and Nutritional	F 272		

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F 272	Continued From page 8	F 272		

Status. In the column titled, "Location and Date of CAA documentation" the facility staff documented "New Care Plan Started ..." (sic) The column did not document the location and date of the supporting documentation for the care plan decision making for Cognition, Communication, Urinary Incontinence, Mood State and Falls.
The surveyor continued to review the Admission MDS assessment with the ARD of 5/10/16. The surveyor reviewed the CAA summary worksheets. Review of the CAA summary worksheets did not document the date and/or location of the supporting documentation for the care planning decision making for Cognition, Communication, Urinary Incontinence, Mood State and Falls.
On October 14, 2016 at 9 a.m. the surveyor notified the Director of Nursing (DON) that Resident #2's CAA's were not complete and accurate. The surveyor and DON reviewed Resident #2's Admission MDS assessment with the ARD of 5/10/16. The surveyor pointed out that Section V. CAA's and the CAA worksheets did not document the date and location of the supporting documentation for the decision making process regarding care plans. The DON stated that she had spoken with the MDS Nurse on 10/13/16 and that probably all of the comprehensive assessments CAA ' s would be inaccurate.
On October 14, 2016 at 10 a.m. the survey team met with the Administrator (Adm), DON and Corporate Compliance Nurse (CCN). The surveyor notified the Administrative Team (AT) that the facility staff failed to ensure complete and accurate CAA's for Resident #2. The surveyor notified the AT that the facility staff failed to document the date and location of the supporting documentation regarding the care plan decision making.
No additional information was provided prior to

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F 272	Continued From page 9 exiting the facility as to why the facility staff failed to ensure complete and accurate CAA's for Resident #2. 3. For Resident #3 the facility staff failed to ensure a complete and accurate Care Area Assessment (CAA) on an Admission and 5 Day Medicare Minimum Data Set (MDS) assessment with an Assessment Reference Date (ARD) of 8/26/16. Resident #3 was a 57 year old male was originally admitted on 11/11/15 and readmitted on 8/19/16. Admitting diagnoses included, but were not limited to: chronic obstructive pulmonary disease, anxiety, impulse disorder and schizophrenia. The most current Minimum Data Set (MDS) assessment located in the clinical record was a 30 Day Medicare MDS assessment with an Assessment Reference Date (ARD) of 9/14/16. The facility staff coded that Resident #3 had a Cognitive Summary Score of 13. The facility staff also coded that Resident #3 required set up (1/1) to limited assistance (2/2) with Activities of Daily Living (ADL's). On October 13, 2016 at 9:25 a.m. the surveyor reviewed Resident #3's clinical record. Review of the clinical record produced an Admission and 5 Day Medicare MDS assessment with an ARD of 8/26/16. The facility staff coded that Resident #3 had a Cognitive Summary Score of 13. The facility staff also coded that Resident #3 required set up (1) to limited assistance (2/2) with ADL ' s. In Section V. Care Area Assessment Summary (CAA ' s) Resident #3 "triggered" for Cognitive Loss, Visual Function, ADL Function, Urinary Inconstancy, Psychosocial Well-Being, Falls and Nutritional Status. In the column titled, "Location and Date of CAA documentation" the facility staff documented "Current Care Plan Cont (continued) ..." (sic) The column did not document the	F 272		

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F 272	Continued From page 10 location and date of the supporting documentation for the care plan decision making for Cognition, Vision, ADL Function, Urinary Incontinence, Psychosocial Well-being and Falls. The surveyor continued to review the Admission and 5 Day Medicare MDS assessment with the ARD of 8/26/16. The surveyor reviewed the CAA summary worksheets. Review of the CAA summary worksheets did not document the date and/or location of the supporting documentation for the care planning decision making for Cognition, Vision, ADL Function, Urinary Incontinence, Psychosocial Well-being and Falls. On October 13, 2016 at 11 a.m. the surveyor notified the Director of Nursing (DON) that Resident #3's CAA's were not complete and accurate. The surveyor and DON reviewed Resident #3's Admission and 5 Day Medicare MDS assessment with the ARD of 8/26/16. The surveyor pointed out that Section V. CAA's and the CAA worksheets did not document the date and location of the supporting documentation for the decision making process regarding care plans. The DON stated that she had spoken with the MDS Nurse on 10/13/16 and that probably all of the comprehensive assessments CAA's would be inaccurate. On October 13, 2016 at 4:20 p.m. the survey team met with the Administrator (Adm), DON and Corporate Compliance Nurse (CCN). The surveyor notified the Administrative Team (AT) that the facility staff failed to ensure complete and accurate CAA's for Resident #3. The surveyor notified the AT that the facility staff failed to document the date and location of the supporting documentation regarding the care plan decision making. No additional information was provided prior to exiting the facility as to why the facility staff failed	F 272		

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to ensure complete and accurate CAA's for Resident #3.

4. For Resident #4 the facility staff failed to ensure a complete and accurate Care Area Assessment (CAA) on an Annual Minimum Data Set (MDS) assessment with an Assessment Reference Date (ARD) of 10/3/16.

Resident #4 was a 76 year old female who was admitted on 10/26/15. Admitting diagnoses included, but were not limited to: chronic obstructive pulmonary disease, atrial fibrillation, diabetes mellitus, major depression, polyarthritis, fall and hyperlipidemia.

On October 13, 2016 at 1:20 p.m. the surveyor reviewed Resident #4"s clinical record. Review of the clinical record produced the most current MDS. The most current Minimum Data Set (MDS) located in the clinical record was an Annual MDS assessment with an Assessment Reference Date (ARD) of 10/3/16. The facility staff coded that Resident #4 had a Cognitive Summary Score of 14. The facility staff also coded that Resident #4 required total nursing care (4/2) with Activities of Daily Living (ADL's). In Section V. Care Area Assessment Summary (CAA's) Resident #4 "triggered" for Communication, ADL Function, Incontinence, Falls, Nutritional Status, Dehydration, Dental Care, Pressure Ulcer, Psychotropic Drug Use and Pain. In the column titled, "Location and Date of CAA documentation" the facility staff documented "Current Care Plan Cont (continued) ..." (sic) The column did not document the location and date of the supporting documentation for the care plan decision making for Communication, ADL Function, Incontinence, Falls, Nutritional Status, Dehydration, Dental Care, Pressure Ulcer, Psychotropic Drug Use and Pain.

The surveyor continued to review the Annual

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MDS assessment with the ARD of 10/3/16. The surveyor reviewed the CAA summary worksheets. Review of the CAA summary worksheets did not document the date and/or location of the supporting documentation for the care planning decision making for Communication, ADL Function, Incontinence, Falls, Nutritional Status, Dehydration, Dental Care, Pressure Ulcer, Psychotropic Drug Use and Pain.

On October 13, 2016 at 2:50 p.m. the surveyor notified the Administrator (Adm) and Director of Nursing (DON) that Resident #4's CAA's were incomplete/inaccurate.

On October 13, 2016 at 4:20 p.m. the survey team met with the Administrator Adm, DON and Corporate Compliance Nurse (CCN). The surveyor notified the Administrative Team (AT) that the facility staff failed to ensure complete and accurate CAA's for Resident #4. The surveyor notified the AT that the facility staff failed to document the date and location of the supporting documentation regarding the care plan decision making.

No additional information was provided prior to exiting the facility as to why the facility staff failed to ensure complete and accurate CAA's for Resident #4.

5. For Resident #5, facility staff failed to ensure documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS).

Resident #5 was admitted to the facility on 6/9/16 with diagnoses including chronic kidney disease, hypertension, cognitive communication deficit, muscle weakness, and dementia with behavioral disturbance. On the quarterly minimum data assessment with assessment reference date

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9/14/16, the resident scored 4/15 on the brief interview of mental status and exhibited symptoms of inattention, disorganized thinking, and daily wandering.

The resident's annual MDS assessment with assessment reference date 6/20/16 was not completed to include assessment documentation on the Care Area Assessment (CAA) worksheets or the CAA summary section of the assessment. During an interview on 10/12/16, the director of nursing stated that the former MDS coordinator had not put that information on the CAA summaries or CAA assessment worksheets. She stated she had interviewed the new MDS coordinator and the new coordinator reported that she also did not put that information in the MDS assessments.

The administrator and director of nursing were notified of the concern. The director of nursing stated that the information would be recorded on the CAA worksheets or CAA summaries in the future.

6. For Resident #8, facility staff failed to ensure documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS).

Resident #8 was admitted to the facility on 1/16/13. Current diagnoses included dementia without behavior disturbance, hypertension, falls, anxiety, depression, and post traumatic stress disorder. On the quarterly minimum data set (MDS) assessment with assessment reference date 8/23/16, the resident scored 3/15 on the brief interview for mental status, 4/8 on for signs

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of delirium, no signs of psychosis, and physical and verbal behavior 1-3 days of the week.

The resident's annual MDS assessment with assessment reference date 12/28/16 was not completed to include assessment documentation on the Care Area Assessment (CAA) worksheets or the CAA summary section of the assessment. During an interview on 10/12/16, the director of nursing stated that the former MDS coordinator had not put that information on the CAA summaries or CAA assessment worksheets. She stated she had interviewed the new MDS coordinator and the new coordinator reported that she also did not put that information in the MDS assessments.

The surveyor discussed the concern with the incomplete CAA summaries and worksheets on 10/13/14, and reported to the administrator, director of nursing, and a corporate clinical consultant on 10/14/16.

7. For Resident #7, facility staff failed to ensure documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS).

Resident #7 was admitted to the facility on 2/19/13 with diagnoses including non-Alzheimer's dementia without behavior, hypertension, diabetes mellitus, rheumatoid arthritis, dysphagia, anxiety, depression, bipolar disorder, and psychosis. On the quarterly minimum data set assessment (MDS) with assessment reference date 2/10/16, the resident scored 9/15 on the brief interview for mental status and was 4/8 on

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the assessment for delirium.

The comprehensive admission MDS assessment with assessment reference date 2/1/16 was not completed to include assessment documentation on the Care Area Assessment (CAA) worksheets or the CAA summary section of the assessment. During an interview on 10/12/16, the director of nursing stated that the former MDS coordinator had not put that information on the CAA summaries or CAA assessment worksheets. She stated she had interviewed the new MDS coordinator and the new coordinator reported that she also did not put that information in the MDS assessments.

The resident's comprehensive care plan did not address the symptoms to be treated by the antipsychotic medication or the resident's contractures of both hands requiring occupational therapy.

The surveyor discussed the concern with restorative therapy and the lack of indication for the antipsychotic medication and the incomplete CAA summaries and worksheets on 10/13/14, and reported to the administrator, director of nursing, and a corporate clinical consultant on 10/14/16.

8. For Resident #6, facility staff failed to ensure documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS).

Resident #6 was admitted to the facility on 6/19/14 with diagnoses including dementia, end

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stage renal disease (ESRD), malignant neoplasm of prostate, rheumatoid arthritis, depression, and dysphasia. On the quarterly minimum data set assessment (MDS) with assessment reference date 5/5/16, the resident was assessed with short and long term memory deficits, impaired ability to make daily decisions, and scored 0/8 on the assessment for delirium.

The comprehensive annual MDS assessment with assessment reference date 8/5/16 was not completed to include assessment documentation on the Care Area Assessment (CAA) worksheets or the CAA summary section of the assessment. During an interview on 10/12/16, the director of nursing stated that the former MDS coordinator had not put that information on the CAA summaries or CAA assessment worksheets. She stated she had interviewed the new MDS coordinator and the new coordinator reported that she also did not put that information in the MDS assessments.

The surveyor discussed the concern with restorative therapy and the lack of indication for the antipsychotic medication and the incomplete CAA summaries and worksheets on 10/13/14, and reported to the administrator, director of nursing, and a corporate clinical consultant on 10/14/16.

9. For Resident #9, facility staff failed to ensure documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS).

Resident #9 was admitted to the facility on

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F 272	Continued From page 17 12/3/10 with diagnoses including dementia, cardiopulmonary disease, cognitive/communication deficit, pain, general weakness, depression, anxiety, and dysphagia. On the quarterly minimum data set assessment (MDS) with assessment reference date 7/25/16, the resident scored 7/15 on the brief interview for mental status and was assessed as without signs of delirium, psychosis, or behaviors affecting others. The comprehensive annual MDS assessment with assessment reference date 2/12/16 was not completed to include assessment documentation on the Care Area Assessment (CAA) worksheets or the CAA summary section of the assessment. During an interview on 10/12/16, the director of nursing stated that the former MDS coordinator had not put that information on the CAA summaries or CAA assessment worksheets. She stated she had interviewed the new MDS coordinator and the new coordinator reported that she also did not put that information in the MDS assessments. The surveyor discussed the concern with restorative therapy and the lack of indication for the antipsychotic medication and the incomplete CAA summaries and worksheets on 10/13/14, and reported to the administrator, director of nursing, and a corporate clinical consultant on 10/14/16.	F 272		
F 279 SS=E	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.	F 279		11/30/16

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The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.

The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).

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 develop a Comprehensive Care Plan (CCP) for 4 of 17 Residents in the sample survey, Resident #1, Resident #5, Resident #7 and Resident #9.
The Findings Included:
1. For Resident #1 the facility staff failed to develop a Comprehensive Care Plan (CCP) for pain as identified and triggered on an Annual Minimum Data Set (MDS) assessment with an Assessment Reference Date (ARD) of 2/26/16.
Resident #1 was a 76 year old female who was admitted on 3/28/15. Admitting diagnoses included, but were not limited to: uterine Cancer, diabetes mellitus, dementia without behaviors and failure to thrive.
The most current MDS located in the clinical

F 279
Corrective Action(s):
Resident #1's comprehensive care plan has been reviewed and revised to reflect appropriate goals and interventions and approaches to address the resident's specific medical and treatment needs to include treating and managing Resident #1's pain. A Facility Incident & Accident Form was completed for this incident.

