Our Home, Our Family, Our Life, Too.

Heritage Hall of Dillwyn • 9 Brickyard Drive • Dillwyn, VA 23936 • (P) 434.983.2058

April 18, 2016

Center for Quality Health Services & Consumer Protection
Division of Long Term Care Services
9960 Mayland Drive – Suite 401
Attn: Wietske G. Weigel-Delano, Long Term Care Supervisor
Richmond, VA 23233-1463

Ms. Weigel-Delano,

Attached to this cover letter you will find Heritage Hall – Dillwyn'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) 983-2058.

Sincerely;

Angela H. Moore

Angela H. Moore
Administrator

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495317	A. BUILDING _____ B. WING _____	04/07/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HALL DILLWYN	119 BRICKYARD DRIVE DILLWYN, VA 23936

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F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 04/05/16 through 04/07/16. 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 59 at the time of the survey. The survey sample consisted of 13 current resident reviews (Residents #1 through #13) and four closed record reviews (Residents # 14 through # 17).	F 000		
F 281 SS=E	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, it was determined that the facility staff failed to follow professional standards of practice for one of 17 residents in the survey sample, Resident #9; and failed to ensure one of one medication room was free from expired dressing change kits. 1. The facility staff failed to clarify Resident #9's physician's order for *Tylenol (used to treat mild pain) to ensure the order included route of administration. Also, the facility staff failed to accurately transcribe the Tylenol order onto the MAR (medication administration record) to ensure the MAR included route of administration	F 281	**F281** **Corrective Action(s):** Resident #9's attending physician has been notified that the facility staff failed to accurately transcribe the resident's Tylenol medication order and failed to accurately enter Tylenol order on the MAR. Resident #9's physician orders and MAR's have been reviewed to ensure all medication and treatment orders are correctly written and transcribed. A Facility Incident & Accident Form was completed for this incident. All of the expired Sterile Dressing change kits were removed from the medication room and disposed of. A Facility Incident & Accident Form was completed for this incident. RECEIVED APR 21 2016 VDH/OLC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Angela W. Moore, LNHA	Administrator	04/18/2016

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

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F 281	Continued From page 1 and frequency. 2. The medication room was observed to contain 11 Medik Mark (Brand) sterile dressing change kits available for use with an expiration date of 11/2015. The findings include: 1. Resident #9 was admitted to the facility on 3/15/16. Resident #9's diagnoses included but were not limited to: high blood pressure, major depressive disorder and **peripheral vascular disease (a condition that causes decreased blood flow to the legs and feet). Resident #9's most recent MDS (minimum data set), a 14 day Medicare assessment with an ARD (assessment reference date) of 3/28/16, coded the resident's cognition as being moderately impaired. Review of Resident #9's clinical record revealed a physician's telephone order dated 3/30/16 that documented, "Tylenol 650 mg (milligrams) PRN (as needed) Q (every) 6 hour (sic) for pain or elevated temp. (temperature)." Resident #9's March 2016 and April 2016 MARs (medication administration records) documented, "Tylenol 650 mg for pain or elevated temp PRN." A check mark with a nurse's initials was documented on 3/30/16, indicating Resident #9 was administered Tylenol on that date. Resident #9's comprehensive care plan reviewed on 3/29/16 documented, "He is at risk for unrelieved pain r/t (related to) recent surgery ***brain biopsy (surgery) and he has ****neuropathy (damaged nerves in the body)...Monitor for pain. Treat as ordered..."	F 281	**Identification of Deficient Practices/Corrective Action(s):** All other residents may have been potentially affected. The DON, ADON and/or designee will conduct a 100% review of all resident medication and treatment orders and MAR's and TAR's to ensure all orders are written and transcribed correctly according to professional standards and the facility policy and procedure. 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 incorrect medication order. Additionally, the Medication Room and all Medication Carts and Treatment carts have been inspected for any expired medications or biologicals. Any negative finds were corrected at time of discovery and a facility Incident & Accident form will be completed for each negative finding. **Systemic Change(s):** The facility policy and procedure has been reviewed and no revisions are warranted at this time. The nursing assessment process as evidenced by the 24 Hours Report, documentation in the medical record and physician orders remains the source document for the development and monitoring of the plan care which includes, obtaining, transcribing and administering physician ordered medications and treatments per physician order. Licensed staff will be inserviced by the DON and/or regional	

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F 281	Continued From page 2 On 4/6/16 at 4:35 p.m., an interview was conducted with LPN (licensed practical nurse) #1 (the unit manager). This surveyor read the above physician's order and MAR regarding Tylenol and asked LPN #1 what was missing. LPN #1 stated there was no route documented on the physician's order and no route or frequency documented on the MAR. LPN #1 stated she could correct the order and the MAR. LPN #1 stated she usually double checks herself when writing physician's orders and transcribing the orders onto the MAR. LPN #1 stated the order and the MAR should match and should include the route, frequency, dosage, name and diagnosis. LPN #1 stated she would write an order to clarify Resident #9's Tylenol. On 4/6/16 at 5:07 p.m., a telephone interview was conducted with LPN #3 (the nurse responsible for documenting the above Tylenol order). LPN #3 was asked what information should be included in a physician's order. LPN #3 stated the order should include the dose, route, frequency, patient name, date of birth, how often and what the medication is for. LPN #3 stated the frequency, time, route and dosage should be documented on the MAR. The above Tylenol order was read aloud and LPN #3 was asked if anything was missing from the order. LPN #3 stated, "I think I didn't put oral (route)." This surveyor read the Tylenol order on Resident #9's March 2016 MAR and asked what was missing. LPN #3 stated the MAR was missing the frequency of every six hours and didn't document an oral route. LPN #3 stated if she had given the Tylenol to Resident #9 then she would have checked and corrected the order and MAR.	F 281	nurse consultant on the procedure for obtaining and transcribing physician medication & treatment orders, as well as monitoring and removing any expired medications or biologicals from the medication rooms and medication & treatment carts. **Monitoring:** The DON is responsible for maintaining compliance. The DON, Unit Manager and/or designee will performs chart audits weekly coinciding with the care plan calendar in order to maintain compliance. The Unit Manager will also perform weekly inspections of all medication rooms and medication & treatment carts to monitor for compliance with expired medications and biologicals. Any/all negative findings 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: May 16, 2016**	

