STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495323	A. BUILDING _____ B. WING _____	03/15/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HALL - LAUREL MEADOWS	16600 DANVILLE PIKE LAUREL FORK, VA 24352

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard and complaint survey was conducted 03/13/18 through 03/15/18. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety survey/report will follow. Two complaints were investigated during the survey. The census in this 60 certified bed facility was 57 at the time of the survey. The survey sample consisted of 15 current Resident reviews and 4 closed record reviews.	F 000		
F 625 SS=D	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At	F 625	**F625** **Corrective Action(s):** Resident #35 and their RP have been notified of the facilities bed-hold policy and procedure and the requirement that it be reviewed and issued in writing to the resident and the RP when discharge to the hospital or when going out on therapeutic leave. A facility Incident and Accident form has been completed for each resident identified in the review. **Identification of Deficient Practice(s) and Corrective Action(s):** All other residents could potentially be affected. The Bed-Hold policy and forms are now kept at the nursing station for after hour's transfers to the hospital to be completed by the charge nurse. The Social Services director/Admissions director will be responsible for normal business hour transfer notification of all bed-holds to residents and/or Responsible parties.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Wrightley C. Darnell	Administrator	4-6-18

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 625	Continued From page 1 the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review, and facility document review, the facility failed to offer a bed hold at the time of the Residents transfer to an acute care hospital for one of 19 Residents, Resident #35. The findings included. The facility failed to offer the Resident a bed hold when they were transferred and admitted to an acute care hospital. The record review revealed that Resident #35 had been admitted to the facility, 03/07/17 and had been readmitted on 02/27/18. Diagnoses included, but were not limited to, chronic kidney disease, gastro-esophageal reflux disease, constipation, anxiety, and hypertension. Section C (cognitive patterns) of the Residents admission MDS (minimum data set) assessment with an ARD (assessment reference date) of 03/06/18 included a BIMS (brief interview for mental status) summary score of 7 out of a possible 15 points. The clinical record included a physicians telephone order dated 01/30/18 "May send to _____ hospital ER (emergency room) for eval." The Resident was admitted and returned to the facility 02/27/18.	F 625	**Systemic Change(s):** The facility Policy and Procedure has been reviewed and no changes are warranted at this time. The Social Services Director, Admissions Director and licensed staff have been inserviced by the administrator on the bed-hold requirement and the proper use and notification of Bed-Hold policy. **Monitoring:** The Admissions Director/Social Service Director are responsible for compliance. All transfers/discharges from the facility will be audited the by the Social service director and/or Admissions Director to ensure proper bed-hold notification was completed at the time of transfer or therapeutic leave. Any/all negative findings will be corrected at time of discovery. The results of these audits will be forwarded to the Quality Assurance Committee quarterly for review, analysis, and recommendations for change in facility policy, procedure, and/or practice. **Completion Date:** 4/27/18	

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F 625	Continued From page 2 When asked about the bed hold the facility provided the surveyor with a copy of a bed hold that was offered on 02/14/18. The facility policy/procedure titled "Bed-Holds and Returns" read in part "Prior to transfers...residents or resident representatives will be informed in writing of the bed-hold and return policy..." The administrative staff of the facility was notified that Resident #35 was not offered a bed hold prior to being transferred to an acute care hospital on 01/31/18 during a meeting with the survey team on 03/14/18 at approximately 4:10 p.m. No further information regarding this issue was provided to the survey team prior to the exit conference.	F 625		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as	F 656	**F656** **Corrective Action(s):** Resident #43 has had their comprehensive care plan reviewed and revised to reflect appropriate goals and interventions and approaches to address the residents pain management needs. A Facility Incident & Accident Form was completed for this incident.	

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F 656	Continued From page 3 required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to implement a person centered comprehensive care plan for 1 of 19 residents in the survey sample (Resident #43). The findings included: Resident #43 was readmitted to the facility on 4/30/17 with the following diagnoses of, but not limited to high blood pressure, peripheral vascular	F 656	**Identification of Deficient Practices & Corrective Action(s):** All residents may have potentially been affected. A 100% review of all resident centered comprehensive care plans will be conducted by the DON and/or RCC to identify residents with inaccurate or incomplete comprehensive 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. **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 Hours 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, revision & implementation process of individualized care plans.	