Resident #5's comprehensive care plan has been reviewed and completely revised to reflect the appropriate goals, interventions and approaches to address the resident's specific medical and treatment needs as identified on the comprehensive MDS assessment. A Facility Incident & Accident Form was completed for this incident.

Resident #7's Medication Regimen has been reviewed by the attending physician to determine the continued need and use of the antipsychotic medication Seroquel. Resident #7's comprehensive care plan has been reviewed and revised to reflect appropriate goals and interventions and approaches to address the resident's specific medical and treatment needs to include the use of psychoactive medications and the need for restorative nursing for contracture prevention. A Facility Incident & Accident Form was completed for this incident.

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F 279	Continued From page 19 record was a Quarterly MDS assessment with an ARD of 8/9/16. The facility staff coded that Resident #1 had a Cognitive Summary Score of 4. The facility staff also coded that Resident #1 required extensive (3/2) to total nursing care (4/2) with Activities of Daily Living (ADL's). On October 13, 2016 at 7:45 a.m. the surveyor reviewed Resident #1's clinical record. Review of the clinical record produced an Annual MDS assessment with an ARD of 2/26/16. The facility staff coded that Resident #1 had a Cognitive Summary Score of 4. The facility staff also coded that Resident #1 required limited (2/2) to total nursing care (4/2) with ADL's. In Section J. Health Conditions the facility staff coded that Resident #1 received scheduled pain medication and received PRN (as needed) pain medication over the past 5 days. In Section J the facility staff also coded that Resident #1 stated that she frequently had pain, had pain during the night and that the pain limited her day to day activities because of the pain. In Section V. Care Area Assessment Summary (CAA's) Resident #1 "triggered" for pain. The facility staff documented that a Comprehensive Care Plan (CCP) would be developed to address Resident #1 ' s pain. Continued review of the clinical record produced the CCP that was initiated on 3/3/16. Review of the CCP failed to produce a care plan that addressed Resident #1's pain. On October 13, 2016 at 8:35 a.m. the surveyor notified the Director of Nursing (DON) that the facility staff failed to develop a CCP for Resident #1. The surveyor notified the DON that the facility staff failed to develop a care plan that addressed Resident #1's pain. The surveyor and DON reviewed Resident #1's Annual MDS assessment with the ARD of 2/26/16. The surveyor pointed out that in Section V. CAA's Resident #1 "triggered"	F 279	Resident #9's comprehensive care plan has been reviewed and revised to reflect the current appropriate goals, interventions and approaches to address the resident's specific medical and treatment needs to include the need for restorative nursing care. A Facility Incident & Accident Form was completed for this incident. **Identification of Deficient Practices & Corrective Action(s):** All residents may have potentially been affected. A 100% review of all comprehensive care plans will be conducted by the DON, ADON, RCC and/or designee to identify residents with inaccurate or incomplete care plans. Resident identified with inaccurate or incomplete care plans will have their care plan reviewed and updated to reflect their current interventions and appropriate approaches to address their medical and treatment needs. A Facility Incident & Accident Form will be completed for each incident identified.	

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F 279	Continued From page 20 for pain and that the facility staff documented that a care plan would be developed to address Resident #1's pain. The surveyor and DON reviewed Resident #1's CCP dated 3/3/16. The DON was unable to locate a care plan that addressed Resident #1's pain. On October 13, 2016 at 4:20 p.m. the survey team met with the Administrator (Adm), DON and Corporate Compliance Nurse (CCN). The surveyor notified the Administrative Team (AT) that the facility staff failed to develop a CCP to include a care plan for pain for Resident #1. The surveyor notified the AT that Resident #1 "triggered" for pain on the Annual MDS assessment with the ARD of 2/26/16. The surveyor notified the AT that the facility staff documented that a care plan would be developed to address Resident #1's pain. The surveyor notified the AT that review of the CCP, dated 3/3/16, failed to produce a care plan for pain. No additional information was provided prior to exiting the facility as to why the facility staff failed to develop a CCP for Resident #1. 2. For Resident #5, facility staff failed to use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. Resident #5 was admitted to the facility on 6/9/16 with diagnoses including chronic kidney disease, hypertension, cognitive communication deficit, muscle weakness, and dementia with behavioral disturbance. On the quarterly minimum data assessment with assessment reference date 9/14/16, the resident scored 4/15 on the brief interview of mental status and exhibited symptoms of inattention, disorganized thinking, and daily wandering. The resident's annual MDS assessment with	F 279	**Systemic Changes:** The facility Policy and Procedure has been reviewed and no changes are warranted at this time. The nursing assessment process as evidenced by the 24 Hour Report and documentation in the medical record and physician orders will be used to develop and revise comprehensive plans of care. The RCC, IDT and the DON will be inserviced by the regional nurse consultant on the development and implementation process of individualized care plans. As well as the mandate to develop individualized care plans within 7 days of the completion and/or revisions to the comprehensive assessment and as indicated with any changes in resident condition. **Monitoring:** The RCC and DON are responsible for maintaining compliance. The facility care plan audit tool will be used for monitoring compliance. The DON and/or RCC will perform care plan audits weekly coinciding with the care plan calendar. Any/all negative findings will be reported to the DON / RCC for immediate correction. Detailed findings of the interdisciplinary team's audit will be reported to the Quality Assurance Committee for review, analysis, and recommendations for change in facility policy, procedure, and/or practice. **Completion Date:11/30/16**	

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assessment reference date 6/20/16 was not completed to include assessment documentation on the Care Area Assessment (CAA) worksheets or the CAA summary section of the assessment. During an interview on 10/12/16, the director of nursing stated that the former MDS coordinator had not put that information on the CAA summaries or CAA assessment worksheets. She stated she had interviewed the new MDS coordinator and the new coordinator reported that she also did not put that information in the MDS assessments.

The administrator and director of nursing were notified of the concern. The director of nursing stated that the information would be recorded on the CAA worksheets or CAA summaries in the future.

3. For Resident #7, facility staff failed to use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.

Resident #7 was admitted to the facility on 2/19/13 with diagnoses including non-Alzheimer's dementia without behavior, hypertension, diabetes mellitus, rheumatoid arthritis, dysphagia, anxiety, depression, bipolar disorder, and psychosis. On the quarterly minimum data set assessment (MDS) with assessment reference date 2/10/16, the resident scored 9/15 on the brief interview for mental status and was 4/8 on the assessment for delirium.

The comprehensive admission MDS assessment with assessment reference date 2/1/16 was not completed to include assessment documentation on the Care Area Assessment (CAA) worksheets or the CAA summary section of the assessment.

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F 279	Continued From page 22 During an interview on 10/12/16, the director of nursing stated that the former MDS coordinator had not put that information on the CAA summaries or CAA assessment worksheets. She stated she had interviewed the new MDS coordinator and the new coordinator reported that she also did not put that information in the MDS assessments. Clinical record review on 10/14/16 revealed a physician's order for Quetiapine fumarate 75 mg (milligram) tab 2 times a day Dx: dementia with associated behaviors. Quetiapine fumarate is an antipsychotic medication (also called Seroquel). The surveyor was unable to locate documentation of a diagnosis for which antipsychotic medication is approved. The surveyor was unable to locate documentation of the behaviors for which the antipsychotic medication had been ordered. The clinical record indicated that the resident had been receiving the medication at least since the last readmission from the hospital on 1/25/16. Behavior monitoring was documented from 1/25/16 through the end of the survey on 10/17/16. Physician notes did not document diagnoses or behaviors supporting the use of an antipsychotic medication. The resident's Psychotropic Quarterly Evaluations were blank under the section "Behavior warranting the use of medication". Clinical record review on 5/14/16 revealed a restorative nursing order dated 5/3/16 for "don resting hand splints to both hands for 4 hours per day". Restorative nursing records indicated the resident received the treatment 20 days in July 2016, 24 days in August 2016, and 20 days in	F 279		

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September 2016. The surveyor asked the restorative aid on 10/13/16 about the days the resident's hands were not splinted. The aid stated that the resident had received the treatment on the days the restorative aid worked. The aid was unaware of procedures for days when she did not work. The surveyor asked the resident's medication nurse if the resident's splinting was tracked and the nurse referred the surveyor to the restorative aid record. The surveyor interviewed the occupational therapist on 10/14/16 at 8:15 AM. The therapist stated that the expectation was for the splinting to be done daily to maintain condition. The therapist stated that the long-term treatment alternated between periods of active treatment, when splinting was not used (the resident was receiving active treatment from September 28 through the time of the survey) and passive treatment with splinting. He stated that failure to splint every day could contribute to deterioration of the resident's condition, but that it would not change the active-passive treatment cycles.

The resident's comprehensive care plan did not address the symptoms to be treated by the antipsychotic medication or the resident's contractures of both hands requiring occupational therapy.

The surveyor discussed the concern with restorative therapy and the lack of indication for the antipsychotic medication and the incomplete CAA summaries and worksheets on 10/13/14, and reported to the administrator, director of nursing, and a corporate clinical consultant on 10/14/16.

4. For Resident #9, facility staff failed to use the

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results of the assessment to develop, review and revise the resident's comprehensive plan of care.

Resident #9 was admitted to the facility on 12/3/10 with diagnoses including dementia, cardiopulmonary disease, cognitive/communication deficit, pain, general weakness, depression, anxiety, and dysphagia. On the quarterly minimum data set assessment (MDS) with assessment reference date 7/25/16, the resident scored 7/15 on the brief interview for mental status and was assessed as without signs of delirium, psychosis, or behaviors affecting others.

The comprehensive annual MDS assessment with assessment reference date 2/12/16 was not completed to include assessment documentation on the Care Area Assessment (CAA) worksheets or the CAA summary section of the assessment. During an interview on 10/12/16, the director of nursing stated that the former MDS coordinator had not put that information on the CAA summaries or CAA assessment worksheets. She stated she had interviewed the new MDS coordinator and the new coordinator reported that she also did not put that information in the MDS assessments.

During clinical record review on 10/14/17, the surveyor noted the resident's comprehensive care plan updated 7/28/16 indicated under Problem/Need: Occasional episodes of urinary incontinence related to loss of bladder muscle tone, on restorative nursing and under Goal: continue with RNP (restorative nursing plan). The surveyor asked for the resident's restorative notes, which were not available in the restorative documentation binder. During an interview on

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F 279	Continued From page 25 10/17/16, the restorative aid reported that the resident's restorative plan had ended on March 28 and that therapy had not addressed toileting. The director of nursing was unable to provide an explanation for the comprehensive care plan listing restorative toileting. The surveyor discussed the concern with restorative therapy the incomplete CAA summaries and worksheets on 10/17/14, and reported to the administrator, director of nursing, and a corporate clinical consultant on 10/17/16.	F 279		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced	F 280	**F-280** **Corrective Action(s):** Resident #5's comprehensive care plan has been reviewed and revised to reflect the resident's current dietary orders currently in place. A Facility Incident & Accident Form was completed for this incident. Resident #7's comprehensive care plan has been reviewed and revised to reflect the current indications for the use antipsychotic medication ss well as the restorative nursing interventions in place for contracture management. A Risk Management Incident & Accident Form was completed for this incident.	11/30/16

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by:

Based on staff interview and clinical record review it was dtermined that the facility staff failed to review and revise the Comprehensive Care Plan (CCP) for 5 of 17 Residents in the sample survey, Resident #5, Resident #7, Resident #8, Resident #9 and Resident #2.

1. For Resident #5, facility staff failed to ensure the comprehensive care plan was periodically reviewed and revised by a team of qualified persons after each assessment to address the resident's current condition.

Resident #5 was admitted to the facility on 6/9/16 with diagnoses including chronic kidney disease, hypertension, cognitive communication deficit, muscle weakness, and dementia with behavioral disturbance. On the quarterly minimum data assessment with assessment reference date 9/14/16, the resident scored 4/15 on the brief interview of mental status and exhibited symptoms of inattention, disorganized thinking, and daily wandering.

The resident's annual MDS assessment with assessment reference date 6/20/16 was not completed to include assessment documentation on the Care Area Assessment (CAA) worksheets or the CAA summary section of the assessment. During an interview on 10/12/16, the director of nursing stated that the former MDS coordinator had not put that information on the CAA summaries or CAA assessment worksheets. She stated she had interviewed the new MDS coordinator and the new coordinator reported that she also did not put that information in the MDS assessments.

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Resident #8's medication regime has been reviewed by the attending physician to determine the continued need for the antipsychotic medication Seroquel. Resident #8's comprehensive care plan has been reviewed and revised to reflect the current medications and measures in use to manage the resident's behaviors as well as non-medication interventions in use to manage behaviors. A Risk Management Incident & Accident Form was completed for this incident.

Resident #9's comprehensive care plan has been reviewed and revised and restorative nursing has been removed as an approach for bladder incontinence. Resident #9 has been screened by therapy for any possible interventions needed for bladder incontinence. A Risk Management Incident & Accident Form was completed for this incident.

Resident #2's comprehensive care plan has been reviewed and revised to reflect Hospice services are in place. The facility has incorporated the Hospice care plan into the facility's current plan of care for resident #2. A Risk Management Incident & Accident Form was completed for this incident.

Identification of Deficient Practices & Corrective Action(s):
Any/all residents may have potentially been affected. A 100% review of all resident comprehensive care plans will be conducted by the RCC and/or designee to identify residents at risk. Residents identified at risk will be corrected at time of discovery and a Risk Management Incident & Accident Form will be completed for each incident identified.