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F 281	Continued From page 3 On 4/6/16 at 6:18 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above findings. ASM #2 was asked if the facility followed a standard of practice regarding the above matter. ASM #2 stated the facility follows its own practice. ASM #2 stated she and other managers review copies of orders and the consulting pharmacist conducts audits. The facility policy titled, 'Medication Orders" documented, "Purpose: The purpose of this procedure is to establish uniform guidelines in the receiving and recording of medication orders...Recording Orders: 2. PRN Medication Orders- When recording PRN medication orders, specify the type, route, dosage, frequency, strength and the reason for administration. Example: Tylenol 500 mg p.o. (by mouth) q4h (every four hours) prn mild pain or temp > (greater than) 101F (Fahrenheit)..." No further information was presented prior to exit. In Potter-Perry, Fundamentals of Nursing, 6th edition, page 841, a noted standard of practice is: "When medications are first ordered, the nurse compares the medication recording form or computer orders with the prescriber's written orders." On page 852, regarding the administration of oral medications, "Check accuracy and completeness of each MAR or computer printout with prescriber's written medication order." According to Fundamentals of Nursing, 6th edition Potter and Perry, 2005, page 846, "A medication order is required for any medication to be administered by a nurse...If the medication order is incomplete, the nurse should inform the	F 281		

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F 281	Continued From page 4 prescriber and ensure completeness before carrying out any medication order." *This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/druginfo/meds/a681004.html **This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/ency/article/000170.htm ***This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/ency/article/003018.htm ****This information was obtained from the website: https://vsearch.nlm.nih.gov/vivisimo/cgi-bin/query-meta?v%3Aproject=medlineplus&v%3Asources=medlineplus-bundle&query=neuropathy 2. On 4/5/16 at 1:10 p.m., observation of the medication room was conducted. 11 Medik Mark (Brand) sterile dressing change kits were observed with an expiration date of 11/2015. Two Medik Mark sterile dressing change kits were observed with an expiration date of 2/1015. On 4/5/16 at 1:11 p.m., an interview was conducted with LPN (Licensed practical nurse) #4. When asked who was responsible for cleaning out the medication room for expired treatment supplies she stated, "Usually the unit manager or DON (Director of Nursing)." On 4/7/16 a.m., at approximately 9:00 a.m., an interview was conducted with ASM (administrative	F 281		

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F 281	Continued From page 5 staff member) #2, the DON. When asked who was responsible for cleaning out the medication rooms for expired treatment supplies she stated, "Myself or the unit manager. We just cleaned out the medication room but we must of overlooked the expired kits." On 4/6/16 at 6:10 p.m., administration was made aware of the above findings. No further information was presented prior to exit. Facility policy titled, "Common Storage Terminology" documents in part, the following: "According to the United States Pharmacopenia (USP), expiration dates expressed in the terms of only the month and year can be used until the last day of the stated month and year unless otherwise specified." A medical product is typically labeled by the manufacturer with an expiration date. This reflects the time period during which the product is expected to remain stable, or retain its identity, strength, quality, and purity, when it is properly stored according to its labeled storage conditions. This information was obtained from the website: http://www.fda.gov	F 281		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by:	F 282	**F282** **Corrective Action(s):** Resident #1 & #2's attending physician has been notified that facility staff failed to apply a physician ordered Tab alarm to each resident while the residents were up in the wheelchair. A facility incident and accident form has been completed for this incident.	

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F 282	Continued From page 6 Based on observation, staff interview, clinical record review and facility document review it was determined that facility staff failed to follow the plan of care for two of 17 residents in the survey sample; Residents #1 and #2. 1. Resident #1 was observed on multiple occasions in her wheelchair without a tab alarm in place per the physician's orders and comprehensive plan of care. 2. The facility staff failed to implement a tab alarm per Resident #2's plan of care. The findings include: 1. Resident #1 was observed on multiple occasions in her wheelchair without a tab alarm in place per the physician's orders and comprehensive plan of care. Resident #1 was admitted to the facility on 5/26/15 with diagnoses that included but were not limited to anemia, high blood pressure, diabetes, high cholesterol, Non-Alzheimer's Dementia, anxiety, psychotic disorder, and major depressive disorder. Resident #1's most recent MDS (Minimum Data Set) was a quarterly assessment with an ARD (Assessment Reference Date) of 2/22/16. Resident #1 was coded as being cognitively intact in the ability to make daily decisions scoring 15 out of 15 on the BIMS (Brief Interview for Mental Status). Resident #1 was coded as needing extensive assistance from staff with transferring, dressing, and personal hygiene; and total dependence on staff with bathing. The following observations were made during the course of survey:	F 282	**Identification of Deficient Practices/Corrective Action(s):** All other residents with physician ordered tab alarms or other preventive devices to prevent falls may have been potentially affected. The DON and/or Unit Manager will conduct a 100% review of all residents with physician ordered tab 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 in-service all Licensed Nursing staff regarding proper use of fall prevention equipments to include wheelchair and bed alarms to prevent falls. **Monitoring:** The DON is responsible for maintaining compliance. The DON and/or Unit Manager 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: May 16, 2016**	

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F 282	Continued From page 7 On 4/5/16 at 4:15 p.m., Resident #1 had fallen asleep in her wheelchair. No tab alarm was observed on the wheelchair. On 4/6/16 at 11: 31 a.m., Resident #1 was up in her wheelchair. No tab alarm was observed on the wheelchair. On 4/6/16 at 2:30 p.m., Resident #1 received a dressing change while up in her wheelchair. No tab alarm was observed on the wheelchair. On 4/6/16 at 3:30 p.m., Resident #1 was up in her wheelchair with no tab alarm in place. Review of the clinical record revealed a nurse's note that documented in part, the following: "2/16/15 11: 13 A.M. (Name of Resident) dtr (daughter) in law (Name) returned my call. Discussed discontinuation of restorative therapies, decline in ability to ambulated (sic) and declining of arm exercises. Voiced understanding requested tab alarm for resident, to continue with her LE (lower extremity) exercises...Areas of concern relayed to therapy resident is still on OT (Occupational Therapy) caseload." Further review of Resident #1's clinical record revealed a telephone order dated 2/26/16 that documented the following: " Tab alarm while up in w/c (wheelchair)." This order was signed by the physician on 3/1/16. Review of Resident #1's care plan dated 9/2/15 and revised on 2/26/15 documented in part, the following: "2/26/16 tab alarm while up in w/c (wheelchair)."	F 282		