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F 656	Continued From page 4 disease, obstructive uropathy, diabetes, cerebrovascular accident, hemiplegia, anxiety disorder and depression. On the quarterly MDS (Minimum Data Set(with an ARD (Assessment Reference Date) of 12/20/17 coded the resident as having a BIMS (Brief Interview for Mental Status) score of 13 out of a possible score of 15. Resident #43 was also coded as requiring extensive assistance of 1 staff member for dressing and bathing and is totally dependent on 2 staff members for bathing. The surveyor conducted a clinical record review of Resident #43's record on 3/13/18 at 1 pm. The surveyor noted that the resident had a physician order for "Oxycodone HCL 5 mg (milligram) tablet po (by mouth) Q4h (every 4 hours) prn (as needed) for pain". It was noted by the surveyor that from March 1, 2018 through March 13, 2018, the resident had received this medication for pain 12 times in the said time frame. The surveyor reviewed the care plan also. It was noted that pain was not in the person centered comprehensive care plan. The surveyor notified the MDS nurse #1 of the above documented findings on 3/13/18 at 3:30 pm. The surveyor asked the MDS nurse #1 if the resident had been care planned for pain. The MDS nurse #1 reviewed the care plan and MDS and stated, "The resident did not trigger for pain and that was why it was not care planned." The surveyor reviewed the MAR for November and December 2017 with the MDS nurse #1. It was noted that the resident received the above documented medication had been administrated to the resident 24 times in the month of November and 23 times in the month of December. The surveyor asked MDS nurse #1	F 656	**Monitoring:** The RCC and DON are responsible for maintaining compliance. The DON and/or RCC will perform care plan audits weekly coinciding with the care plan calendar 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:4/27/18**	

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F 656	Continued From page 5 after reviewing this, should the resident been care planned for pain so that it would had of been a person centered comprehensive care plan? The MDS nurse #1 stated, "Yes, it should have been." The surveyor notified the administrative team of the above documented findings on 3/15/18 at 2:45 pm in the conference room. No further information was provided to the surveyor prior to the exit conference on 3/15/18.	F 656		
F 684 SS=E	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to follow a physician order for medication administration for 1 of 19 residents in the survey sample (Resident #43). The findings included: Resident #43 was readmitted to the facility on 4/30/17 with the following diagnoses of, but not limited to high blood pressure, peripheral vascular disease, obstructive uropathy, diabetes, cerebrovascular accident, hemiplegia, anxiety disorder and depression. On the quarterly MDS	F 684	**F684** **Corrective Action(s):** Residents #43's attending physician was notified that the facility failed to administer Metformin as ordered by the attending physician. A facility Medication Error form was completed for this incident. **Identification of Deficient Practices/Corrective Action(s):** All other residents with physician ordered medications to be given with meals may have been potentially affected. The DON and/or Unit Manager will conduct a 100% audit of all resident's physician orders and MAR's to identify resident at risk. Residents identified at risk will be corrected at time of discovery and their comprehensive plans of care updated to reflect their resident specific needs. The attending physicians will be notified of each negative finding and a facility Incident & Accident Form will be completed for each negative finding.	