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During initial tour on 10/12/16, the surveyor observed the resident walking in the halls and then sitting in a chair in an alcove near the resident's room. The nurse touring with the resident stated that the resident walked a lot and liked to sit in the alcove where there was a view out the doors at the end of the hall and of the nurse's station. The surveyor observed the resident frequently walking in the halls or sitting in the chair in the alcove on 10/13 and 14. On 10/17/16 at 8:30 the surveyor found another resident in the room where the resident was observed the prior week. The resident was not in the dining room, the hall, or the alcove where he had been previously observed. The surveyor asked the nurse who had administered the resident's medications on 10/13/16 where the resident had gone. The nurse stated that there was a hospice resident in the room and he had probably been moved to give that resident privacy. The nurse was unable to say when the resident had moved. A second nurse said the resident had probably moved Friday or Saturday. The resident was observed in the new room sitting in a chair against the wall between the two beds with an overbed tray table and the resident's room mate in a wheelchair with his back to the resident between the resident and the door. The resident was in the chair with the tray table in front of him each of the 6 times the surveyor observed him on 10/17/16. The resident was not observed out of his room between 9 AM and 3 PM on 10/17/16.

The resident's comprehensive care plan (CCP) provided on 10/13/16 listed under problem/need: "Resident is on a regular diet with thin liquids. Resident has confusion..."with approaches including "provide diet as ordered honoring food

Systemic Changes:
The assessment process will continue to be utilized as the primary tool for developing comprehensive plans of care. The RCC is responsible for implementing the RAI Process. The nursing assessment process as evidenced by the 24 Hours Report and documentation in the medical record/physician orders will be used to develop and revise comprehensive plans of care. The Regional Nurse Consultant and/or RCC will provide in-service training to the interdisciplinary care plan team on the mandate to develop individualized care plans within 7 days of the completion of the comprehensive assessment and/or revisions to the comprehensive care plan as indicated with any changes in condition.

Monitoring:
The RCC and DON are responsible for maintaining compliance. The interdisciplinary team will audit all comprehensive care plans prior to finalization to monitor for compliance. Any/all negative findings will be reported to the DON and RCC for immediate correction. Detailed findings of the interdisciplinary team's audit will be reported to the Quality Assurance Committee for review, analysis, and recommendations for change in facility policy, procedure, and/or practice.
Completion Date:11/30/2016

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F 280	Continued From page 28 preferences as feasible". Clinical record review on 10/13/16 revealed a physician order dated 6/28/16 for regular diet double portions to breakfast, lunch, and dinner trays. Dietary services confirmed on 10/13/16 that the resident was receiving double potions on his trays. The administrator and director of nursing were notified of the concern on 10/13/16. 2. For Resident #7, facility staff failed to ensure the comprehensive care plan was periodically reviewed and revised by a team of qualified persons after each assessment to address the resident's current condition. Resident #7 was admitted to the facility on 2/19/13 with diagnoses including non-Alzheimer's dementia without behavior, hypertension, diabetes mellitus, rheumatoid arthritis, dysphagia, anxiety, depression, bipolar disorder, and psychosis. On the quarterly minimum data set assessment (MDS) with assessment reference date 2/10/16, the resident scored 9/15 on the brief interview for mental status and was 4/8 on the assessment for delirium. The comprehensive admission MDS assessment with assessment reference date 2/1/16 was not completed to include assessment documentation on the Care Area Assessment (CAA) worksheets or the CAA summary section of the assessment. During an interview on 10/12/16, the director of nursing stated that the former MDS coordinator had not put that information on the CAA	F 280		

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F 280	Continued From page 29 summaries or CAA assessment worksheets. She stated she had interviewed the new MDS coordinator and the new coordinator reported that she also did not put that information in the MDS assessments. Clinical record review on 10/14/16 revealed a physician's order for Quetiapine fumarate 75 mg (milligram) tab 2 times a day Dx: dementia with associated behaviors. Quetiapine fumarate is an antipsychotic medication (also called Seroquel). The surveyor was unable to locate documentation of a diagnosis for which antipsychotic medication is approved. The surveyor was unable to locate documentation of the behaviors for which the antipsychotic medication had been ordered. The clinical record indicated that the resident had been receiving the medication at least since the last readmission from the hospital on 1/25/16. Behavior monitoring was documented from 1/25/16 through the end of the survey on 10/17/16. Physician notes did not document diagnoses or behaviors supporting the use of an antipsychotic medication. The resident's Psychotropic Quarterly Evaluations were blank under the section "Behavior warranting the use of medication". Clinical record review on 5/14/16 revealed a restorative nursing order dated 5/3/16 for "don resting hand splints to both hands for 4 hours per day". Restorative nursing records indicated the resident received the treatment 20 days in July 2016, 24 days in August 2016, and 20 days in September 2016. The surveyor asked the restorative aid on 10/13/16 about the days the resident's hands were not splinted. The aid	F 280		

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stated that the resident had received the treatment on the days the restorative aid worked. The aid was unaware of procedures for days when she did not work. The surveyor asked the resident's medication nurse if the resident's splinting was tracked and the nurse referred the surveyor to the restorative aid record. The surveyor interviewed the occupational therapist on 10/14/16 at 8:15 AM. The therapist stated that the expectation was for the splinting to be done daily to maintain condition. The therapist stated that the long-term treatment alternated between periods of active treatment, when splinting was not used (the resident was receiving active treatment from September 28 through the time of the survey) and passive treatment with splinting. He stated that failure to splint every day could contribute to deterioration of the resident's condition, but that it would not change the active-passive treatment cycles.

The resident's comprehensive care plan did not address the symptoms to be treated by the antipsychotic medication or the resident's contractures of both hands requiring occupational therapy.

The surveyor discussed the concern with restorative therapy and the lack of indication for the antipsychotic medication and the incomplete CAA summaries and worksheets on 10/13/14, and reported to the administrator, director of nursing, and a corporate clinical consultant on 10/14/16.

3. For Resident #8, facility staff failed to ensure the comprehensive care plan was periodically reviewed and revised by a team of qualified persons after each assessment to address the

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resident's current condition.

Resident #8 was admitted to the facility on 1/16/13. Current diagnoses included dementia without behavior disturbance, hypertension, falls, anxiety, depression, and post traumatic stress disorder. On the quarterly minimum data set (MDS) assessment with assessment reference date 8/23/16, the resident scored 3/15 on the brief interview for mental status, 4/8 on for signs of delirium, no signs of psychosis, and physical and verbal behavior 1-3 days of the week.

The resident's annual MDS assessment with assessment reference date 12/28/16 was not completed to include assessment documentation on the Care Area Assessment (CAA) worksheets or the CAA summary section of the assessment. During an interview on 10/12/16, the director of nursing stated that the former MDS coordinator had not put that information on the CAA summaries or CAA assessment worksheets. She stated she had interviewed the new MDS coordinator and the new coordinator reported that she also did not put that information in the MDS assessments.

Clinical record review on 10/14/16 revealed a physician's order for Quetiapine fumarate 50 mg (milligram) tab take 1 tab by mouth 3 times a day Dx: dementia with associated behaviors. Quetiapine fumarate is an antipsychotic medication (also called Seroquel). The surveyor was unable to locate documentation of a diagnosis for which antipsychotic medication is approved. The surveyor was unable to locate documentation of the behaviors for which the antipsychotic medication had been ordered. The clinical record indicated that the resident had

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been receiving the medication at least since the last readmission from the hospital on 11/14/15. Behavior monitoring was documented from 8/28/16 through the end of the survey on 10/17/16. Behaviors documented included cursing, pacing, and hitting.

Physician notes did not document diagnoses or behaviors supporting the use of an antipsychotic medication. The resident's Psychotropic Quarterly Evaluations were blank under the section "Behavior warranting the use of medication".

The resident's comprehensive care plan did not address the symptoms to be treated by the antipsychotic medication.

The surveyor discussed the concern with the lack of indication for the antipsychotic medication and the incomplete CAA summaries and worksheets on 10/13/14, and reported to the administrator, director of nursing, and a corporate clinical consultant on 10/14/16.

On 10/17/16, the director of nursing offered a hospital geriatric psychiatric unit discharge plan dated 4/20/2012 documenting behaviors including hitting, kicking, pinching, and other oppositional combative behaviors with strategies to help manage those behaviors. Antipsychotic medications were not mentioned in the summary. The director of nursing also offered physician's notes from 2014. One note dated 4/1/14 stated "Pt seen for anxiety- has Parkinson's Dx- gets easily agitated. already on Seroquel & Namenda. Will add Aricept 5mg. Dx- Parkinson's, anxiety, dementia. Plan- start Aricept 5 mg". The resident did not have orders for medications to treat

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Parkinson's.

The adminsitrator and director of nursing were notified of the ongoing concern during a summary meeting on 10/17/16.

4. For Resident #9, facility staff failed to ensure the comprehensive care plan was periodically reviewed and revised by a team of qualified persons after each assessment to address the resident's current condition.

Resident #9 was admitted to the facility on 12/3/10 with diagnoses including dementia, cardiopulmonary disease, cognitive/communication deficit, pain, general weakness, depression, anxiety, and dysphagia. On the quarterly minimum data set assessment (MDS) with assessment reference date 7/25/16, the resident scored 7/15 on the brief interview for mental status and was assessed as without signs of delirium, psychosis, or behaviors affecting others.

The comprehensive annual MDS assessment with assessment reference date 2/12/16 was not completed to include assessment documentation on the Care Area Assessment (CAA) worksheets or the CAA summary section of the assessment. During an interview on 10/12/16, the director of nursing stated that the former MDS coordinator had not put that information on the CAA summaries or CAA assessment worksheets. She stated she had interviewed the new MDS coordinator and the new coordinator reported that she also did not put that information in the MDS assessments.

During clinical record review on 10/14/17, the

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F 280	Continued From page 34 surveyor noted the resident's comprehensive care plan updated 7/28/16 indicated under Problem/Need: Occasional episodes of urinary incontinence related to loss of bladder muscle tone, on restorative nursing and under Goal: continue with RNP (restorative nursing plan). The surveyor asked for the resident's restorative notes, which were not available in the restorative documentation binder. During an interview on 10/17/16, the restorative aid reported that the resident's restorative plan had ended on March 28 and that therapy had not addressed toileting. The director of nursing was unable to provide an explanation for the comprehensive care plan listing restorative toileting. The surveyor discussed the concern with restorative therapy thecare plan on 10/17/14, and reported to the administrator, director of nursing, and a corporate clinical consultant on 10/17/16. 5. For Resident #2 the facility staff failed to review and revise the Comprehensive Care Plan (CCP) to include a care plan for Hospice Services. Resident #2 was an 84 year old male who was admitted on 4/28/16. Admitting diagnoses included, but were not limited to: chronic obstructive pulmonary disease, dysphagia, seizures, pneumonia, myocardial infarction, osteoporosis and hypothyroidism. 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 10/11/16. The facility staff coded that Resident #2 had short and long term memory impairment (1/1) and was severely impaired (3) with daily decision making regarding Activities of Daily Living (ADL's). The facility staff also coded that Resident #2 required total nursing	F 280		

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F 280	Continued From page 35 care (4/2) with ADL's. In Section O. Special Treatments, Procedures, and Programs the facility staff coded that Resident #2 was receiving Hospice Services. On October 12, 2016 at 1:45 p.m. a surveyor made the initial tour of the facility. The facility staff identified that Resident #2 was receiving Hospice services. On October 14, 2016 at 7:45 a.m. the surveyor reviewed Resident #2's clinical record. Review of the clinical record produced the most current Comprehensive Care Plan (CCP) that was initiated on 10/13/16. Review of the CCP did not include the incorporation of a Hospice care plan. On October 14, 2016 at 9 a.m. the surveyor notified the Director of Nursing (DON) that Resident #2 was receiving Hospice Service and did not have care plan for Hospice Services. The surveyor and DON reviewed Resident #2's clinical record to include the CCP. The surveyor pointed out that the care plan did not include the incorporation of a Hospice care plan. On October 14, 2016 at 10 a.m. the survey team met with the Administrator (Adm), DON and Corporate Compliance Nurse (CCN). The surveyor notified the Administrative Team (AT) that the Resident #2 was receiving Hospice Services and did not have a care plan for Hospice Services. The surveyor notified the AT that the CCP did not include the incorporation of a Hospice care plan. No additional information was provided prior to exiting the facility as to why the facility staff failed to review and revise the CCP to include a care plan for the incorporation of Hospice Services for Resident #2.	F 280		
F 309 SS=E	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING	F 309		11/30/16

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F 309	Continued From page 36	F 309		11/30/16

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, in accordance with the comprehensive assessment and plan of care.

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 ensure the highest practicable wellbeing for 4 of 17 Residents in the sample survey, Resident #1, Resident #2, Resident #3 and Resident #10.
The Findings Included:
1. For Resident #1 the facility staff failed to follow a physician's order to notify the physician if Resident #1's blood sugar was greater than 500. Resident #1's blood sugar was 558 on 10/2/16 and the physician was not notified.
Resident #1 was a 76 year old female who was admitted on 3/28/15. Admitting diagnoses included, but were not limited to: uterine Cancer, diabetes mellitus, dementia without behaviors and failure to thrive.
The most current MDS located in the clinical record was a Quarterly MDS assessment with an ARD of 8/9/16. The facility staff coded that Resident #1 had a Cognitive Summary Score of 4. The facility staff also coded that Resident #1 required extensive (3/2) to total nursing care (4/2) with Activities of Daily Living (ADL's).
On October 13, 2016 at 7:45 a.m. the surveyor reviewed Resident #1's clinical record. Review of the clinical record produced signed physician

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Corrective Action(s):
Resident #1's attending physician was notified that the facility staff failed to notify the physician of a blood glucose over 500 per physician order. A facility Incident and Accident form was completed for this incident.