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F 282	Continued From page 8 On 4/6/16 at 3:00 p.m., an interview was conducted with CNA (certified nursing assistant) #4 regarding how CNAs know what safety device is required for each resident. CNA #4 stated, "In the resident's closet they have an ADL (activities of daily living) tracker form. Safety devices should be listed on that sheet." When asked how the ADL tracker form is updated she stated, "Nursing." CNA #4 viewed Resident #1's ADL tracker form and stated, "I don't think she was ordered a tab alarm. She had one a long time ago but I think it was discontinued." On 4/6/16 at 3:05 p.m., an interview was conducted with LPN (licensed practical nurse) #5. When asked who was responsible for updating the ADL tracker form she stated, "After there is an order for the safety device the care plan is updated by (Name of MDS nurse) and I know she has updated the ADL tracker card before. Let me go ask her." On 4/6/16 at approximately 4:30 p.m., an interview was conducted with RN (Registered Nurse) #1, the MDS Coordinator. When asked who was responsible for updating the ADL tracker card she stated, "Either I do it or I give a memo to the CNA manager, but it is ultimately my responsibility." RN #1 stated that she must have overlooked updating Resident #1's ADL tracker card. She stated that she updates the care plan when new orders or changes are put in place. On 4/7/16 at 8:35 a.m., an interview was conducted with LPN #1. When asked the purpose of the care plan she stated, "We use the care plan to know the resident's needs, diagnoses and how to care for the resident individually." When asked who looks at the care	F 282		

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F 282	Continued From page 9 plan she stated, "Everybody. CNA's, nurses, anyone." When asked if a safety device should be in place if it is listed on the care plan she stated, "Yes." On 4/6/16 at 6:10 p.m., administration was made aware of the above findings. No further information was provided prior to exit. Facility policy titled, "Using the Care Plan" documents in part, the following: "The care plan shall be used in developing the resident's daily care routines and will be available to staff personnel who have responsibility for providing care or services to the resident." According to Fundamentals of Nursing Lippincott Williams and Wilkins 2007 pages 65-77 documented, "A written care plan serves as a communication tool among health care team members that helps ensure continuity of care...The nursing care plan is a vital source of information about the patient's problems, needs, and goals. It contains detailed instructions for achieving the goals established for the patient and is used to direct care...expect to review, revise and update the care plan regularly, when there are changes in condition, treatments, and with new orders..." 2. The facility staff failed to implement a tab alarm per Resident #2's plan of care. Resident #2 was admitted to the facility on 7/11/12 and readmitted to the facility on 1/22/16.	F 282		

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F 282	Continued From page 10 Resident #2's diagnoses included but were not limited to: *Alzheimer's disease, **hemiplegia and fracture of the first cervical (neck) vertebra. Resident #2's most recent MDS (minimum data set), a 30 day Medicare assessment with an ARD (assessment reference date) of 2/17/16, coded the resident's cognitive skills for daily decision making as severely impaired. Section J documented Resident #2 had not sustained any falls since the prior assessment. Review of Resident #2's clinical record revealed the resident sustained the following falls: · 5/13/15- Resident #2 was observed on the floor in his room (no injury). · 6/27/15- Resident #2 was observed on the floor in his room (no injury). · 1/19/16- Resident #2 was observed on the floor in his room (the resident was sent to the hospital and diagnosed with a cervical fracture). Resident #2's fall risk assessment dated 1/22/16 documented the resident was at high risk for falls. Resident #2's comprehensive care plan revised on 3/11/16 documented, "(Name of Resident #2) is at increased risk for falls r/t (related to) hemiplegia, cogniitve (sic) deficits from dementia, lack of safety awareness, arthritis, recent fall with injury C1 (first cervical vertebra) fracture and the use of a cervical collar at all times, impaired vision, and debilitated condition...Approaches: Tab alarm at all times..." A physician's order summary signed by the physician on 3/29/16 documented an order with a start date of 1/25/16 for a tab alarm at all times.	F 282		

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F 282	Continued From page 11	F 282		

Resident #2's CNA (certified nursing assistant) care plan dated 3/9/16 (and located in the resident's closet) documented, "Safety: tab alarm @ (at) all times..."

On 4/5/16 at 2:17 p.m. and 3:22 p.m., Resident #2 was observed in a wheelchair in the bedroom. No tab alarm was observed attached to the resident.

On 4/6/16 at 11:00 a.m. and 11:54 a.m., Resident #2 was observed in a wheelchair in the bedroom. The tab alarm box and clip was observed lying on the resident's bed and was not attached to Resident #2.

On 4/6/16 at 2:07 p.m., Resident #2 was observed in a wheelchair in the hall. No tab alarm was observed attached to the resident.

On 4/6/16 at 2:35 p.m., an interview was conducted with CNA #1. CNA #1 was asked how she was made aware of the type of safety devices required for each resident. CNA #1 stated most of the time she knew what types of safety devices was required for each resident but if she didn't then she asked the CNA supervisor. CNA #1 stated there was also a care guide in residents' closets. CNA #1 was asked what types of safety devices were used for Resident #2. CNA #1 stated the resident had a bed alarm, chair alarm, mat on the floor and a low bed. At this time, Resident #2 remained in a wheelchair in the hall. CNA #1 was asked to observe the resident and the resident's wheelchair for an alarm. CNA #1 confirmed the resident didn't have an alarm.

On 4/6/16 at 2:45 p.m., an interview was

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F 282	Continued From page 12 conducted with LPN (licensed practical nurse) #2. LPN #2 was asked how she was made aware of the type of safety devices required for each resident. LPN #2 stated she looks at the physician's orders and she also consults with the lead CNA. LPN #2 was asked what types of safety devices were used for Resident #2. LPN #2 reviewed the resident's physician's orders and stated, "Boots on heels, abdominal binder, Hoyer lift with the assist of two (staff) and a tab alarm at all times to make sure he doesn't fall again." LPN #2 was made aware of the above observations of Resident #2 without a tab alarm in place. LPN #2 stated staff would correct this. On 4/6/16 at 6:18 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above findings. On 4/7/16 at 8:35 a.m., an interview was conducted with LPN #1 (the unit manager). LPN #1 was asked the purpose of residents' care plans. LPN #1 stated the staff uses care plans to know patients and their needs. LPN #1 was asked who looks at residents' care plans and stated, "Everybody; CNAs and nurses." LPN #1 stated safety devices are documented on residents' care plans and the care cards in residents' closets. LPN #1 confirmed safety devices documented on residents' care plans should be implemented." The facility policy titled, "Falls and Fall Risk, Managing" documented, "Policy Statement: Based on previous evaluations and current data, the staff will identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and to try to	F 282		