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F 684	Continued From page 6 (Minimum Data Set(with an ARD (Assessment Reference Date) of 12/20/17 coded the resident as having a BIMS (Brief Interview for Mental Status) score of 13 out of a possible score of 15. Resident #43 was also coded as requiring extensive assistance of 1 staff member for dressing and bathing and is totally dependent on 2 staff members for bathing. The surveyor conducted a clinical record review of Resident #43's record on 3/13/18 at 1 pm. It was noted by the surveyor that the resident had the following physician ordered: "Metformin HCL 1,000 mg (milligram) tablet po (by mouth) 2XD (2 times a day) with meals." The times that the medication was administered was 8 am and 8 pm. This medication had an original order date of 5/1/17. The surveyor reviewed the resident's MAR (Medication Administration Record) for the months beginning June 2017 through March 13, 2018. It was noted that this medication, Metformin, was administrated 2 times a day but the times listed for administration was 8 am and 8 pm and was not given with a meal at 8 pm. The surveyor notified the director of nursing of the above documented findings on 3/13/18 at 1:45 pm. The director of nursing reviewed the physician order and then the MAR and stated, "The 8 pm dose was not given with a meal. Supper is usually between 5 and 5:30." The surveyor notified the administrative team of the above documented findings on 3/15/17 at 2:45 pm. No further information was provided to the	F 684	**Systemic Change(s):** The facility policy and procedures have been reviewed and no revisions are warranted at this time. The nursing assessment process as evidenced by the 24 Hour Report and documentation in the medical record /physician orders remains the source document for the development and monitoring of the provision of care, which includes, obtaining, transcribing and completing physician orders, medication orders, treatment orders. The DON and/or Regional nurse consultant will inservice all licensed nursing staff on the procedure for obtaining, transcribing, and completing physician medication and treatment orders. **Monitoring:** The DON will be responsible for maintaining compliance. The DON and/or Unit Managers will perform weekly chart audits coinciding with the care plan calendar to monitor for compliance. Any/all negative findings and 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:** **4/27/18**	

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F 684	Continued From page 7 surveyor prior to the exit conference on 3/15/18.	F 684		
F 697 SS=D	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to develop a care plan for pain for 1 of 19 residents in the survey sample (Resident #43). The findings included: Resident #43 was readmitted to the facility on 4/30/17 with the following diagnoses of, but not limited to high blood pressure, peripheral vascular disease, obstructive uropathy, diabetes, cerebrovascular accident, hemiplegia, anxiety disorder and depression. On the quarterly MDS (Minimum Data Set(with an ARD (Assessment Reference Date) of 12/20/17 coded the resident as having a BIMS (Brief Interview for Mental Status) score of 13 out of a possible score of 15. Resident #43 was also coded as requiring extensive assistance of 1 staff member for dressing and bathing and is totally dependent on 2 staff members for bathing. The surveyor reviewed the resident's CCP (comprehensive care plan) on 3/13/18 at 1 pm. It was noted by the surveyor that the CCP did not have pain care planned. The surveyor notified	F 697	**F697** **Corrective Action(s):** Residents #43's attending physician was notified that the facility failed to develop a resident centered care plan to address the residents pain levels or the residents pain management plan. A facility Incident & Accident form was completed for this incident. **Identification of Deficient Practices & Corrective Action(s):** All other residents receiving scheduled or PRN pain medication may have potentially been affected. A 100% review of all residents receiving PRN or scheduled pain medications will be conducted by the DON, RCC and/or designee to verify a resident centered care plan is in place to address the residents pain levels and the residents pain management plan. All negative findings will be corrected at time of discovery, the attending physician will be notified of any pain management issues and a facility 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 RCC will be inserviced by the regional nurse consultant on the development of resident centered care plans to include resident comprehensive pain management plans.	

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F 697	Continued From page 8 MDS nurse #1 of the documented findings at 3:30 pm. The MDS nurse #1 stated, "The resident did not trigger for pain so he wasn't care planned for it." The surveyor and MDS nurse #1 reviewed the usage of the prn (as needed) pain medication by the resident. It was noted that the resident had used prn pain medication for approximately 23 times in the February 2018. The surveyor asked MDS nurse #1, "If after reviewing the usage of prn pain medication for February, would you say that the care plan is a resident centered care plan?" The MDS nurse #1 stated, "No it isn't. We should have had pain care planned." The administrative team was notified of the above documented findings on 3/14/18 at approximately 4 pm in the conference room. No further information was provided to the surveyor prior to the exit conference on 3/15/18.	F 697	**Monitoring:** The RCC is responsible for maintaining compliance. The RCC will complete weekly care plan audits coinciding with the care plan calendar to monitor the accuracy of care plans. 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:4/27/18**	
F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug.	F 756	**F756** **Corrective Action(s):** Resident #25 had their diabetic management orders reviewed and revised to reflect her current diabetic management plan to include an accurate accucheck with sliding scale coverage parameters. Resident #25's comprehensive care plans has been revised to reflect approaches and interventions to meet the resident's current needs.	