Resident #2's attending physician was notified that the facility staff failed to obtain a physician's order for hospice services prior to initiating hospice services, failed to incorporate hospice care and treatment notes in to the medical record and failed to obtain weekly weights as ordered by the physician. A facility Incident and Accident form was completed for this incident.

Residents #3's attending physician was notified that the facility failed to administer or follow the bowel protocol as ordered by the physician for resident #3 who did not have a bowel movement documented for 11days. A facility Incident and Accident form was completed for this incident.

Residents #10's attending physician was notified that the facility failed to administer or follow the bowel protocol as ordered by the physician for resident #10 who did not have a bowel movement documented for 14days. A facility Incident and Accident form was completed for this incident.

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 309 Continued From page 37
orders dated 9/28/16. Signed physician orders included, but were not limited to: "E11.9 Type2 diabetes mellitus without complications FSBS (finger stick blood sugar) AND QAM (every morning) and QHS (and at bedtime) NOTIFY MD IF LESS THAN 50 OR GREATER THAN 500 DX (diagnoses): DM (diabetes mellitus)." (sic) The order originated on 6/3/16.
Continued review of the clinical record produced the October 2016 Medication Administration Records (MAR's). Review of the October 2016 MAR's revealed that Resident #1's blood sugar was 558 on 10/2/16 at 8 p.m.
Further review of the clinical record failed to produce documentation that the facility staff notified the physician of Resident #1's blood sugar being 558 on 10/2/16 at 8 p.m.
On October 13, 2016 at 8:35 a.m. the surveyor notified the Director of Nursing (DON) that Resident #1 had a physician order to notify the physician if Resident #1's blood sugar was greater than 500. The surveyor notified the DON that Resident #1's blood sugar was 558 on 10/2/16 at 8 p.m. The surveyor and DON reviewed Resident #1's clinical record. The surveyor specifically pointed out the physician order to notify the physician if the blood sugar was greater than 500. The surveyor also pointed out that the October 2016 MAR's documented that Resident #1's blood sugar was 558 on 10/2/16 at 8 p.m. The DON reviewed the clinical record and was unable to locate documentation that the physician was notified of the blood sugar being 558 on 10/2/16.
On October 13, 2016 at 4:20 p.m. the survey team met with the Administrator (Adm), DON and Corporate Compliance Nurse (CCN). The surveyor notified the Administrative Team (AT) that the facility staff failed to follow physician

F 309

Identification of Deficient Practices/Corrective Action(s):
All other residents may have been potentially affected. The DON and/or ADON will conduct a 100% audit of all resident's physician orders, MAR's and ADL records to identify resident at risk. Residents identified at risk will be corrected at time of discovery and their comprehensive plan of care updated to reflect their resident specific needs. The attending physician will be notified of each negative finding and a facility Incident & Accident Form will be completed for each negative finding.

Systemic Change(s):
Facility policy and procedures have been reviewed. No revisions are warranted at this time. The nursing assessment process as evidenced by the 24 Hour Report and documentation in the medical record and physician orders remains the source document for the development and monitoring of the provision of care, which includes, obtaining, transcribing and completing physician medication orders & treatment orders. The DON and/or Regional nurse consultant will inservice all licensed staff on the procedure for obtaining, transcribing, and completing physician ordered medication and treatment orders and the monitoring of resident bowel protocols.

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F 309	Continued From page 38 orders for Resident #1. The surveyor notified the AT that Resident #1 had a physician order to notify the physician if Resident #1's blood sugar was greater than 500. The surveyor notified the AT that Resident #1's blood sugar was 558 on 10/2/16 at 8 p.m. The surveyor notified the AT that review of the clinical record failed to produce evidence/documentation that the physician was notified. No additional information was provided prior to exiting the facility as to why the facility staff failed to follow physician orders for Resident #1. 2. For Resident #2 the facility staff failed to obtain a physician's order prior to providing Hospice Service, failed to ensure that Hospice Notes were included within the clinical record and failed to obtain physician ordered weekly weights. Resident #2 was an 84 year old male who was admitted on 4/28/16. Admitting diagnoses included, but were not limited to: chronic obstructive pulmonary disease, dysphagia, seizures, pneumonia, myocardial infarction, osteoporosis and hypothyroidism. 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 10/11/16. The facility staff coded that Resident #2 had short and long term memory impairment (1/1) and was severely impaired (3) with daily decision making regarding Activities of Daily Living (ADL's). The facility staff also coded that Resident #2 required total nursing care (4/2) with ADL's. In Section O. Special Treatments, Procedures, and Programs the facility staff coded that Resident #2 was receiving Hospice Services. On October 12, 2016 at 1:45 p.m. a surveyor made the initial tour of the facility. The facility staff identified that Resident #2 was receiving	F 309	**Monitoring:** The DON is responsible for maintaining compliance. The DON and/or ADON will audit all MAR's and bowel movement reports weekly to monitor for compliance. Any/all negative findings or errors will be corrected at time of discovery and disciplinary action will be taken as needed. Aggregate findings of these audits will be reported to the Quality Assurance Committee quarterly for review, analysis, and recommendations for change in facility policy, procedure, and/or practice. **Completion Date:11/30/2016**	

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Hospice services.
On October 14, 2016 at 7:45 a.m. the surveyor reviewed Resident #2's clinical record. Review of the clinical record produced the most current signed Physician Order Sheets (POS's). The POS's were signed and dated 10 5/16. The signed and dated POS's did not include an order for Hospice services.
Continued review of the clinical record produced "Departmental Notes," nursing notes, that documented Hospice saw Resident #2 on 9/27/16, and 9/1/16.
Further review of the clinical record did not produce any Hospice notes in the clinical record since 9/6/16.
Additional review of the clinical record produced a physician telephone order dated 8/4/16. The physician telephone order read in part ... "weekly weights." (sic)
Further review of the clinical record failed to produce documentation that the weekly weights were obtained as ordered by the physician. The clinical record documented the following weights:

8/3/16	156.4
8/9/16	157.5
8/15/16	160.9
9/8/16	161.0
10/7/16	160.6

On October 14, 2016 at 8:50 a.m. the surveyor interviewed a Registered Nurse (RN #1) who was sitting at the nurses' station. The surveyor asked the RN (#1) if the facility had a Hospice notebook that contained Hospice Notes for Resident #2. RN (#1) answered, "No." The surveyor asked RN (#1) if the Hospice Nurse left notes with the facility staff when Hospice visited. RN (#1) stated, "No." RN (#1) stated that the Hospice Nurse got a facility staff member to sign off on their paper work each time they visited.

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F 309	Continued From page 40 On October 14, 2016 at 9 a.m. the surveyor notified the Director of Nursing (DON) that Resident #2 was receiving Hospice Service and did not have a physician's order to receive the Hospice Services. Additionally, the surveyor notified the DON that the Departmental Notes documented that Hospice saw Resident #2 on 9/27/16 and 9/1/16. The surveyor notified the DON that the most current Hospice Notes were dated 9/4/16. Lastly, the surveyor notified the DON that Resident #2 had a physician order to obtain weekly weights. The surveyor notified the DON that review of the clinical record failed to produce documentation that the weekly weights were obtained. The surveyor and DON reviewed Resident #2 ' s clinical record. The surveyor pointed out that the POS's signed and dated 10/5/16 did not include a physician order for Hospice Services. The surveyor reviewed the Departmental Notes with the DON and the surveyor pointed out that Hospice saw Resident #2 on 9/27/16 and 9/1/16. The surveyor then reviewed the Hospice Notes with the DON. The surveyor pointed out that the most current Hospice Note was dated 9/4/16. Lastly, the surveyor reviewed the telephone order dated 8/4/16 for the facility to obtain weekly weights. The surveyor reviewed the weights documented in the clinical record. The surveyor pointed out that the weekly weights were not obtained as ordered by the physician. The DON stated that the facility staff had monitored Resident #2's weights and thought that the weights were stable and so they decided to stop obtaining the weekly weights. The surveyor notified the DON that the order for the weekly weights had not been discontinued and still was an active order. On October 14, 2016 at 10 a.m. the survey team met with the Administrator (Adm), DON and	F 309		

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F 309	Continued From page 41 Corporate Compliance Nurse (CCN). The surveyor notified the Administrative Team (AT) that the Resident #2 was receiving Hospice Services and did not have a physician order for Hospice Services. The surveyor also notified the AT that review of the clinical record did not contain the most recent Hospice notes. The surveyor notified the AT that Hospice had seen Resident #2 on 9/27/16 and 9/1/16. The surveyor notified the AT that the most current Hospice Note was dated 9/4/16. Lastly, the surveyor notified the AT that Resident #2 had a physician order for weekly weights and that the weekly weights were not obtained as ordered by the physician. No additional information was provided prior to exiting the facility as to why the facility staff failed to obtain a physician order for Hospice Services prior to providing Hospice, failed to ensure that Hospice Notes were contained in the clinical record and failed to obtain physician ordered weekly weights. 3. For Resident #3 the facility staff failed to follow the bowel protocol. Resident #3 was a 57 year old male was originally admitted on 11/11/15 and readmitted on 8/19/16. Admitting diagnoses included, but were not limited to: chronic obstructive pulmonary disease, anxiety, impulse disorder and schizophrenia. The most current Minimum Data Set (MDS) assessment located in the clinical record was a 30 Day Medicare MDS assessment with an Assessment Reference Date (ARD) of 9/14/16. The facility staff coded that Resident #3 had a Cognitive Summary Score of 13. The facility staff also coded that Resident #3 required set up (1/1) to limited assistance (2/2) with Activities of Daily Living (ADL's). On October 13, 2016 at 9:25 a.m. the surveyor reviewed Resident #3's clinical record. Review of	F 309		

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F 309	Continued From page 42 the clinical record produced signed "Standing Orders" for Resident #3. The "Standing Orders" included, but were not limited to: "Constipation: MOM PO 1 oz. PRN (Milk of Magnesia by mouth 1 ounce as needed) (Not to exceed 2 days in a row). Duloclax sup. 10 mg Q day PRN (Dulcolax suppository 10 mg everyday as needed) (not to exceed 2 days in a row). Fleets enema Q Day PRN (Fleets enema everyday as needed). " (sic) Continued review of the clinical record produced the "Bowel Report Roster." Review of the "Bowel Report Roster" documented that Resident #3 did not have a bowel movement from 9/4/16 through 9/15/16. Continued review of the clinical record produced the September 2016 Medication Administration Records (MAR's). Review of the September 2016 MAR's did not document that the facility staff initiated the bowel protocol. Further review of the clinical record produced the "Departmental Notes," nursing notes, for September 2016. Review of the "Departmental Notes" failed to document assessment of Resident #3's gastrointestinal status. The Departmental Notes also failed to document that the facility staff notified the physician that Resident #3 did not have a bowel movement for 11 days. On October 13, 2016 at 11 a.m. the surveyor notified the Director of Nursing (DON) that Resident #3 went 11 days without having a bowel movement. The surveyor reviewed the clinical record with the DON. The surveyor reviewed the "Bowel Report Roster" with the DON and pointed out that Resident #3 did not have a bowel movement from 9/4/16 through 9/15/16. The surveyor also reviewed the September 2016 MAR's with the DON. The DON stated that Resident #3 was able to take himself to the	F 309		

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bathroom. The surveyor notified the DON that someone should have picked up on the fact that Resident #3 was not documented as having a bowel movement for 11 days. The surveyor informed the DON that the facility staff failed to assess, monitor and initiate the bowel protocol for Resident #3.

On October 13, 2016 at 4:20 p.m. the survey team met with the Administrator (Adm), DON and Corporate Compliance Nurse (CCN). The surveyor notified the Administrative Team (AT) that review of Resident #3's record failed to document a bowel movement for 11 days in September 2016. The surveyor notified the AT that the facility staff failed to assess, monitor and initiate the bowel protocol for Resident #3.

No additional information was provided prior to exiting the facility as to why the facility staff failed to implement physician ordered bowel protocol for Resident #3.

4. For Resident #10 the facility staff failed to monitor and assess for bowel movements.

Resident #10 went 12 days without a documented Bowel movement.

Resident #10 was a 47 year old female who was admitted on 9/29/16. Admitting diagnoses included, but were not limited to: open wound right ankle, Schizophrenia, seizures, insomnia and cellulitis of the right lower limb.