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F 282	Continued From page 13 minimize complications from falling. Policy Interpretation and Implementation: 1. The staff, with the input of the Attending Physician, will identify appropriate interventions to reduce the risk of falls..." No further information was presented prior to exit. *"Alzheimer's disease (AD) is the most common form of dementia among older people. Dementia is a brain disorder that seriously affects a person's ability to carry out daily activities." This information was obtained from the website: https://vsearch.nlm.nih.gov/vivisimo/cgi-bin/query-meta?v%3Aproject=medlineplus&v%3Asources=medlineplus-bundle&query=alzheimer%27s+disease **Hemiplegia is the loss of muscle function in part of your body. This information was obtained from the website: https://vsearch.nlm.nih.gov/vivisimo/cgi-bin/query-meta?v%3Aproject=medlineplus&v%3Asources=medlineplus-bundle&query=hemiplegia	F 282		
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: Based on observation, staff interview, facility	F 323	**F323** **Corrective Action(s):** Resident #1 & #2's attending physician has been notified that facility staff failed to apply a physician ordered Tab alarm to each resident while the residents were up in the wheelchair. A facility incident and accident form has been completed for this incident.	

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F 323	Continued From page 14 document review and clinical record review, it was determined that the facility staff failed to implement physician ordered assistive devices to prevent accidents for two of 17 residents in the survey sample, Residents #2 and #1. 1. The facility staff failed to implement Resident #2's physician ordered tab alarm. 2. The facility staff failed to place a tab alarm to Resident #1's wheelchair as ordered by the physician on 2/26/16. The findings include: 1. The facility staff failed to implement Resident #2's physician ordered tab alarm. Resident #2 was admitted to the facility on 7/11/12 and readmitted to the facility on 1/22/16. Resident #2's diagnoses included but were not limited to: *Alzheimer's disease, **hemiplegia and fracture of the first cervical (neck) vertebra. Resident #2's most recent MDS (minimum data set), a 30 day Medicare assessment with an ARD (assessment reference date) of 2/17/16, coded the resident's cognitive skills for daily decision making as severely impaired. Section J documented Resident #2 had not sustained any falls since the prior assessment. Review of Resident #2's clinical record revealed the resident sustained the following falls: · 5/13/15- Resident #2 was observed on the floor in his room (no injury). · 6/27/15- Resident #2 was observed on the floor in his room (no injury). · 1/19/16- Resident #2 was observed on the	F 323	**Identification of Deficient Practices/Corrective Action(s):** All other residents with physician ordered tab alarms or other preventive devices to prevent falls may have been potentially affected. The DON and/or Unit Manager will conduct a 100% review of all residents with physician ordered tab 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 in-service all Licensed 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 15 floor in his room (the resident was sent to the hospital and diagnosed with a cervical fracture). Resident #2's fall risk assessment dated 1/22/16 documented the resident was at high risk for falls. Resident #2's comprehensive care plan revised on 3/11/16 documented, "(Name of Resident #2) is at increased risk for falls r/t (related to) hemiplegia, cogniitve (sic) deficits from dementia, lack of safety awareness, arthritis, recent fall with injury C1 (first cervical vertebra) fracture and the use of a cervical collar at all times, impaired vision, and debilitated condition...Approaches: Tab alarm at all times..." A physician's order summary signed by the physician on 3/29/16 documented an order with a start date of 1/25/16 for a tab alarm at all times. Resident #2's CNA (certified nursing assistant) care plan dated 3/9/16 (and located in the resident's closet) documented, "Safety: tab alarm @ (at) all times..." On 4/5/16 at 2:17 p.m. and 3:22 p.m., Resident #2 was observed in a wheelchair in the bedroom. No tab alarm was observed attached to the resident. On 4/6/16 at 11:00 a.m. and 11:54 a.m., Resident #2 was observed in a wheelchair in the bedroom. The tab alarm box and clip was observed lying on the resident's bed and was not attached to Resident #2. On 4/6/16 at 2:07 p.m., Resident #2 was observed in a wheelchair in the hall. No tab alarm was observed attached to the resident.	F 323	**Monitoring:** The DON is responsible for maintaining compliance. The DON and/or Unit Manager 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: May 16, 2016**	

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F 323	Continued From page 16 On 4/6/16 at 2:35 p.m., an interview was conducted with CNA #1. CNA #1 was asked how she was made aware of the type of safety devices required for each resident. CNA #1 stated most of the time she knew what types of safety devices was required for each resident but if she didn't then she asked the CNA supervisor. CNA #1 stated there was also a care guide in residents' closets. CNA #1 was asked what types of safety devices were used for Resident #2. CNA #1 stated the resident had a bed alarm, chair alarm, mat on the floor and a low bed. At this time, Resident #2 remained in a wheelchair in the hall. CNA #1 was asked to observe the resident and the resident's wheelchair for an alarm. CNA #1 confirmed the resident didn't have an alarm. On 4/6/16 at 2:45 p.m., an interview was conducted with LPN (licensed practical nurse) #2. LPN #2 was asked how she was made aware of the type of safety devices required for each resident. LPN #2 stated she looks at the physician's orders and she also consults with the lead CNA. LPN #2 was asked what types of safety devices were used for Resident #2. LPN #2 reviewed the resident's physician's orders and stated, "Boots on heels, abdominal binder, Hoyer lift with the assist of two (staff) and a tab alarm at all times to make sure he doesn't fall again." LPN #2 was made aware of the above observations of Resident #2 without a tab alarm in place. LPN #2 stated staff would correct this. On 4/6/16 at 6:18 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above findings.	F 323		