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F 756	Continued From page 9 (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review the pharmacy failed to identify and report an irregularity in regards to diabetic management for one of 19 Residents, Resident #25. The findings included. The pharmacy failed to recognize during the drug regimen review that a diabetic order had been transcribed incorrectly. The clinical record review revealed that Resident #25 had been admitted to the facility on 06/03/10 and had been readmitted on 01/07/18. Diagnoses included, but were not limited to, diabetes,	F 756	**Identification of Deficient Practices & Corrective Action(s):** All other residents receiving diabetic medications may have been potentially affected. The pharmacy consultant will conduct a 100% review of all resident receiving diabetic medications to identify residents in need of pharmacy recommendations, follow up, and review. Any/all negative findings will be corrected at time of discovery. A Risk Management Incident/Accident form will be completed for each incident identified. **Systemic Change(s):** The facility Policy and Procedure has been reviewed and no changes are warranted at this time. The consultant pharmacist will review all resident's medication regime monthly to address appropriate use, reduction, elimination if needed and accuracy of the medication orders. All licensed nursing staff will be inserviced by the DON on the importance of monitoring medication regimens for accurate medication orders, accurate medication instructions and monitoring parameters. The DON and/or ADON will review all pharmacy recommendations monthly to ensure that any/all pharmacy recommendations have been addressed and proper notification to attending physicians has been completed.	

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F 756	Continued From page 10 encephalopathy, dementia, and chronic kidney disease. Section C (cognitive patterns) of the Residents admission MDS (minimum data set) assessment with an ARD (assessment reference date) of 01/17/18 had been coded 1/1/3 to indicate the Resident had problems with long and short term memory and was severely impaired in cognitive skills for daily decision making. The clinical record included a physician signed POS (physician order summary) dated 01/23/18 that included an order for "Accucheck PRN (as needed) Diabetics: Follow facility protocol for signs of hypo/hyperglycemia. Notify MD (medical doctor) is sugar si > (greater than) 60 or < (less than) 400. May administer glucogel 1 tube SL (sublingual) if BS (blood sugar) >50..." (sic) A review of the Residents eMARs (electronic medication administration records) for February and March 2018 revealed that the facility staff had transcribed the order on the Residents eMARs the exact same way. However, the surveyor was unable to find any documentation to indicate the order had been followed as written. When asked about the above order the unit manager verbalized to the surveyor that she was the person who transcribed the order from their standing orders and it had been transcribed incorrectly. The unit manager provided the surveyor with a copy of the facility standing orders that read- "Diabetes...Hypoglycemia (blood sugar below 60)...Give juice, milk, food or fluids (may sweeten with sugar pack if patient symptomatic) or Insta	F 756	**Monitoring:** The DON is responsible for maintaining compliance. The DON, and/or designee will perform weekly medication audits of all diabetic residents to ensure that the orders are accurate and being followed as ordered. Any/all negative findings will be corrected at time of discovery. Detail findings of this review will be reported to the Quality Assurance Committee for review, analysis, and recommendations for change in facility policy, procedure, and/or practice. **Completion Date: 4/27/18**	

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F 756	Continued From page 11 Glucose, 1 package by mouth. Recheck blood sugar in 10 min. and p.r.n. until > 100...May use 1 cc. IM glucogon if patient is unable to take p.o. (by mouth) food/fluid...Hyperglycemia (blood sugar above 500 on two occasions 6 hours apart)...Notify Physician immediately unless other parameters have been set by Physician." These standing orders had been signed by the physician 10/09/10. The unit manager stated the standing orders had been reactivated upon the Residents readmission. The administrative team was notified of the incorrect orders in regards to the Residents diabetic management during a meeting with the survey team on 03/15/18 at approximately 2:45 p.m. No further information regarding this issue was provided to the survey team prior to the exit conference.	F 756		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a	F 758	**F 758** **Corrective Action(s):** Resident #10's attending physician has reviewed resident #10's Medication orders and the PRN Trazodone medication has been discontinued by the attending physician. Resident #20's attending physician has reviewed resident #20's Medication orders and the PRN Xanax medication has been discontinued by the attending physician. Resident #23's attending physician has reviewed resident #23's Medication orders and the PRN Ativan medication has been discontinued by the attending physician.	