The most current Minimum Data Set (MDS) assessment located in the clinical record was an Admission and Medicare 5 Day MDS assessment with an Assessment Reference Date (ARD) of 10/6/16. The facility staff coded that Resident #10 had short and long term memory impairment (1/1) and was severely impaired (3) with daily decision making regarding Activities of Daily Living (ADL's). The facility staff also coded that Resident #10 required extensive (3/2) to total

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F 309	Continued From page 44 nursing care (4/2) with ADL's. The facility staff coded that Resident #10 was totally dependent (4/2) on staff for toileting. In Section H. Bowel and Bladder the facility staff coded that Resident #10 was frequently incontinent of bowels. On October 17, 2016 at 2:05 p.m. the surveyor reviewed Resident #10's clinical record. Review of the clinical record produced the "Bowel Report Roster." Review of the Bowel Report Roster failed to document a bowel movement for Resident #10 from October 3, 2016 through October 14, 2016. Further review of the clinical record produced the October 2016 Medication Administration Records (MAR's). Review of the October 2016 MAR's did not document the administration of a laxative. Continued review of the clinical record produced the "Departmental Notes," nursing notes. Review of the Departmental Notes failed to document assessment of Resident #10's gastrointestinal status. The Department Notes also did not document that the facility staff notified the physician that Resident #10 did not have a bowel movement for 12 days. On October 17, 2016 at 2:50 p.m. the surveyor notified the Corporate Compliance Nurse (CCN) that Resident #10 went 12 days without a documented bowel movement. The surveyor reviewed the clinical record with the CCN. The surveyor pointed out that Resident #10 did not have a bowel movement from October 3, 2016 through October 14, 2016. On October 17, 2016 at 3:25 p.m. the survey team met with the Administrator (Adm), Director of Nursing (DON) and CCN. The surveyor notified the Administrative Team (AT) that Resident #10 did not have a documented bowel movement from October 3, 2016 through October 14, 2016. The surveyor notified the AT that review of the clinical record did not produce	F 309		

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F 309	Continued From page 45 assessment, monitoring or physician notification that Resident #10 did not have a documented bowel movement for 12 days. No additional information was provided prior to exiting the facility as to why the facility staff failed to monitor, assess and notify the physician that Resident #10 did not have a documented bowel movement for 12 days.	F 309		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and clinical record review it was determined that the facility staff failed to obtain physician orders for routine Foley catheter care for 1 of 17 Residents in the sample survey, Resident #13. The Findings included: Resident #13 was a 92 year old female who was admitted on 10/4/16. Admitting diagnoses included, but were not limited to: left hip fracture, hypertension, hypothyroidism, dementia, depression, glaucoma and urinary retention. The most current Minimum Data Set (MDS) assessment located in the clinical record was an	F 315	**F315** **Corrective Action(s):** Resident #13's attending physician was notified that the facility failed to obtain complete Foley Catheter care orders to include when to change, flush, type and size of Foley catheter. A facility Incident & Accident report has been completed for this incident. **Identification of Deficient Practices & Corrective Action(s):** All other residents with a Foley Catheter may have potentially been affected. The DON and/or ADON will review 100% of residents with a Foley Cather to ensure each resident has specific Foley catheter orders. Any/all negative findings identified will be corrected at the time of discovery. A facility Incident & Accident Form will be completed for each incident identified.	11/30/16

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F 315	Continued From page 46 Admission and 5 Day Medicare MDS assessment with an Assessment Reference Date (ARD) of 10/10/16. The facility staff coded that Resident #13 had short and long term memory loss (1/1) and was severely impaired with daily decision making regarding Activities of Daily Living (ADL 's). The facility staff also coded that Resident #1 required total nursing care (4/3) with ADL's. In Section H. Bladder and Bowel the facility staff coded that Resident #13 had a indwelling catheter. On October 17, 2016 at 11:50 a.m. the surveyor observed Resident #13 lying in bed. A Foley catheter was observed on the right hand side of the bed and attached to the bedframe. Medium amber urine was observed in the Foley catheter tubing and bag. On October 17, 2016 at 11:55 a.m. the surveyor reviewed Resident #13's clinical record. Review of the clinical record produced signed physician orders dated 10/5/16. Signed physician orders included, but were not limited to: "Administer foley catheter care q (every) shift and prn (as needed)." (sic) The surveyor observed that the physician orders did not include orders for intake and output, Foley catheter size, bulb size, orders on how often to change the Foley catheter and orders to follow if the Foley catheter became dislodged or clogged. On October 17, 2016 at 12:40 p.m. the surveyor notified the Director of Nurses (DON) that Resident #13 had a Foley catheter. The surveyor notified the DON that review of the physician orders did not include orders intake and output, Foley catheter size, bulb size, orders on how often to change the Foley catheter and orders to follow if the Foley catheter became dislodged or clogged. The surveyor and DON reviewed Resident #13's clinical record. The surveyor	F 315	**Systemic Change(s):** Reviewed current facility policy and procedure, no changes warranted at this time. All licensed nursing will be inserviced by the DON and/or ADON on the proper Foley catheter care orders to be implemented for all residents with a physician ordered Foley Catheter. To include Foley size, Bulb size, treatment to be provided if dislodged or clogged as well when to change the Foley catheter and routine daily care. **Monitoring:** The DON and ADON are responsible for maintaining compliance. DON and/or ADON will complete post admission chart audits to monitor for compliance with routine Foley catheter care orders. Any negative findings will be corrected at time of discovery and disciplinary action will be taken as necessary. Aggregate findings will be reported to the QA Committee for review, analysis, and recommendations of change in facility policy, procedure, or practice. **Completion Date:11/30/2016**	

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F 318	Continued From page 49 On October 13, 2016 at 4:20 p.m. the survey team met with the Administrator (Adm), DON and Corporate Compliance Nurse (CCN). The surveyor notified the Administrative Team (AT) that Resident #3 had a physician's order for Restorative Nursing services for AROM and ambulation. The surveyor notified the AT that review of the clinical record failed to produce documentation verifying that the Restorative Nursing services were provided to Resident #3. No additional information was provided prior to exiting the facility as to why the facility staff failed to provide physician ordered Restorative Nursing services for Resident #3. 2. Resident #7 was admitted to the facility on 2/19/13 with diagnoses including non-Alzheimer's dementia without behavior, hypertension, diabetes mellitus, rheumatoid arthritis, dysphagia, anxiety, depression, bipolar disorder, and psychosis. On the quarterly minimum data set assessment (MDS) with assessment reference date 2/10/16, the resident scored 9/15 on the brief interview for mental status and was 4/8 on the assessment for delirium. Clinical record review on 5/14/16 revealed a restorative nursing order dated 5/3/16 for "don resting hand splints to both hands for 4 hours per day". Restorative nursing records indicated the resident received the treatment 20 days in July 2016, 24 days in August 2016, and 20 days in September 2016. The surveyor asked the restorative aid on 10/13/16 about the days the resident's hands were not splinted. The aid stated that the resident had received the treatment on the days the restorative aid worked. The aid was unaware of procedures for days when she did not work. The surveyor asked the resident's medication nurse if the resident's	F 318	findings of this audit will be reported to the Quality Assurance Committee for review, analysis, and recommendations for change in facility policy, procedure, and/or practice. **Completion Date:11/30/2016**	

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F 318	Continued From page 50 splinting was tracked and the nurse referred the surveyor to the restorative aid record. The surveyor interviewed the occupational therapist on 10/14/16 at 8:15 AM. The therapist stated that the expectation was for the splinting to be done daily to maintain condition. The therapist stated that the long-term treatment alternated between periods of active treatment, when splinting was not used (the resident was receiving active treatment from September 28 through the time of the survey) and passive treatment with splinting. He stated that failure to splint every day could contribute to deterioration of the resident's condition, but that it would not change the active-passive treatment cycles. The resident's comprehensive care plan did not address the resident's contractures of both hands requiring occupational therapy. The surveyor discussed the concern with restorative therapy with the administrator, director of nursing, and a corporate clinical consultant on 10/14/16.	F 318		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by:	F 323	**F323** **Corrective Action(s):** Resident #3's attending physician has been notified that facility staff failed to apply a physician ordered bed and wheelchair alarm per physician order. A facility incident and accident form has been completed for this incident.	11/30/16

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F 323	Continued From page 51 Based on observation, staff interview and clinical record review, it was determined that the facility staff failed to ensure an environment free of accident hazards for 1 of 17 Residents in the sample survey, Resident #3. The Findings included: For Resident #3 the facility staff failed to apply a physician ordered bed alarm and wheelchair alarm. Resident #3 was a 57 year old male was originally admitted on 11/11/15 and readmitted on 8/19/16. Admitting diagnoses included, but were not limited to: chronic obstructive pulmonary disease, anxiety, impulse disorder and schizophrenia. The most current Minimum Data Set (MDS) assessment located in the clinical record was a 30 Day Medicare MDS assessment with an Assessment Reference Date (ARD) of 9/14/16. The facility staff coded that Resident #3 had a Cognitive Summary Score of 13. The facility staff also coded that Resident #3 required set up (1/1) to limited assistance (2/2) with Activities of Daily Living (ADL's). On October 13, 2016 at 7:30 a.m. the surveyor observed Resident #3 lying in bed. Resident #3 was sleeping and had his head covered with the bed linens. The surveyor did not observe a bed or wheelchair alarm. On October 13, 2016 at 9:25 a.m. the surveyor reviewed Resident #3's clinical record. Review of the clinical record produced signed physician orders dated 9/19/16. Signed physician orders included, but were not limited to: "Pad alarm to bed and chair at all times." (sic) The order originated on 8/19/16. Continued review of the clinical record revealed the Comprehensive Care Plan (CCP) initiated on 8/25/16. The facility staff identified that Resident #3 was at risk for falls. The CCP read ...	F 323	**Identification of Deficient Practices/Corrective Action(s):** All other residents with physician ordered bed and wheelchair alarms or other preventive devices to prevent falls may have been potentially affected. The DON and/or ADON will conduct a 100% review of all residents with physician ordered alarms and fall prevention devices to identify residents at risk for inconsistent application and monitoring of the equipment. All residents identified at risk will be corrected at time of discovery and an Incident & Accident form will be completed for each negative finding. The attending physician will be notified of each incident. **Systemic Change(s):** The facility policy and procedure for fall prevention and management has been reviewed and no revisions are warranted at this time. The DON and/or regional nurse consultant will inservice all nursing staff regarding proper use of fall prevention equipments to include wheelchair and bed alarms to prevent falls.	

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F 323	Continued From page 52 "Problem/Need: Resident is at risk for falls related to decrease mobility, general muscle weakness last fall noted 7-7-16 NAI (no apparent injury). Goal &Target Date: Have no falls by next review." (sic) On October 13, 2016 at 8:15 a.m. Resident #3 was observed walking independently to the nurses' station. Resident #3 stepped to the nurses' desk and requested a cup of juice. On October 13, 2016 at 10:10 a.m. the surveyor observed Resident #3 dressed in street clothing and lying in bed. No bed or wheelchair alarm was observed by the surveyor. On October 13, 2016 at 11 a.m. the surveyor requested for the Director of Nursing (DON) to accompany her to Resident #3's room. The surveyor notified the DON that Resident #3 had a physician order for a bed and wheelchair alarm. The surveyor notified the DON that a bed or wheelchair alarm was not visible to the surveyor. The surveyor and DON walked to Resident #3's room and entered the room. Resident #3 was lying in bed. The DON was unable to locate a bed or wheelchair alarm. On October 13, 2016 at 4:20 p.m. the survey team met with the Administrator (Adm), DON and Corporate Compliance Nurse (CCN). The surveyor notified the Administrative Team (AT) that Resident #3 had a physician order for a bed and wheelchair alarm. The surveyor notified the AT that the facility staff had identified that Resident #3 was at risk for falls on the CCP. The surveyor notified the AT that Resident #3 was observed walking in the hallway independently. The surveyor also informed the AT that a bed and wheelchair alarm were not in place. No additional information was provided prior to exiting the facility as to why the facility staff failed to implement physician ordered safety	F 323	**Monitoring:** The DON is responsible for maintaining compliance. The DON and/or ADON will perform daily inspections of all residents with physician order fall prevention devices to monitor for compliance. Any/all negative findings will be corrected at time of discovery and disciplinary action will be taken as needed. Aggregate findings of these reviews will be reported to the Quality Assurance Committee quarterly for review, analysis, and recommendations for change in facility policy, procedure, and/or practice. **Completion Date:11/30/2016**	

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F 323 Continued From page 53 F 323

interventions for Resident #3.

F 328 SS=D 483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS F 328

The facility must ensure that residents receive proper treatment and care for the following special services:
Injections;
Parenteral and enteral fluids;
Colostomy, ureterostomy, or ileostomy care;
Tracheostomy care;
Tracheal suctioning;
Respiratory care;
Foot care; and
Prostheses.

This REQUIREMENT is not met as evidenced by:
Based on observation, staff interview and clinical record review, it was determined that the facility staff failed to administer oxygen as ordered by the physician for 1 of 17 Residents in the sample survey, Resident #4.
The Findings Included:
Resident #4 was a 76 year old female who was admitted on 10/26/15. Admitting diagnoses included, but were not limited to: chronic obstructive pulmonary disease, atrial fibrillation, diabetes mellitus, major depression, polyarthritis, fall and hyperlipidemia.
The most current Minimum Data Set (MDS) located in the clinical record was an Annual MDS assessment with an Assessment Reference Date (ARD) of 10/3/16. The facility staff coded that Resident #4 had a Cognitive Summary Score of 14. The facility staff also coded that Resident #4 required total nursing care (4/2) with Activities of

F 328

11/30/16

Corrective Action(s):
Resident #4 has had their oxygen administration orders clarified with the attending physician. The attending physician has been notified that the Resident #4 did not receive oxygen at the correct flow rate as ordered by the physician. A facility Incident & Accident form has been completed for this incident.

Identification of Deficient Practices & Corrective Action(s):
All residents receiving oxygen therapy may have potentially been affected. A 100% review of all residents oxygen orders will be conducted by the DON and/or ADON to identify residents at risk. Residents found to be at risk will be corrected at the time of discovery. A facility Incident & Accident form will be completed for each item discovered.

Systemic Change(s):
The facility policy and procedure for Oxygen administration has been reviewed and no changes were warranted at this time. All licensed nursing staff will be inserviced on the facility policy and procedure for accurate oxygen administration and monitoring per physician order. Inservices will include the delivery of oxygen per physician order and the monitoring of portable oxygen tanks throughout the shift.