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F 323	Continued From page 17 The facility policy titled, "Falls and Fall Risk, Managing" documented, "Policy Statement: Based on previous evaluations and current data, the staff will identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and to try to minimize complications from falling. Policy Interpretation and Implementation: 1. The staff, with the input of the Attending Physician, will identify appropriate interventions to reduce the risk of falls..." No further information was presented prior to exit. *"Alzheimer's disease (AD) is the most common form of dementia among older people. Dementia is a brain disorder that seriously affects a person's ability to carry out daily activities." This information was obtained from the website: https://vsearch.nlm.nih.gov/vivisimo/cgi-bin/query-meta?v%3Aproject=medlineplus&v%3Asources=medlineplus-bundle&query=alzheimer%27s+disease **Hemiplegia is the loss of muscle function in part of your body. This information was obtained from the website: https://vsearch.nlm.nih.gov/vivisimo/cgi-bin/query-meta?v%3Aproject=medlineplus&v%3Asources=medlineplus-bundle&query=hemiplegia 2. Facility staff failed to place a tab alarm to Resident #1's wheelchair as ordered by the	F 323		

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F 323	Continued From page 18 physician on 2/26/16. Resident #1 was admitted to the facility on 5/26/15 with diagnoses that included but were not limited to anemia, high blood pressure, diabetes, high cholesterol, Non-Alzheimer's Dementia, anxiety, psychotic disorder, and major depressive disorder. Resident #1's most recent MDS (Minimum Data Set) was a quarterly assessment with an ARD (Assessment Reference Date) of 2/22/16. Resident #1 was coded as being cognitively intact in the ability to make daily decisions scoring 15 out of 15 on the BIMS (Brief Interview for Mental Status). Resident #1 was coded as needing extensive assistance from staff with transferring, dressing, and personal hygiene; and total dependence on staff with bathing. The following observations were made during the course of survey: On 4/5/16 at 4:15 p.m., Resident #1 had fallen asleep in her wheelchair. No tab alarm was observed on the wheelchair. On 4/6/16 at 11: 31 a.m., Resident #1 was up in her wheelchair. No tab alarm was observed on the wheelchair. On 4/6/16 at 2:30 p.m., Resident #1 received a dressing change while up in her wheelchair. No tab alarm was observed on the wheelchair. On 4/6/16 at 3:30 p.m., Resident #1 was up in her wheelchair with no tab alarm in place. Review of the clinical record revealed a nurse's note that documented in part, the following: "2/16/15 11: 13 A.M. (Name of Resident) dtr	F 323		

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F 323	Continued From page 19 (daughter) in law (Name) returned my call. Discussed discontinuation of restorative therapies, decline in ability to ambulated (sic) and declining of arm exercises. Voiced understanding requested tab alarm for resident, to continue with her LE (lower extremity) exercises...Areas of concern relayed to therapy resident is still on OT (Occupational Therapy) caseload." Further review of Resident #1's clinical record revealed a telephone order dated 2/26/16 that documented the following: " Tab alarm while up in w/c (wheelchair)." This order was signed by the physician on 3/1/16. Review of Resident #1's care plan dated 9/2/15 and revised on 2/26/15 documented in part, the following: "2/26/16 tab alarm while up in w/c (wheelchair)." The clinical record also revealed that Resident #1 had a prior history of falls the last fall documented on 1/23/16. Resident #1 had a history of trying to get up unassisted. Review of Resident #1's ADL (activities of daily living) care card revealed no documentation regarding the use of a tab alarm. On 4/6/16 at 3:00 p.m., an interview was conducted with CNA (certified nursing assistant) #4 regarding how CNAs know what safety device is required for each resident. CNA #4 stated, "In the resident's closet they have an ADL (activities of daily living) tracker form. Safety devices should be listed on that sheet." When asked how the ADL tracker form is updated she stated, "Nursing." CNA #4 viewed Resident #1's ADL tracker form and stated, "I don't think she was	F 323		

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F 323	Continued From page 20 ordered a tab alarm. She had one a long time ago but I think it was discontinued." On 4/6/16 at 3:05 p.m., an interview was conducted with LPN (licensed practical nurse) #5. When asked who was responsible for updating the ADL tracker form she stated, "After there is an order for the safety device the care plan is updated by (Name of MDS nurse) and I know she has updated the ADL tracker card before. Let me go ask her." On 4/6/16 at approximately 4:30 p.m., an interview was conducted with RN (Registered Nurse) #1, the MDS Coordinator. When asked who was responsible for updating the ADL tracker card she stated, "Either I do it or I give a memo to the CNA manager, but it is ultimately my responsibility." RN #1 stated that she must have overlooked updating Resident #1's ADL tracker card. She stated that she updates the care plan when new orders or changes are put in place. On 4/6/16 at 6:10 p.m., administration was made aware of the above findings. No further information was presented prior to exit.	F 323		
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	F 329	**F 329** **Corrective Action(s):** Resident #5 has had their current medication regime reviewed for unnecessary drugs and dosage reductions by the attending physician. None are warranted at this time. Resident #5's comprehensive cares plan has been	

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F 329	Continued From page 21 combinations of the reasons above. Based on a comprehensive assessment of a 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 observation, staff interview, clinical record, and facility document review it was determined that facility staff failed to ensure one of 17 residents drug regimen was free of unnecessary medications; Resident #5. The facility staff failed to monitor Resident #5's behaviors for the use of Haldol (1) that was ordered by the physician on 12/6/15. Haldol is an antipsychotic used to diminish signs and symptoms of psychoses. The findings include: Resident #5 was admitted to the facility on 8/8/2014 and readmitted 3/9/2016 with diagnoses that include but were not limited to: anemia, hypertension, high cholesterol, stroke with	F 329	reviewed and revised to reflect the pre and post administration behavior monitoring to be completed for the Haldol being administered. A Facility Incident & Accident Form was completed for this incident. **Identification of Deficient Practice(s) and Corrective Action(s):** All residents presently receiving routine antipsychotic medication may be potentially affected. The facility will conduct a 100% review of all residents receiving antipsychotic medication for appropriate medical diagnosis to support use, and that routine dosage reduction and behavior monitoring is being done. The attending physicians for all residents identified at risk will be contacted for appropriate intervention. A Facility Incident &Accident form will be completed for each negative finding. **Systemic Change(s):** The facility policy and procedure has been reviewed and no changes are warranted at this time. The nursing staff will be in-serviced by the DON and/or regional nurse consultant on the requirement to complete pre and post behavior monitoring on all resident receiving routine or PRN antipsychotic medications and to perform GDR per pharmacist recommendations as required.	