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F 758	Continued From page 12 resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to ensure that three of 19 residents were free from unnecessary	F 758	**Identification of Deficient Practice(s) and Corrective Action(s):** All other residents receiving PRN Psychotropic medications may have been potentially affected. The DON, Unit Manager and/or Pharmacy consultant will review the medication orders of all residents receiving PRN Psychotropic medication to ensure that no unnecessary medications have been ordered and that PRN Antipsychotic medication orders are not in place for longer than 14 days without a physician evaluation. 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. The DON has reviewed the regulatory requirement for PRN psychotropic medication usage and time limits with the facility attending physicians. 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 psychotropic medication to include the need for PRN psychotropic medication orders to be limited to 14 days without physician review. **Monitoring:** The DON is responsible for maintaining compliance. The DON, Unit Manager and/or designee will complete weekly physician orders and MAR audits	

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F 758	Continued From page 13 medications (Resident #10, #20 and #23). The findings included. 1. For Resident #10, the attending physician failed to provide the rationale in the Residents clinical record as to why the Resident should receive the psychotropic medication trazadone for greater than 14 days. The record review revealed that Resident #10 had been admitted to the facility 07/13/12. Diagnoses included, but were not limited to, Parkinson's disease, hypertension, asthma, rheumatoid arthritis, pain, dysphagia, obstructive sleep apnea, and cognitive communication deficit. Section C (cognitive patterns) of the Residents quarterly MDS (minimum data set) assessment with an ARD (assessment reference date) of 02/19/18 included a BIMS (brief interview for mental status) summary score of 8 out of a possible 15 points. The Residents clinical record included an order for the psychotropic medication "TRAZODONE 5O MG TABLET Give half tablet at hs (bedtime/hour of sleep) prn (as needed) for sleep may give up to 10pm as needed for sleep." The date on this order had been documented as 10/27/18. The nurse consultant was asked for the rationale for continuing the medication more than 14 days on 03/15/18 at approximately 10:40 a.m. On 03/15/18 at approximately 10:45 a.m., the nurse consultant verbalized to the surveyor that they were unable to locate any further	F 758	coinciding with the Care plan calendar to monitor 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: 4/27/18**	

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F 758	Continued From page 14 information. The administrative staff were notified of the above during a meeting with the survey team on 03/15/18 at approximately 2:45 p.m. Prior to the exit conference the facility staff provided the surveyor with a copy of a physicians telephone order dated 03/15/18 to D/C (discontinue) trazadone prn secondary to nonuse. No further information was provided to the survey team regarding this issue prior to the exit conference. 2. For Resident #20, the attending physician failed to provide the rationale in the Resident's clinical record as to why the Resident should receive the psychotropic medication, Xanax, for greater than 14 days. Resident #20 was readmitted to the facility on 9/29/14 with the following diagnoses of, but not limited to diabetes, anxiety disorder and psychotic disorder. On the quarterly MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 2/8/18 which coded the resident with short term and long term memory problems. Resident #20 was also coded with difficulty in making decisions in new situations. The resident requires extensive assistance with dressing and personal hygiene. During the clinical record review on 3/15/18 that the surveyor performed, the surveyor noted that Resident #20 had the following medication order: "Xanax o.5 mg (milligram) Give 1 tab (tablet) po (by mouth) Q8H (every 8 hours) as needed ..." The physician had ordered this medication on 8/29/17. The surveyor noted that there was no	F 758		

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F 758	Continued From page 15	F 758		

stop date or a rational of why the psychotropic medication should had given to the resident for a longer period than 14 days.