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F 328	Continued From page 54 Daily Living (ADL's). In Section O Special Treatment, Procedures, and Programs the facility staff documented that Resident #4 received Oxygen. On October 12, 2016 at 3:15 p.m. the surveyor observed Resident #4 lying in bed and receiving Oxygen at 2 Liters per minute via a nasal cannula. On October 13, 2016 at 7:40 a.m. the surveyor observed Resident #4 lying in bed and receiving oxygen at 2 liters per minute via a nasal cannula. On October 13, 2016 at 1:20 p.m. the surveyor reviewed Resident #4's clinical record. Review of the clinical record produced signed physician orders dated 9/28/16. Signed physician orders included, but were not limited to: "O2 (oxygen) @ (at) 4LM (4 liters per minute) VIA N/C (nasal cannula) continuously." (sic) The order originated on 10/26/15. On October 13, 2016 at 2:15 p.m. the surveyor observed 2 Licensed Practical Nurses (LPN's #1 and #2) provide wound care to Resident #4. The surveyor observed that Resident #4 was receiving oxygen at 2 liters per minute via nasal cannula. After the wound care was provided the surveyor and LPN (#2) stepped out into the hallway. The surveyor notified LPN (#2) that Resident #4 was receiving oxygen at 2 liters a minute, however, the physicians' order ordered for the oxygen to be administered at 4 liters per minute. The surveyor asked for LPN (#2) to go back into Resident #4's room and verify that the oxygen was being administered at 2 liters a minute. LPN (#2) stepped back into Resident #4's room and observed Resident #4's oxygen. LPN (#2) verified that Resident #4 was receiving oxygen at 2 liters per minute. The surveyor asked for LPN (#2) to accompany her to the conference room to review Resident #4's clinical record. The LPN	F 328	**Monitoring:** The DON is responsible for maintaining compliance. The DON and/or ADON will perform daily audits of all residents using oxygen to monitor for compliance. All negative findings will be corrected at time of discovery and appropriate disciplinary action will be taken as needed. All negative findings will be reported to the Quality Assurance Committee for review, analysis, and recommendations for change in facility policy, procedure, and/or practice. **Completion Date:11/30/2016**	

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F 328	Continued From page 55 (#4) and the surveyor walked to the conference room and reviewed Resident #4's clinical record. The surveyor pointed out the specific physician order for Resident #4 to receive oxygen at 4 Liters per minute. On October 13, 2016 at 2:50 p.m. the surveyor notified the Administrator (Adm) and Director of Nursing (DON) that Resident #4 was observed on multiple occasions receiving oxygen at 2 liters per minute. The surveyor notified the Adm and DON that Resident #4's physicians' order for oxygen ordered for the oxygen to be administered at 4 liters per minute. On October 13, 2016 at 4:20 p.m. the survey team met with the Adm, DON and Corporate Compliance nurse (CCN). The surveyor notified the Administrative Team (AT) that Resident #4 was observed on several occasions receiving oxygen at 2 liters per minute. The surveyor notified the AT that Resident #4 physicians' order read to administer oxygen ay 4 liters per minute. No additional information was provided as to why the facility staff failed to administer oxygen as ordered by the physician for Resident #4.	F 328		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a	F 329	**F 329** **Corrective Action(s):** Resident #10's attending physician was notified that the facility staff failed to perform behavior monitoring prior to and after administration of the antipsychotic medications Seroquel and Haldol. A facility Incident & Accident form and a medication error form was completed for this incident.	11/30/16

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F 329	Continued From page 56 resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review it was determined that the facility staff failed to ensure that 3 or 17 Residents in the sample survey were free from unnecessary medications, Resident #10, Resident #7 and Resident #8. The Findings Included: 1. For Resident #10 the facility staff failed to monitor for psychotropic drug use, Seroquel and Haldol, to include specific behaviors, interventions, side effects and effectiveness of drug use. Resident #10 was a 47 year old female who was admitted on 9/29/16. Admitting diagnoses included, but were not limited to: open wound right ankle, Schizophrenia, seizures, insomnia and cellulitis of the right lower limb. The most current Minimum Data Set (MDS) assessment located in the clinical record was an Admission and Medicare 5 Day MDS assessment with an Assessment Reference Date (ARD) of 10/6/16. The facility staff coded that Resident	F 329	Resident #8's attending physician was notified that the facility staff failed to perform behavior monitoring prior to and after administration of the antipsychotic medications Seroquel. The attending physician has reviewed the medication regime for resident #8 to provide an appropriate diagnosis and behaviors to be monitored and to review for any possible adjustments or reductions to the antipsychotic medication usage. A facility Incident & Accident form and a medication error form was completed for this incident. Resident #7's attending physician was notified that the facility staff failed to perform behavior monitoring prior to and after administration of the antipsychotic medications Seroquel. The attending physician has reviewed the medication regime for resident #7 to provide an appropriate diagnosis and behaviors to be monitored and to review for any possible adjustments or reductions to the antipsychotic medication usage. A facility Incident & Accident form and a medication error form was completed for this incident.	

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F 329	Continued From page 57 #10 had short and long term memory impairment (1/1) and was severely impaired (3) with daily decision making regarding Activities of Daily Living (ADL's). The facility staff also coded that Resident #10 required extensive (3/2) to total nursing care (4/2) with ADL's. On October 17, 2016 at 2:05 p.m. the surveyor reviewed Resident #10's clinical record. Review of the clinical record produced signed physician orders dated 10/5/16. Signed physician orders included, but were not limited to: "Quetiapine Fumarate (Seroquel) 300 mg tab (tablet) give one tablet by mouth dx. (diagnoses) dementia with behaviors (this medication was being administered at 6 a.m.), Quetiapine Fumarate 400 mg tab (tablet) give on tablet by mouth at bedtime dx. dementia with behaviors, Quetiapine Fumarate 300 mg tab give one tablet at noon. Haldol 5 mg tablet give one table by mouth two times a day dx: schizophrenia." (sic) Continued review of the clinical record failed to produce monitoring for specific behaviors, interventions, side effects and effectiveness in the administration of the Seroquel and Haldol. On October 17, 2016 at 2:50 p.m. the surveyor notified the Corporate Compliance Nurse (CCN) that Resident #10 received Seroquel and Haldol. The surveyor notified the CCN that review of the clinical record failed to produce behavior monitoring to include specific behaviors, interventions, side effects and effectiveness of the Seroquel and Haldol use. The CCN asked if the surveyor had looked at the Medication Administration Records (MAR's). The surveyor informed the CCN that the MAR's had been reviewed and that behavior monitoring was not on the MAR's. The surveyor reviewed Resident #10's clinical record with the CCN. The surveyor pointed out the physician orders for the Seroquel	F 329	**Identification of Deficient Practice(s) and Corrective Action(s):** All other residents receiving antipsychotic medications may have been potentially affected. The DON and/or ADON will review the medication orders of all residents receiving antipsychotic medication to ensure that an appropriate diagnosis for use and the required monitoring are in place and being completed. Any/all negative findings will be communicated to the attending physicians for corrective action. A Facility Incident & Accident form will be completed for each negative finding. **Systemic Change(s):** The facility Policy and Procedure has been reviewed. No revisions are warranted at this time. All nursing staff will be inserviced by the DON and/or regional nurse consultant and issued a copy of the facility policy and procedure for proper administration and monitoring of all medications. This includes pre-administration and post administration monitoring of antipsychotic medications. **Monitoring:** The DON is responsible for maintaining compliance. The DON and/or ADON will complete weekly MAR audits to monitor for compliance. All negative findings will be corrected immediately and appropriate disciplinary action will be taken as necessary. Aggregate findings of these audits will be provided to the Quality Assurance Committee for review, analysis, and recommendations for change in facility policy, procedure, and/or practice. **Completion Date:11/30/2016**	

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and Haldol. The CCN was unable to locate behavior monitoring to include specific behaviors, interventions, side effects and effectiveness of the psychotropic drug use.
On October 17, 2016 at 3:25 p.m. the survey team met with the Administrator (Adm), Director of Nursing (DON) and CCN. The surveyor notified the Administrative Team (AT) that Resident #10 was receiving Seroquel and Haldol and that behavior monitoring to include specific behaviors, interventions, side effects and effectiveness 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 monitor for psychotropic drug use, Seroquel and Haldol, to include specific behaviors, interventions, side effects and effectiveness for Resident #10.
2. For Resident #8, facility staff failed to provide adequate monitoring and adequate indications for the use of quetiapine fumarate (Seroquel).

Resident #8 was admitted to the facility on 1/16/13. Current diagnoses included dementia without behavior disturbance, hypertension, falls, anxiety, depression, and post traumatic stress disorder. On the quarterly minimum data set (MDS) assessment with assessment reference date 8/23/16, the resident scored 3/15 on the brief interview for mental status, 4/8 on for signs of delirium, no signs of psychosis, and physical and verbal behavior 1-3 days of the week.

The resident's annual MDS assessment with assessment reference date 12/28/16 was not completed to include assessment documentation on the Care Area Assessment (CAA) worksheets or the CAA summary section of the assessment.

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During an interview on 10/12/16, the director of nursing stated that the former MDS coordinator had not put that information on the CAA summaries or CAA assessment worksheets. She stated she had interviewed the new MDS coordinator and the new coordinator reported that she also did not put that information in the MDS assessments.

Clinical record review on 10/14/16 revealed a physician's order for Quetiapine fumarate 50 mg (milligram) tab take 1 tab by mouth 3 times a day Dx: dementia with associated behaviors. Quetiapine fumarate is an antipsychotic medication (also called Seroquel). The surveyor was unable to locate documentation of a diagnosis for which antipsychotic medication is approved. The surveyor was unable to locate documentation of the behaviors for which the antipsychotic medication had been ordered. The clinical record indicated that the resident had been receiving the medication at least since the last readmission from the hospital on 11/14/15. Behavior monitoring was documented from 8/28/16 through the end of the survey on 10/17/16. Behaviors documented included cursing, pacing, and hitting.

Physician notes did not document diagnoses or behaviors supporting the use of an antipsychotic medication. The resident's Psychotropic Quarterly Evaluations were blank under the section "Behavior warranting the use of medication".

The resident's comprehensive care plan did not address the symptoms to be treated by the antipsychotic medication.

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The surveyor discussed the concern with the lack of indication for the antipsychotic medication and the incomplete CAA summaries and worksheets on 10/13/14, and reported to the administrator, director of nursing, and a corporate clinical consultant on 10/14/16.

On 10/17/16, the director of nursing offered a hospital geriatric psychiatric unit discharge plan dated 4/20/2012 documenting behaviors including hitting, kicking, pinching, and other oppositional combative behaviors with strategies to help manage those behaviors. Antipsychotic medications were not mentioned in the summary. The director of nursing also offered physician's notes from 2014. One note dated 4/1/14 stated "Pt seen for anxiety- has Parkinson's Dx- gets easily agitated. already on Seroquel & Namenda. Will add Aricept 5mg. Dx- Parkinson's, anxiety, dementia. Plan- start Aricept 5 mg". The resident did not have orders for medications to treat Parkinson's.

The adminsitrator and director of nursing were notified of the ongoing concern during a summary meeting on 10/17/16.

3. For Resident #7, facility staff failed to provide adequate monitoring for the use of quetiapine (Seroquel).

Resident #7 was admitted to the facility on 2/19/13 with diagnoses including non-Alzheimer's dementia without behavior, hypertension, diabetes mellitus, rheumatoid arthritis, dysphagia, anxiety, depression, bipolar disorder, and psychosis. On the quarterly minimum data set assessment (MDS) with assessment reference date 2/10/16, the resident scored 9/15 on the

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F 329	Continued From page 61 brief interview for mental status and was 4/8 on the assessment for delirium. The comprehensive admission MDS assessment with assessment reference date 2/1/16 was not completed to include assessment documentation on the Care Area Assessment (CAA) worksheets or the CAA summary section of the assessment. During an interview on 10/12/16, the director of nursing stated that the former MDS coordinator had not put that information on the CAA summaries or CAA assessment worksheets. She stated she had interviewed the new MDS coordinator and the new coordinator reported that she also did not put that information in the MDS assessments. Clinical record review on 10/14/16 revealed a physician's order for Quetiapine fumarate 75 mg (milligram) tab 2 times a day Dx: dementia with associated behaviors. Quetiapine fumarate is an antipsychotic medication (also called Seroquel). The surveyor was unable to locate documentation of a diagnosis for which antipsychotic medication is approved. The surveyor was unable to locate documentation of the behaviors for which the antipsychotic medication had been ordered. The clinical record indicated that the resident had been receiving the medication at least since the last readmission from the hospital on 1/25/16. Behavior monitoring was documented from 1/25/16 through the end of the survey on 10/17/16. Physician notes did not document diagnoses or behaviors supporting the use of an antipsychotic medication. The resident's Psychotropic Quarterly Evaluations were blank under the section "Behavior warranting the use of	F 329		

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F 329	Continued From page 62 medication". Clinical record review on 5/14/16 revealed a restorative nursing order dated 5/3/16 for "don resting hand splints to both hands for 4 hours per day". Restorative nursing records indicated the resident received the treatment 20 days in July 2016, 24 days in August 2016, and 20 days in September 2016. The surveyor asked the restorative aid on 10/13/16 about the days the resident's hands were not splinted. The aid stated that the resident had received the treatment on the days the restorative aid worked. The aid was unaware of procedures for days when she did not work. The surveyor asked the resident's medication nurse if the resident's splinting was tracked and the nurse referred the surveyor to the restorative aid record. The surveyor interviewed the occupational therapist on 10/14/16 at 8:15 AM. The therapist stated that the expectation was for the splinting to be done daily to maintain condition. The therapist stated that the long-term treatment alternated between periods of active treatment, when splinting was not used (the resident was receiving active treatment from September 28 through the time of the survey) and passive treatment with splinting. He stated that failure to splint every day could contribute to deterioration of the resident's condition, but that it would not change the active-passive treatment cycles. The resident's comprehensive care plan did not address the symptoms to be treated by the antipsychotic medication or the resident's contractures of both hands requiring occupational therapy. The surveyor discussed the concern with	F 329		