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F 329	Continued From page 22 paralysis of one side of the body, Non-Alzheimer's dementia, psychotic disorder, type 2 diabetes, and osteoarthritis. Resident #5's most recent MDS (Minimum Data Set) was a 14 day scheduled assessment with an ARD (Assessment Reference Date) of 3/23/16. Resident #5 was coded as being severely cognitively impaired in the ability to make daily decisions scoring 99 on the BIMS (Brief Interview for Mental Status). Resident #5 was code as requiring extensive assistance from staff with most ADLS (Activities of Daily Living). Review of the clinical record revealed a GDR (Gradual Dose Reduction) dated 11/19/15 that recommended a trial discontinuation for Haldol. The physician accepted this recommendation on 12/1/15. Review of the telephone order sheet revealed the following order dated 12/1/15 "D/C (discontinue Haldol 0.25 mg (milligrams) QHS (every night)." Further review of the telephone orders revealed the following order dated 12/6/15 "Restart Haldol 0.25 mg po (by mouth) q pm (every evening)." Review of the physician note dated 12/22/15 documented the following: "...Pt (patient) had a GDR of Haldol and had d/c'd on 12/1/15. Pt unable to sleep with increased agitation and delusions secondary to d/c of Haldol of 0.25 mg." Review of the nurses' notes dated December 2015 through April 2016 revealed four notes related to the Resident's behaviors. Review of the February, March and April 2016 MARS revealed no documentation of behavior	F 329	**Monitoring:** The DON and/or Unit Manager are responsible for compliance. The Antipsychotic Drug review will be completed monthly to monitor for compliance. The results of these audits will be forwarded to the Quality Assurance Committee monthly/prn for review, analysis, and recommendations for change in facility policy, procedure, and/or practice. **Completion Date: May 16, 2016**	

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F 329	Continued From page 23 monitoring for the use of Haldol. Review of Resident #1's care plan under category "Mood State" dated 7/27/2010 and updated on 3-18-16 documented the following under "Approaches": "Meds (medications) as ordered. Monitor for adverse side effects...for behaviors cursing, agitation, caring presence by familiar staff, validate feeling, gentle redirect, reapproach (sic) later if indicated, assess for comfort, hunger, pain , thirst, warmth, avoid confrontational communication." On 4/06/16 at 5:45 p.m., an interview was conducted with LPN (licensed practical nurse) #6. When asked how behaviors are documented she stated that each time a psychoactive medication is given a prompt on the computer system will ask if the resident displayed any behaviors and the frequency of behaviors. When asked if behaviors should be monitored with the use of Haldol, she stated, "Yes." When shown Resident # 5's MARs, LPN #6 stated, "I think someone put that order in the computer wrong, so the prompts were not brought up to monitor behavior." LPN #6 stated that Resident #5's Haldol had been discontinued before but she was having behaviors so the physician put her back on the medication. LPN #6 stated, "I was the one who called the physician to place her back on the Haldol." LPN #6 stated that Resident #5 was having episodes of paranoia. When asked if she had documented this behavior, she stated, "I am not sure." Review of the clinical record revealed no notes from nursing documenting her behaviors prior to being placed back on Haldol 0.25 mg on 12/6/15.	F 329		

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F 329	Continued From page 24 On 3/6/16 at 6:10 p.m., administration was made aware of the above findings. No further information was presented prior to exit. ASM (Administrative Staff Member) #2, the DON (Director of Nursing) stated, "We fixed that order in the computer system." Facility policy titled "Behavior Assessment and Monitoring" documents in part, the following: "Monitoring 1. If the resident is being treated for problematic behavior or mood, the staff and physician will obtain and document ongoing reassessments of changes (positive or negative) in the individual's behavior, mood, and function. 2. The staff will document (either in progress notes, behavior assessment forms, or other comparable approaches) the following information about specific problem behaviors: a. Number and frequency of episodes; b. Preceding or precipitating factors; c. Interventions attempted (if psychoactive drug is used as a intervention, institute appropriate psychoactive drug monitoring); and d. Outcomes associated with interventions." (1) Davis's Drug Guide for Nurses, 11th edition. p.613.	F 329		
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions	F 371	**F 371** **Corrective Action(s):** The expired Ham identified in the walk-in refrigerator during the initial kitchen tour was immediately removed and disposed of. A facility Incident and Accident form was completed for this incident.	

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F 371	Continued From page 25 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview it was determined that facility staff failed to store food in a safe and sanitary manner. Facility staff failed to ensure one of three kitchen refrigerators was free from expired ham. The findings include: On 4/5/16 at 10:55 a.m., observation of the kitchen was conducted. At 11: 05 a.m., a zip lock bag containing slices of ham was observed inside the kitchen refrigerator. The zip lock bag documented the following: "U/b (use by) 4/2/16." On 4/5/16 at 11:10 a.m., an interview was conducted with OSM (Other Staff Member) #2, the dietary manager. When asked how often the refrigerator is cleaned out for expired food items she stated, "Weekly. There should not be expired items." OSM 2 was then shown the zip lock bag that contained ham slices and documented "U/b 4/2/16". OSM #2 stated, "Yes that would only be good for seven days. This should be discarded." She stated that the ham was opened the week prior but OSM #2 could not provide evidence that the ham in the zip lock bag was the same ham used on the menu the previous week. OSM # 2 could not provide a policy on expired food items. On 4/5/16 at 11: 11 a.m., OSM #3, the dietary aide stated that the refrigerator was checked	F 371	**Identification of Deficient Practices & Corrective Action(s):** All other residents may have been potentially affected. Certified Dietary Manager and/or Registered Dietician will randomly monitor the kitchen preparation area before, during and after meals to identify any negative findings. The freezers and refrigerators in the kitchen will be monitored daily for proper storage of food items. Any expired food or beverages or other negative findings will be corrected at time of discovery and appropriate disciplinary action taken as needed. A facility Incident and Accident form will be completed for each negative finding identified. **Systemic Change(s):** Current facility policy & procedure has been reviewed and no changes are warranted at this time. The consulting Registered Dietician will in-service the CDM and dietary staff on the proper preparing, storing and distribution of food under sanitary conditions, as well as the policy and procedure for proper sanitation and hand washing. **Monitoring:** The CDM is responsible for maintaining compliance. The Administrator and/or Certified Dietary Manager will complete the Dietary audit tool weekly for monitoring and maintaining compliance. 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: May 16, 2016**	