The director of nursing (DON) was notified of the above documented findings on 3/15/18 at approximately 10:30 am. The DON stated, "I looked at this earlier when another surveyor found this on another record. I can't give you a reason why this was not done."

The administrative team was notified of the above documented findings on 3/15/18 at 2:45 pm.

No further information was provided to the surveyor prior to the exit conference on 3/15/18.

3. For Resident #23 the facility staff failed to discontinue the prn (as needed) medication Ativan after 14 days.

Resident #23 was admitted to the facility on 02/13/18. Diagnoses included but not limited to congestive heart failure, hypertension, end stage renal disease, diabetes mellitus, hip fracture, cerebrovascular accident, anxiety, depression and respiratory failure.

The most recent MDS (minimum data set) with an ARD (assessment reference date) of 02/22/18 coded the Resident as 10 of 15 in section C, cognitive patterns. This is an admission MDS.

Resident #23's clinical record was reviewed on 03/15/18. It contained a signed physician's order summary for the month of February, which read in part, "Ativan 0.5mg tablet po q (every) 6 hours prn anxiety". This entry had an order date of 02/13/18 and a start date of 02/13/18. There was

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F 758	Continued From page 16	F 758		

not a discontinue date listed on this physician's order summary; however, the clinical record contained a consultation report from the pharmacist, dated 03/13/18, which read in part, "Comment: ... (Resident #23) has a PRN order for an anxiolytic, which has been in place for greater than 14 days without a stop date: Lorazepam (Ativan) 0.5 mg every 6 hours as needed for anxiety. Recommendation: Please discontinue PRN Lorazepam. If the medication cannot be discontinued at this time, current regulations require that the prescriber document the indication for use, the intended duration of therapy, and the rationale for the extended time period. Physician's Response: [x] I accept the recommendation(s) above, please implement as written."

The Resident's clinical record contained a nurses note which read in part, "3/13/2018 2:57 PM New order to dc (discontinue) prn Ativan. Rp (responsible party) aware". The clinical record also contained nurses notes which read in part "3/14/2018 3:33 PM Resident to desk crying states 'I been on Ativan for years. Please, please get Ativan back" and "3/14/2018 5:40 PM notified r/p of Ativan order".

The clinical record contained a physician's telephone order dated 03/14/18 which read in part "Ativan 0.5mg po (by mouth) q 6 hours prn anxiety".

Surveyor spoke with the RNC (regional nurse consultant) on 02/15/18 at approximately 1100 regarding the Resident's Ativan order. RNC stated that there was no documented rationale for extending the prn Ativan.

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F 758	Continued From page 17 The concern of not having a stop date for the Ativan nor a documented rationale for continued usage was discussed with the administrative team during a meeting on 0315/18 at approximately 1500. No further information was provided prior to exit.	F 758		
F 760 SS=D	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review the facility failed to ensure one of 19 Residents was free of a significant medication error (Resident #25). The findings included. The facility staff administered 10 units of insulin when they should have administered 6 units. The clinical record review revealed that Resident #25 had been admitted to the facility on 06/03/10 and had been readmitted on 01/07/18. Diagnoses included, but were not limited to, diabetes, encephalopathy, dementia, and chronic kidney disease. Section C (cognitive patterns) of the Residents admission MDS (minimum data set) assessment with an ARD (assessment reference date) of 01/17/18 had been coded 1/1/3 to indicate the Resident had problems with long and short term memory and was severely impaired in cognitive	F 760	**F760** **Corrective Action(s):** Resident #25's attending physician has been notified that the facility failed to administer Novolog Sliding scale insulin per physician order. The nurse involved in administering the sliding scale insulin order incorrectly has received one-on-one inservice training from the DON on the administration of physician ordered medications. A facility Medication error form was completed for each incident. **Identification of Deficient Practice(s) and Corrective Action(s):** All other residents receiving Physician ordered Sliding Scale Insulin may have potentially been affected. A 100% review of all residents with insulin orders will be conducted to identify residents at risk. All residents identified at risk will be corrected at time of discovery and appropriate disciplinary action taken. An Incident and Accident form will be completed for each negative finding.	