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F 329	Continued From page 63 restorative therapy and the lack of indication for the antipsychotic medication and the incomplete CAA summaries and worksheets on 10/13/14, and reported to the administrator, director of nursing, and a corporate clinical consultant on 10/14/16.	F 329		
F 425 SS=E	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. 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. The facility must employ or obtain the services of a licensed pharmacist who 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 and clinical record review it was determined that the facility staff failed to ensure that physician ordered medications were available for administration for 1 of 17 Residents in the sample survey, Resident	F 425	**F425** **Corrective Action(s):** Resident #10's attending physician has been notified that the facility failed to ensure that physician ordered medications Eszopiclone 2mg, Tramadol and Bactrim DS were unavailable from pharmacy for administration to Resident #10. A facility Incident and Accident form has been completed for this incident. **Identification of Deficient Practices & Corrective Action(s):** All residents may have potentially been affected. A 100% review of all resident's medication regimen has been conducted by the DON and/ or ADON to identify residents at risk. Residents found to be at risk due to the medication being unavailable from the pharmacy will be corrected at time of discovery and their attending physician will be notified. A facility Incident and Accident form has been completed for each.	11/30/16

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#10.
The Findings Included:
Resident #10 was a 47 year old female who was admitted on 9/29/16. Admitting diagnoses included, but were not limited to: open wound right ankle, Schizophrenia, seizures, insomnia and cellulitis of the right lower limb.
The most current Minimum Data Set (MDS) assessment located in the clinical record was an Admission and Medicare 5 Day MDS assessment with an Assessment Reference Date (ARD) of 10/6/16. The facility staff coded that Resident #10 had short and long term memory impairment (1/1) and was severely impaired (3) with daily decision making regarding Activities of Daily Living (ADL's). The facility staff also coded that Resident #10 required extensive (3/2) to total nursing care (4/2) with ADL's.
On October 17, 2016 at 2:05 p.m. the surveyor reviewed Resident #10's clinical record. Review of the clinical record produced signed physician orders dated 10/5/16. Signed physician orders included, but were not limited to: "Eszopiclone 2 mg tablet give one tablet by mouth at bedtime dx: (diagnoses) insomnia, Tramadol HCl 50 mg tablet take 2 tabs (tablets) (100mg) po (by mouth) TID (three times a day) dx. pain, Bactrim DS tablet take 1 tab po BID (twice a day) dx: right surg (surgical) ankle wound infection." (sic)
Continued review of the clinical record produced the October 2016 Medication Administration Records (MAR's). Review of the October 2016 MAR's documented that the Eszopiclone 2 mg was not available for administration at 9 p.m. on 10/3/16, 10/4/16, 10/5/16, 10/6/16, 10/7/16, 10/10/16, 10/11/16 and 10/14/16. The October 2016 MAR's also documented that the Tramadol was not available for administration on 10/11/16 at 2 p.m. and 10 p.m., 10/12/16 at 6 a.m., 2 p.m.

Systemic Changes:
The Pharmacy Policy and Procedure has been reviewed and no changes are warranted. All licensed nursing staff have been inserviced on the Policy and Procedure for medication administration to included medications that are unavailable or do not arrive at the facility timely from the pharmacy. The inservice will include the steps the nurse should take should a medication not be delivered timely from the pharmacy.

Monitoring:
The DON is responsible for maintaining compliance. The DON will conduct reviews of resident medication orders each week to confirm the availability of all ordered drugs. All negative findings will be corrected at the time of discovery. Results of the reviews will be reported to the Quality Assurance Committee for review, analysis, and recommendations for change in facility policy, procedure, and/or practice.
Completion Date:11/30/2016

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The October 2016 MAR's also documented that the Bactrim DS was not available for administration on 10/11/16 at 9 p.m.
On October 17, 2016 at 2:50 p.m. the surveyor notified the Corporate Compliance Nurse (CCN) that Resident #10 had multiple physician ordered medications that were not available for administration. The surveyor reviewed the clinical record with the CCN and specifically pointed out that the Eszopiclone, Tramadol and Bactrim were not available for administration on multiple occasions. The surveyor asked the CCN if the facility had a backup pharmacy and the CCN stated that she was sure that the facility did have a backup pharmacy. But the CCN did not know the name of the pharmacy. The CCN stated she would check with the Director of Nurses (DON).
On October 17, 2016 at 3:15 p.m. the DON was notified that Resident #10 had multiple physician ordered medications that were not available for administration. The DON stated that the facility had a backup pharmacy and named a local pharmacy. The surveyor asked for the facility policy and procedure for obtaining medications.
On October 17, 2016 at 3:30 p.m. the DON hand delivered the facility policy and procedure titled, "5.2 Receipt of Interim/Stat/emergency Deliveries." The policy and procedure read in part ...
"Receipt of Interim/Stat/Emergency Deliveries," that had been left on the table in the conference room. The policy and procedure read in part ...
"Procedure 1. The Facility should immediately notify the Pharmacy when the Facility receives from a Physician/Prescriber a medication order that may require an interim/stat/emergency delivery. 2. If a necessary medication is not contained within the Facility's interim/stat/emergency supply, and the Facility

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F 425	Continued From page 66 determined that an interim/stat/emergency delivery is necessary, the Facility should arrange either: 2.1 With Pharmacy to include the interim/stat/emergency medication(s) in an earlier scheduled delivery or a special delivery, as required, or 2.2 For delivery by contract courier, or 2.3 For the medication to be dispensed and delivered by a Third Party Pharmacy to ensure timely receipt." On October 17, 2016 at 3:25 p.m. the survey team met with the Administrator (Adm), Director of Nursing (DON) and CCN. The surveyor notified the Administrative Team (AT) that Resident #10 did not have physician ordered medications available on multiple occasions in October 2016. No additional information was provided prior to exiting the facility as to why the facility staff failed to ensure that physician ordered medications were available for administration for Resident #10.	F 425		
F 502 SS=D	483.75(j)(1) ADMINISTRATION 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: Based on staff interview and clinical record review, it was determined that the facility staff failed to obtain physician ordered laboratory testing for 1 of 17 Residents in the sample survey, Resident #2. The Findings Included: For Resident #2 the facility staff failed to obtain	F 502	**F502** **Corrective Action(s):** Resident #2's attending physician has been notified that the facility failed to obtain a TSH level test as ordered by the physician. A Facility Incident & Accident form has been completed for the missing labs.	11/30/16

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physician's ordered laboratory testing. The facility staff failed to obtain a TSH level ordered on 8/4/16.
Resident #2 was an 84 year old male who was admitted on 4/28/16. Admitting diagnoses included, but were not limited to: chronic obstructive pulmonary disease, dysphagia, seizures, pneumonia, myocardial infarction, osteoporosis and hypothyroidism.
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 10/11/16. The facility staff coded that Resident #2 had short and long term memory impairment (1/1) and was severely impaired (3) with daily decision making regarding Activities of Daily Living (ADL's). The facility staff also coded that Resident #2 required total nursing care (4/2) with ADL's.
On October 14, 2016 at 7:45 a.m. the surveyor reviewed Resident #2's clinical record. Review of the clinical record produced a physician telephone order dated 8/4/16 that read in part ... "CBC, CMP, PSA/ Magnesium/TSH." (sic)
Continued review of the clinical record produced the results of the CBC, CMP, PSA and Magnesium level obtained on 8/5/16. Review of the clinical record failed to produce the results of the physician ordered TSH.
On October 14, 2016 at 9 a.m. the surveyor notified the Director of Nursing (DON) that Resident #2 had a physician telephone order on 8/4/16 to obtain a CBC, CMP, PSA, Magnesium and a TSH. The surveyor notified the DON that review of the clinical record failed to produce the results of the physician ordered TSH. The surveyor and Don reviewed the clinical record. The surveyor specifically pointed out the physician telephone order to obtain the CBC,

F 502

Identification of Deficient Practice(s) & Corrective Action(s):
All other residents who had physician ordered lab tests may have potentially been affected. A 100% audit of all resident lab orders will be completed to identify residents at risk. All negative findings will be corrected at the time of discovery. The attending physicians will be notified of the missing labs, labs not obtained timely and labs obtained without a physician order. A facility Incident & Accident Form will be completed.

Systemic Changes:
The facility policy and procedure has been reviewed and no changes are warranted at this time. The laboratory tracking system has been reviewed with the DON and the ADON and has been implemented to track and validate that required lab work has been completed per physician order and policy and procedure. The DON and/or Nurse Consultant will inservice all licensed staff on physician ordered laboratory-testing, protocols, & tracking system used.

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F 504	Continued From page 69 8/19/16. Resident #2 was an 84 year old male who was admitted on 4/28/16. Admitting diagnoses included, but were not limited to: chronic obstructive pulmonary disease, dysphagia, seizures, pneumonia, myocardial infarction, osteoporosis and hypothyroidism. 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 10/11/16. The facility staff coded that Resident #2 had short and long term memory impairment (1/1) and was severely impaired (3) with daily decision making regarding Activities of Daily Living (ADL's). The facility staff also coded that Resident #2 required total nursing care (4/2) with ADL's. On October 14, 2016 at 7:45 a.m. the surveyor reviewed Resident #2's clinical record. Review of the clinical record produced signed physician orders dated 10/5/16. Signed physician orders included, but were not limited to: "Keppra level Q 3 months (Aug/Nov/Feb/May) (August/November/February/May)." (sic) This order started on 8/4/16. "Levetiracetam (Keppra) 500 mg tablet take one tablet by mouth twice a day Dx. Anti seizure. Generic: Levetiracetam." (sic) This order started on 4/28/16. Continued review of the clinical record produced Keppra levels obtained on 8/7/16 and 8/19/16. The surveyor was unable to locate a physician's order to obtain the second Keppra level on 8/19/16. On October 14, 2016 at 9 a.m. the surveyor notified the Director of Nursing (DON) that Resident #2 had a physician order to obtain a Keppra level every August, November, February and May. The surveyor notified the DON that review of the clinical record produced the results	F 504	**Identification of Deficient Practice(s) & Corrective Action(s):** All other residents may have potentially been affected. A 100% audit of resident clinical records will be completed to identify residents who may have had laboratory tests completed without a physician order. All negative findings will be corrected at the time of discovery and the attending physician will be notified. A Facility Incident & Accident form will be completed for each incident. **Systemic Changes:** The facility policy and procedure has been reviewed and no changes are warranted at this time. Licensed staff will be inserviced on the policy and procedure for obtaining resident laboratory tests, which includes obtaining a physician order prior to obtaining the lab test. **Monitoring:** The DON is responsible for maintaining compliance. The DON or ADON will review all lab tests results weekly to ensure that all resident lab tests obtained had an appropriate physician order for the lab tests prior to obtaining. Any negative findings will be reported to the attending physician and the appropriate disciplinary action taken for staff involved. The results of these audits will be reported to the Quality Assurance Committee for review, analysis, & recommendations for change in facility policy, procedure, and/or practice. **Completion Date:11/30/2016**	

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F 504	Continued From page 70 of two Keppra levels in August 2016. The surveyor notified the DON that the Keppra levels were obtained on 8/7/16 and 8/19/16. The surveyor notified the DON that review of the clinical record did not produce a physician ' s order to obtain the second Keppra level on 8/19/16. The DON reviewed the clinical record and could not locate a physician order to obtain the Keppra level on 8/19/16. On October 14, 2016 at 9:45 a.m. the DON approached the surveyor and informed the surveyor that the Keppra level should not have been obtained on 8/19/16. On October 14, 2016 at 10 a.m. the survey team met with the Administrator (Adm), DON and Corporate Compliance Nurse (CCN). The surveyor notified the Administrative Team (AT) that the facility staff failed to obtain a physician's order prior to obtaining a Keppra level on 8/19/16 on Resident #2. No additional information was provided prior to exiting the facility as to why the facility staff failed to obtain a physician's order prior to obtaining a Keppra level on 8/19/16 on Resident #2. 2. For Resident #3 the facility staff failed to obtain a physician order prior to obtaining a BMP on 9/24/16. Resident #3 was a 57 year old male was originally admitted on 11/11/15 and readmitted on 8/19/16. Admitting diagnoses included, but were not limited to: chronic obstructive pulmonary disease, anxiety, impulse disorder and schizophrenia. The most current Minimum Data Set (MDS) assessment located in the clinical record was a 30 Day Medicare MDS assessment with an Assessment Reference Date (ARD) of 9/14/16. The facility staff coded that Resident #3 had a Cognitive Summary Score of 13. The facility staff also coded that Resident #3 required set up (1/1)	F 504		

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F 504	Continued From page 71 to limited assistance (2/2) with Activities of Daily Living (ADL's). On October 13, 2016 at 9:25 a.m. the surveyor reviewed Resident #3's clinical record. Review of the clinical record produced signed physician orders dated 9/19/16. Signed physician orders included, but were not limited to: "BMP weekly X (times) 6 weeks then monthly." (sic) The order originated on 8/25/16. Continued review of the clinical record revealed the results of a BMP on 9/23/16 and 9/24/16. Further review of the clinical record failed to produce a physician's order to obtain the BMP on 9/24/16. On October 13, 2016 at 11 a.m. the surveyor notified the Director of Nursing (DON) that Resident #3 had 2 BMP's done on 9/23/16 and 9/24/16. The surveyor notified the DON that a physician's order could not be located to obtain the BMP on 9/24/16. The surveyor and DON reviewed Resident #3's clinical record. The surveyor reviewed the physician order for the weekly BMP on 8/25/16. The surveyor then reviewed the results of the BMP's obtained on 9/23/16 and 9/24/16. The DON reviewed the clinical record and was unable to locate a physician's order to obtain the BMP on 9/24/16. On October 13, 2016 at 4:20 p.m. the survey team met with the Administrator (Adm), DON and Corporate Compliance Nurse (CCN). The surveyor notified the Administrative Team (AT) that the facility staff drew a BMP on 9/24/16 without a physician's order. No additional information was provided prior to exiting the facility as to why the facility staff failed to obtain a physician's order prior to obtaining a BMP on 9/24/16 on Resident #3.	F 504		
F 514	483.75(l)(1) RES	F 514		11/30/16