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F 371	Continued From page 26 every day by all dietary staff for expired food items. On 4/6/16 at 6:10 p.m. administration was made aware of the above findings. No further information was presented prior to exit.	F 371		
F 514 SS=E	483.75(l)(1) RES 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, facility document review and clinical record review, it was determined that the facility staff failed to maintain an accurate clinical record for three of 17 residents in the survey sample, Residents #6, #3 and #11. 1. The facility staff failed to accurately document Resident #6's behavior monitoring on multiple occasions from January 2016 through April 2016. 2. For Resident #3, facility staff inaccurately documented targeted behaviors for the use of	F 514	**F514** **Corrective Action(s):** Residents #3, #6 & #11's attending physician has been notified that the facility failed to consistently document accurate pre and post behavior monitoring prior to and after administering physician ordered antipsychotic medications. Residents #, #6 & #11 have had their antipsychotic orders reviewed and behavior monitoring clarified by the attending physician. A facility incident and accident form has been completed for this incident. **Identification of Deficient Practices & Corrective Action(s):** All other residents may have potentially been affected. A 100% review of all residents receiving routine or PRN antipsychotic medication orders and MAR's, will be conducted by the DON and/or Unit Manager to identify residents at risk for inappropriate behavior monitoring. All negative findings will be clarified and/or correct at time of discovery. A facility Incident & Accident form will be completed for each negative finding.	

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F 514	Continued From page 27 Seroquel (1) on the February, March and April 2016 MARS (Medication Administration Records). Seroquel is a mood stabilizer used to decrease manifestations of psychoses, depression, or acute mania. 3. For Resident #11, facility staff inaccurately documented targeted behaviors for the use of Seroquel on the February, March and April 2016 MARS. The findings include: 1. The facility staff failed to accurately document Resident #6's behavior monitoring on multiple occasions from January 2016 through April 2016. Resident #6 was admitted to the facility on 5/17/10 and readmitted to the facility on 3/17/11. Resident #6's diagnoses included but were not limited to: *dementia, anxiety and **convulsions. Resident #6's most recent MDS (minimum data set), an annual assessment with an ARD (assessment reference date) of 2/11/16, coded the resident's cognition as severely impaired. Resident #6's January 2016 through April 2016 MARs (medication administration records) documented the resident presented with the following occurrences of behaviors: 1/1/16- three occurrences 1/9/16- one occurrence 1/10/16 (8:00 a.m.)- one occurrence 1/10/16 (4:00 p.m.)- three occurrences 1/19/16 (8:00 a.m.)- one occurrence 1/19/16 (4:00 p.m.)- three occurrences 1/20/16- one occurrence	F 514	**Systemic Change(s):** The facility policy and procedure has been reviewed and no changes are warranted at this time. All licensed nursing staff will be in-serviced by the DON or regional nurse consultant on the clinical documentation standards per facility policy and procedure. This training will include the standards for maintaining accurate medical records and clinical documentation to include Physician Orders, MAR's, TAR's, and accurate pre and post behavior monitoring for all antipsychotic medication administration according to the acceptable professional standards and practices. **Monitoring:** The DON is responsible for maintaining compliance. The DON, and/or Unit Manager will audit the MAR's weekly coinciding with the MDS 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: May 16, 2016**	

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F 514	Continued From page 28 1/29/16- one occurrence 2/3/16- one occurrence 2/6/16 (8:00 a.m.)- one occurrence 2/6/16 (4:00 p.m.)- one occurrence 2/7/16- one occurrence 2/17/16- one occurrence 2/21/16- one occurrence 3/2/16- one occurrence 3/11/16- three occurrences 3/20/16- three occurrences 3/30/16- three occurrences 4/1/16- one occurrence 4/4/16- three occurrences The MAR administration record notes for January 2016 through April 2016 documented the following: 1/1/16- Behavior Count: 3; Behavior Types: None 1/9/16- Behavior Count: 1; Behavior Types: None 1/10/16 (9:25 a.m.)- Behavior Count 1; Behavior Types: None 1/10/16 (4:28 p.m.)- Behavior Count 3; Behavior Types: None 1/19/16 (10:10 a.m.)- Behavior Count 1; Behavior Types: None 1/19/16 (5:15 p.m.)- Behavior Count 3; Behavior Types: None 1/20/16- Behavior Count: 1; Behavior Types: None 1/29/16- Behavior Count 1; Behavior Types: None 2/3/16- Behavior Count 1; Behavior Types: None 2/6/16 (9:01 a.m.)- Behavior Count 1; Behavior Types: None 2/6/16 (4:16 p.m.)- Behavior Count 1; Behavior Types: None 2/7/16- Behavior Count 1; Behavior Types: None 2/17/16- Behavior Count 1; Behavior Types: None 2/21/16- Behavior Count 1; Behavior Types: None	F 514		

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F 514	Continued From page 29 3/2/16- Behavior Count 1; Behavior Types: None 3/11/16- Behavior Count 3: Behavior Types: None 3/20/16- Behavior Count 3; Behavior Types: None 3/30/16- Behavior Count 3; Behavior Types: None 4/1/16- Behavior Count 1; Behavior Types: None 4/4/16- Behavior Count 3; Behavior Types: None Resident #6's comprehensive care plan reviewed on 2/17/16 failed to document information regarding accurate documentation of behaviors. On 4/6/16 at 4:00 p.m., a telephone interview was conducted with RN (registered nurse) #2 (the nurse responsible for documenting Resident #6's behaviors on 1/9/16, 1/10/16, 1/19/16, 1/20/16, 1/29/16, 2/3/16, 2/6/16, 2/7/16, 2/17/16, 2/21/16, 3/2/16 and 3/20/16). RN #2 stated for the longest time she had to document a "1" because the first couple times she documented behaviors, the computer system wouldn't accept a zero. RN #2 stated she thought she had to document a numeric value. RN #2 was asked if the entries that documented numbers of behaviors but then documented no behavior types were inaccurate. RN #2 stated if she documented a one (beside behavior count) then none (beside behavior type) then the documentation was inaccurate. RN #2 stated if she documented a one (beside behavior count) then cursing (beside behavior type) then the documentation was accurate. RN #2 was asked if the entries that documented a behavior count of three and behavior types as none were inaccurate. RN #2 stated the entries documented that way shouldn't have been her entries (meaning someone else documented those entries). On 4/6/16 at 6:18 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the	F 514		