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F 760	Continued From page 18 skills for daily decision making. The Residents clinical record included a physician signed POS (physician order summary) that included orders for novolog sliding scale insulin before meals and at bedtime. For a BS (blood sugar) of 250-350 the nursing staff was to administer 6 units of insulin. A review of the Residents eMARs (electronic medication administration records) for March 2018 revealed that on March 5, 2018 at 8:30 p.m. the nursing staff had administered 10 units of novolog insulin for a BS of 266 when they should have administered 6 units. The Residents BS the following morning was documented as 270. The administrative staff were notified of the above during a meeting with the survey team on 03/14/18 at approximately 4:10 p.m. No further information regarding this issue was provided to the survey team prior to the exit conference.	F 760	**Systemic Change(s):** The facility policy and procedure has been reviewed and no changes are warranted at this time. All Licensed staff will be inserviced on the facility policy and procedure by the DON regarding the administration of medications per physician orders to include the proper administration of insulin to include sliding scale insulin as ordered by the physician. **Monitoring:** The Director of Nursing is responsible for maintaining compliance. The DON and/or designee will do weekly MAR audits to monitor for compliance. Any negative findings will be addressed at the time of discovery and appropriate disciplinary action taken. Detailed findings of these results will be reported to the Quality Assurance Committee for review, analysis, and recommendations for change in facility policy, procedure, and/or practice. **Completion Date: 4/27/18**	
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and	F 761	**F761** **Corrective Action(s):** The mislabeled Simbrinza 1% - 0.2% eye drops noted on the med pass observation has been removed from the medication cart and a correctly labeled bottle of Simbrinza 1% - 0.2% was obtained. A Facility Medication Error form has been completed for this incident.	

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F 761	Continued From page 19 Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, facility document review, staff interview and clinical record review, the facility staff failed to ensure eye drops were appropriately labeled for 1 of 19 residents in the survey sample (Resident #7). The findings included: Resident #7 was admitted to the facility on 2/19/18 with the following diagnoses of, but not limited to atrial fibrillation, high blood pressure, dementia, hip fracture, depression and anxiety disorder. On the admission, MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 2/26/18 coded the resident as having short term and long-term memory problem and being severely impaired in making decisions. Resident #7 was also coded as being very dependent on one staff member for dressing and personal hygiene and totally dependent on 2 staff members for bathing. During the Medication Administration Observation	F 761	**Identification of Deficient Practices & Corrective Action(s):** All other Medications may have potentially been affected. The DON, Unit Manager and/or designee will conduct a 100% review of all Medication Carts and medication rooms to identify any existing mislabeled, expired or discontinued medications. Any/all negative findings will be corrected at time of discovery. A Facility Incident and Accident form will be completed for each incident identified. **Systemic Change(s):** The facility policy and procedure has been reviewed and no changes are warranted at this time. The licensed nursing staff will be inserviced by the pharmacy consultant and/or DON on the policy for monitoring medications to ensure proper labeling, dating and removal of all expired or discontinued medications and supplies from the medication carts and medication room. **Monitoring:** The DON is responsible for maintaining compliance. The DON or Unit Manager will perform weekly audits of all medication rooms and medication carts to ensure that medications are being labeled and dated appropriately and that all expired or discontinued medications are being removed per protocol. Detail 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:4/27/18**	