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F 514 SS=E	Continued From page 72 RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. 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 ensure a complete and accurate clinical record for 5 of 17 Residents in the sample survey, Resident #1, Resident #2, Resident #13, Resident #5 and Resident #8. The Findings Included: 1. For Resident #1 the facility staff failed to document the administration of a onetime order for Regular Insulin, on 10/9/16. Resident #1 was a 76 year old female who was admitted on 3/28/15. Admitting diagnoses included, but were not limited to: uterine Cancer, diabetes mellitus, dementia without behaviors and failure to thrive. The most current MDS located in the clinical record was a Quarterly MDS assessment with an ARD of 8/9/16. The facility staff coded that Resident #1 had a Cognitive Summary Score of 4. The facility staff also coded that Resident #1	F 514	F514 **Corrective Action(s):** Resident #1's attending physician has been notified that the facility staff failed to document the administration of a one time order of Regular Insulin 10 Units as ordered by MD. A facility incident and accident form has been completed for this incident. Resident #2's attending physician has been notified that the facility staff failed to transcribe a telephone order for weekly weights to the most current POS signed by the physician. A facility incident and accident form has been completed for this incident. Resident #13's attending physician has been notified that the facility staff had comingled resident #10's discharge summary and medication list with resident #13's clinical information. A facility incident and accident form has been completed for this incident. Resident #5's attending physician has been notified that the facility staff failed to document resident #5's room change or the discussion with the RP prior to the room change in the medical record. A facility incident and accident form has been completed for this incident. Resident #8's attending physician has been notified that the facility staff failed to document behavior monitoring and adequate indications for use of an antipsychotic medication. A facility incident and accident form has been completed for this incident.	11/30/16

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F 514	Continued From page 74 Regular Insulin on 10/9/16. On October 13, 2016 at 3:30 p.m. the surveyor spoke with the Licensed Practical Nurse (LPN) #3, who wrote the physician order and Departmental Note dated 10/9/16. LPN (#3) stated that she had administered the Regular Insulin as ordered by the physician. LPN (#3) stated that it was close of midnight when she sat down to do her documentation. LPN (#3) stated she attempted to put in the onetime order and that she believed that since it was close to midnight, the order was discontinued as soon as she entered the order into the electronic system. On October 13, 2016 at 4:20 p.m. the survey team met with the Administrator (Adm), DON and Corporate Compliance Nurse (CCN). The surveyor notified the Administrative Team (AT) that the facility staff failed to ensure a complete and accurate clinical record for Resident #1. The surveyor notified the AT that Resident #1 had a onetime order to administer Regular Insulin 10 Units on 10/9/16. The surveyor notified the AT that review of the clinical record failed to produce documentation/evidence that the Regular Insulin was administered as ordered by the physician. No additional information was provided prior to exiting the facility as to why the facility staff failed to ensure a complete and accurate clinical record for Resident #1. 2. For Resident #2 the facility staff failed to ensure a complete and accurate clinical record. For Resident #2 the facility staff failed to ensure complete and accurate Physician Order Sheets (POS's). Resident #2 was an 84 year old male who was admitted on 4/28/16. Admitting diagnoses included, but were not limited to: chronic obstructive pulmonary disease, dysphagia, seizures, pneumonia, myocardial infarction,	F 514	**Monitoring:** The DON is responsible for maintaining compliance. The DON, and/or ADON will audit medical records, MAR's, TAR's, ADL records and care plans weekly coinciding with the care plan calendar to monitor for compliance. Any/all negative findings will be clarified and corrected at time of discovery and disciplinary action will be taken as needed. The results of this audit will be provided to the Quality Assurance Committee for analysis and recommendations for change in facility policy, procedure, and/or practice. **Completion Date:11/30/2016**	

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F 514	Continued From page 75 osteoporosis and hypothyroidism. 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 10/11/16. The facility staff coded that Resident #2 had short and long term memory impairment (1/1) and was severely impaired (3) with daily decision making regarding Activities of Daily Living (ADL's). The facility staff also coded that Resident #2 required total nursing care (4/2) with ADL's. On October 14, 2016 at 7:45 a.m. the surveyor reviewed Resident #2's clinical record. Review of the clinical record produced a physician telephone order dated 8/4/16. The physician telephone order read in part ... "weekly weights." (sic) Continued review of the clinical record produced signed physician orders dated 10/5/16. The signed POS ' s dated 10/5/16 did not include the order to obtain weekly weights. On October 14, 2016 at 9 a.m. the surveyor notified the Director of Nursing (DON) that Resident #2 had a physician telephone order to obtain weekly weights on 8/4/16. The surveyor notified the DON that the order to obtain the weekly weights had not been transcribed to the most current physician signed POS's dated 10/5/16. The surveyor and DON reviewed Resident #2 ' s clinical record. The surveyor reviewed the physician telephone order dated 8/4/16 with the DON. The surveyor also reviewed the most current POS's with the DON and pointed out that the POS's did not include the order to obtain weekly weights on Resident #2. On October 14, 2016 at 10 a.m. the survey team met with the Administrator (Adm), DON and Corporate Compliance Nurse (CCN). The surveyor notified the Administrative Team (AT)	F 514		

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F 514	Continued From page 76	F 514		

that the facility staff failed to ensure a complete and accurate clinical record for Resident #2. The surveyor notified the AT that Resident #2 had a physician telephone order dated 8/4/16 for weekly weights and that the order had not been transcribed up to the most current signed POS's. No additional information was provided prior to exiting the facility as to why the facility staff failed to ensure a complete and accurate clinical record for Resident #2.

3. For Resident #13 the facility staff failed to ensure a complete and accurate clinical record. Resident #13's clinical record was comingled with another Residents clinical information.

Resident #13 was a 92 year old female who was admitted on 10/4/16. Admitting diagnoses included, but were not limited to: left hip fracture, hypertension, hypothyroidism, dementia, depression, glaucoma and urinary retention.

The most current Minimum Data Set (MDS) assessment located in the clinical record was an Admission and 5 Day Medicare MDS assessment with an Assessment Reference Date (ARD) of 10/10/16. The facility staff coded that Resident #13 had short and long term memory loss (1/1) and was severely impaired with daily decision making regarding Activities of Daily Living (ADL 's).

On October 17, 2016 at 11:55 a.m. the surveyor reviewed Resident #13's clinical record. Review of the clinical record produced Resident #10's "Discharge Summary" and "Discharge Medication List" comingled in Resident #13's clinical record. The documents were dated 9/29/16.

On October 17, 2016 at 12:40 p.m. the surveyor notified the Director of Nurses (DON) that Resident #13's clinical record contained Resident #10's Discharge Summary and Discharge Medication List. The surveyor reviewed Resident

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F 514	Continued From page 77 #13's clinical record with the DON. The surveyor specifically pointed out Resident #10's Discharge Summary and Discharge Medication List in Resident #13's clinical record. On October 17, 2016 at 3:45 p.m. the survey team met with the Administrator (Adm), DON and Corporate Compliance Nurse (CCN). The surveyor notified the Administrative Team (AT) that the facility staff failed to ensure a complete and accurate clinical record for Resident #13. The surveyor notified the AT that Resident #10's clinical information was comingled in Resident #13's clinical record. No additional information was provided to the survey team prior to exiting the facility as to why the facility staff failed to ensure a complete and accurate clinical record for Resident #13. 4. For Resident #5, facility staff failed to document room change and discussion with the responsible party. Resident #5 was admitted to the facility on 6/9/16 with diagnoses including chronic kidney disease, hypertension, cognitive communication deficit, muscle weakness, and dementia with behavioral disturbance. On the quarterly minimum data assessment with assessment reference date 9/14/16, the resident scored 4/15 on the brief interview of mental status and exhibited symptoms of inattention, disorganized thinking, and daily wandering. During initial tour on 10/12/16, the surveyor observed the resident walking in the halls and then sitting in a chair in an alcove near the resident's room. The nurse touring with the resident stated that the resident walked a lot and liked to sit in the alcove where there was a view out the doors at the end of the hall and of the	F 514		

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nurse's station. The surveyor observed the resident frequently walking in the halls or sitting in the chair in the alcove on 10/13 and 14. On 10/17/16 at 8:30 the surveyor found another resident in the room where the resident was observed the prior week. The resident was not in the dining room, the hall, or the alcove where he had been previously observed. The surveyor asked the nurse who had administered the resident's medications on 10/13/16 where the resident had gone. The nurse stated that there was a hospice resident in the room and he had probably been moved to give that resident privacy. The nurse was unable to say when the resident had moved. A second nurse said the resident had probably moved Friday or Saturday. The resident was observed in the new room sitting in a chair against the wall between the two beds with an overbed tray table and the resident's room mate in a wheelchair with his back to the resident between the resident and the door. The resident was in the chair with the tray table in front of him each of the 6 times the surveyor observed him on 10/17/16. The resident was not observed out of his room between 9 AM and 3 PM on 10/17/16.

Clinical record review did not reveal documentation of the room change or the reason for the room change. The surveyor reviewed the resident's orders, nursing, and social service notes. None mentioned the resident changing rooms or the resident's responsible party (RP) being notified of the change.

The surveyor interviewed the resident's responsible party by phone on 10/17/16 at 10:15 AM. The RP stated that she had been told the resident was moved. She stated she was not

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F 514	Continued From page 79 offered a choice. The RP felt the resident was confused by the move and thought he was not allowed to leave the room. She stated he just sat in the chair in the room now instead of going out and walking around the halls. The RP stated the new room "is like a jail to him". The RP felt the resident was not properly oriented to the change and that the resident did not know where he was anymore. She said it took months to acclimate him to the old room and establish a routine. The resident's comprehensive care plan (CCP) provided on 10/13/16 listed under problem/need: resident is at risk Dx dementia with goals 1- find own room with/without cueing 2- find bathroom with/without cueing 3- find dining room with/without cueing and approaches a- provide 24 hour reality orientation b- place calendar where resident has access c- observe fro changes in cognitive status, provide consistent caregiver d- approach resident warmly and positively and e-establish daily routine with resident. The administrator and director of nursing were notified of the concern. The administrator stated that the resident's RP had not objected to the move. After a call to the resident's RP, the administrator stated that the RP was for the move because the resident needed a room mate. The surveyor asked if the resident's care plan goals had been addressed with the move. The administrator offered to speak with the RP again concerning the move. 5. For Resident #8, facility staff failed to document behavior monitoring and adequate indications for the use of an antipsychotic medication.	F 514		

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F 514	Continued From page 80 Resident #8 was admitted to the facility on 1/16/13. Current diagnoses included dementia without behavior disturbance, hypertension, falls, anxiety, depression, and post traumatic stress disorder. On the quarterly minimum data set (MDS) assessment with assessment reference date 8/23/16, the resident scored 3/15 on the brief interview for mental status, 4/8 on for signs of delirium, no signs of psychosis, and physical and verbal behavior 1-3 days of the week. The resident's annual MDS assessment with assessment reference date 12/28/16 was not completed to include assessment documentation on the Care Area Assessment (CAA) worksheets or the CAA summary section of the assessment. During an interview on 10/12/16, the director of nursing stated that the former MDS coordinator had not put that information on the CAA summaries or CAA assessment worksheets. She stated she had interviewed the new MDS coordinator and the new coordinator reported that she also did not put that information in the MDS assessments. Clinical record review on 10/14/16 revealed a physician's order for Quetiapine fumarate 50 mg (milligram) tab take 1 tab by mouth 3 times a day Dx: dementia with associated behaviors. Quetiapine fumarate is an antipsychotic medication (also called Seroquel). The surveyor was unable to locate documentation of a diagnosis for which antipsychotic medication is approved. The surveyor was unable to locate documentation of the behaviors for which the antipsychotic medication had been ordered. The clinical record indicated that the resident had been receiving the medication at least since the last readmission from the hospital on 11/14/15.	F 514		

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Behavior monitoring was documented from 8/28/16 through the end of the survey on 10/17/16. Behaviors documented included cursing, pacing, and hitting.

Physician notes did not document diagnoses or behaviors supporting the use of an antipsychotic medication. The resident's Psychotropic Quarterly Evaluations were blank under the section "Behavior warranting the use of medication".

The resident's comprehensive care plan did not address the symptoms to be treated by the antipsychotic medication.

The surveyor discussed the concern with the lack of indication for the antipsychotic medication and the incomplete CAA summaries and worksheets on 10/13/14, and reported to the administrator, director of nursing, and a corporate clinical consultant on 10/14/16.

On 10/17/16, the director of nursing offered a hospital geriatric psychiatric unit discharge plan dated 4/20/2012 documenting behaviors including hitting, kicking, pinching, and other oppositional combative behaviors with strategies to help manage those behaviors. Antipsychotic medications were not mentioned in the summary. The director of nursing also offered physician's notes from 2014. One note dated 4/1/14 stated "Pt seen for anxiety- has Parkinson's Dx- gets easily agitated. already on Seroquel & Namenda. Will add Aricept 5mg. Dx- Parkinson's, anxiety, dementia. Plan- start Aricept 5 mg". The resident did not have orders for medications to treat Parkinson's.

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495242	A. BUILDING ______ B. WING ______	C 10/17/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HALL - BROOKNEAL	633 COOK AVENUE BROOKNEAL, VA 24528

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 514	Continued From page 82 The adminsitrator and director of nursing were notified of the ongoing concern during a summary meeting on 10/17/16.	F 514		

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