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F 514	Continued From page 30 director of nursing) were made aware of the above findings. The facility policy titled, "Charting Errors and/or Omissions" documented, "Policy Statement: Accurate medical records shall be maintained by this facility..." No further information was presented prior to exit. *"Dementia is the name for a group of symptoms caused by disorders that affect the brain." This information was obtained from the website: https://vsearch.nlm.nih.gov/vivisimo/cgi-bin/query-meta?v%3Aproject=medlineplus&v%3Asources=medlineplus-bundle&query=dementia **Convulsions occur when a person's body shakes rapidly and uncontrollably. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/seizures.html 2. For Resident #3, facility staff inaccurately documented targeted behaviors for the use of Seroquel (1) on the February, March and April 2016 MARS (Medication Administration Records). Seroquel is a mood stabilizer used to decrease manifestations of psychoses, depression, or acute mania. 3. For Resident #11, facility staff inaccurately documented targeted behaviors for the use of Seroquel on the February, March and April 2016 MARS. 2. Resident #3 was admitted to the facility on 10/2/13 with diagnoses that included but were not limited to altered mental status, high blood pressure, high cholesterol, Non-Alzheimer's Dementia, and major depressive disorder. Review of Resident #3's most recent MDS	F 514		

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F 514	Continued From page 31 (Minimum Data Set) was a quarterly assessment with an ARD (Assessment Reference Date) of 1/7/16. Resident #1 was coded as being severely cognitively impaired scoring 99 on the BIMS (Brief Interview for Mental Status). Resident #3 was coded as requiring supervision with ambulation and meals; and limited to extensive assistance from staff with all other ADLS (Activities of Daily Living). Resident #3 was coded as being short tempered and easily annoyed nearly every day in section D (Mood) of the MDS assessment; and coded as having some episodes of wandering in section E (Behaviors) of the MDS. Review of Resident #3's most recently signed physician sheet revealed the following orders: "Seroquel 25 mg (milligrams) Take 1 tab (tablet) po (by mouth) q (every) day and Seroquel 12.5 mg tab Take 1 tab po q day" for "F02.81 Dementia in oth (other) diseases classd (classified) elswhr (elsewhere) w (with) behavioral disturbance." These orders were initiated on 1/26/16. Review of Resident #3's February, March and April 2016 MARS revealed the following documentation: · 2/3/16 (9:44 a.m.) Behavior Count: 1; Behavior Types: None · 2/6/16 (9:39 a.m.) Behavior Count: 2; Behavior Types: None · 2/17/16 (9:06 a.m.)-Behavior Count: 1; Behavior Types: None · 3/02/16 (9:23 a.m.)- Behavior Count 1; Behavior Types: None · 3/11/16 (9:56 p.m.)- Behavior Count 3; Behavior Types: None · 3/30/16 (9:44 a.m.)- Behavior Count 3; Behavior Types: None · 4/04/16 (9:25 a.m.)- Behavior Count 3; Behavior Types: None	F 514		

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F 514	Continued From page 32 On 4/06/16 at 5:45 p.m., an interview was conducted with LPN (licensed practical nurse) #6. When asked how behaviors are documented she stated that each time a psychoactive medication is given a prompt on the computer system will ask if the resident displayed any behaviors and the frequency of behaviors. When asked why on the MARS nursing documented Resident #3 as having behaviors but then wrote "NONE" for behavior type, she stated, "That must have been documented wrong." On 4/06/16 at 6:10 p.m., administration was made aware of the above findings. No further information was presented prior to exit. 3. Resident #11 was admitted to the facility on 11/21/14 with diagnoses that included but were not limited to high blood pressure, peripheral vascular disease, diabetes, Alzheimer's disease, stroke, and venous insufficiency. Resident #11's most recent MDS (Minimum Data Set) was a quarterly assessment with an ARD (Assessment Reference Date) of 1/18/16. Resident #11 was coded as being severely cognitively impaired in the ability to make daily life decisions scoring 99 on the BIMS (Brief Interview for Mental Status). Resident #11 was coded as requiring extensive assistance from staff with most ADLS (Activities of Daily Living); and needing supervision with meals. Resident #11 was coded as being short tempered and easily annoyed in section D (Mood) of the MDS; and coded as having Delusions and other behaviors such as rummaging and wandering. Review of Resident #11's POS (Physician Order Sheet) documented the following orders: "Seroquel 50 mg (milligram) tab (tablet) Take 1 tab po (by mouth) q (every) day at hs (night)...Seroquel 25 mg tab Take 1 tab po at 8am	F 514		

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F 514	Continued From page 33 and 2 pm." Review of Resident #3's February, March and April 2016 MARS revealed the following documentation: · 2/3/16 (8:27 a.m.) Behavior Count: 1; Behavior Types: None · 2/3/16 (1:23 p.m.) Behavior Count: 1; Behavior Types: None · 2/6/16 (8:11 a.m.)-Behavior Count: 1; Behavior Types: None · 2/7/16 (8:33 a.m.)- Behavior Count 1; Behavior Types: None · 2/7/16 (1:51 p.m.)- Behavior Count 1; Behavior Types: None · 2/17/16 (7:50 a.m.)- Behavior Count 1; Behavior Types: None · 2/17/16 (1:59 p.m.)- Behavior Count 1; Behavior Types: None · 2/21/16 (1:13 p.m.)-Behavior Count 1; Behavior Types: None · 3/2/16 (8:32 a.m.)-Behavior Count 1; Behavior Types: None · 3/11/16 (9:35 p.m.)-Behavior Count 3; Behavior Types: None · 3/30/16 (8:53 a.m.)-Behavior Count 3; Behavior Types: None · 3/30/16 (3:03 p.m.)- Behavior Count 3; Behavior Types: None · 4/4/16 (8:28 p.m.)-Behavior Count 3; Behavior Types: None · 4/4/16 (1:47 p.m.)-Behavior Count 3; Behavior Types: None On 4/06/16 at 5:45 p.m., an interview was conducted with LPN (licensed practical nurse) #6. When asked how behaviors are documented she stated that each time a psychoactive medication is given a prompt on the computer system will ask if the resident displayed any behaviors and the frequency of behaviors. When asked why on	F 514		

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F 514	Continued From page 34 the MARS nursing documented Resident #11 as having behaviors but then wrote "NONE" for behavior type, she stated, "That must have been documented wrong." On 4/06/16 at 6:10 p.m., administration was made aware of the above findings. No further information was presented prior to exit. (1) Davis's Drug Guide for Nurses, 11th edition, p.1043.	F 514		