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F 761	Continued From page 20 on 3/14/18 at 9:05 am, the surveyor observed the label on the Simbrinza 1% - 0.2% eye drops read as follows: "Simbrinza 1%-0.2% drops (1) drop into both eyes BID (twice a day)" for Resident #7. Licensed Practical Nurse (LPN) #2 administrated 1 drop in the resident's right eye. The surveyor conducted a clinical record review on Resident #7 at 10:30 am on 3/14/18. It was noted by the surveyor that the resident had the following physician order in the clinical record: " ...Simbrinza1%-0.2% eye drops (1) gtt (drop) R (right) eye only ..." The surveyor notified the director of nursing (DON) at 10:45 am. The surveyor requested a copy of the facility's policy on changing of directions on medication labels. At 11 am, the DON provided a copy of the facility's policy titled "Labeling of Medication Containers". Under "Policy Interpretation and Implementation", it read it part as follows: " ...7. Only the dispensing pharmacy can label or alter the label on a medication container or package ... " 9. The nursing staff must inform the pharmacy of any changes in physician orders for a medication." The surveyor notified the administrative team of the above documented findings on 3/15/18 at 2:45 pm . No further information was provided to the surveyor prior to the exit conference on 3/15/18.	F 761		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5)	F 842		

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F 842	Continued From page 21 §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.	F 842	**F842** **Corrective Action(s):** Resident #25's attending physician has been notified that the facility failed to accurately transcribe physician ordered accuchecks sliding scale insulin orders. A facility Incident & 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 resident Medical Records will be conducted by the DON, Unit Manager and/or designee to identify residents at risk. All negative findings will be clarified and/or correct as applicable at time of discovery. 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. All licensed nursing staff will be in-serviced by the Regional Nurse Consultant or DON 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 departmental notes according to the acceptable professional standards and practices.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495323	A. BUILDING _____ B. WING _____	03/15/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 842	Continued From page 22 §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to maintain a complete and accurate clinical record for one of 19 Residents, Resident#25. The findings included: The facility staff failed to maintain a complete and accurate clinical record in regards to diabetic management. The clinical record review revealed that Resident	F 842	**Monitoring:** The DON and Medical Records director are responsible for maintaining compliance. The DON, ADON and/or designee will conduct weekly chart audits coinciding with the Care Plan schedule 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: 4/27/18**	

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F 842	Continued From page 23 #25 had been admitted to the facility on 06/03/10 and had been readmitted on 01/07/18. Diagnoses included, but were not limited to, diabetes, encephalopathy, dementia, and chronic kidney disease. Section C (cognitive patterns) of the Residents admission MDS (minimum data set) assessment with an ARD (assessment reference date) of 01/17/18 had been coded 1/1/3 to indicate the Resident had problems with long and short term memory and was severely impaired in cognitive skills for daily decision making. The clinical record included a physician signed POS (physician order summary) dated 01/23/18 that included an order for "Accucheck PRN (as needed) Diabetics: Follow facility protocol for signs of hypo/hyperglycemia. Notify MD (medical doctor) is sugar si > (greater than) 60 or < (less than) 400. May administer glucogel 1 tube SL (sublingual) if BS (blood sugar) >50..." (sic) A review of the Residents eMARs (electronic medication administration records) for February and March 2018 revealed that the facility staff had transcribed the order on the Residents eMARs the exact same way. However, the surveyor was unable to find any documentation to indicate the order had been followed as written. The unit manager was asked the above order on 03/15/18 and after reviewing the order the unit manager verbalized to the surveyor that she was the person who transcribed the order from their standing orders and it had been transcribed incorrectly. The unit manager provide the surveyor with a	F 842		

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F 842	Continued From page 24 copy of the facility standing orders that read "Diabetes...Hypoglycemia (blood sugar below 60 ...Give juice, milk, food or fluids (may sweeten with sugar pack if patient symptomatic) or Insta Glucose, 1 package by mouth. Recheck blood sugar in 10 min. and p.r.n. until > 100...May use 1 cc. IM glucogon if patient is unable to take p.o. (by mouth) food/fluid...Hyperglycemia (blood sugar above 500 on two occasions 6 hours apart)...Notify Physician immediately unless other parameters have been set by Physician." These standing orders had been signed by the physician 10/09/10. The unit manager stated the standing orders had been reactivated upon the Residents readmission. The administrative team was notified of the incorrect orders in regards to the Residents diabetic management during a meeting with the survey team on 03/15/18 at approximately 2:45 p.m. No further information regarding this issue was provided to the survey team prior to the exit conference.	F 842		