STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495189	A. BUILDING _____ B. WING _____	C 10/14/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGENCY HEALTH AND REHABILITATION CENTER	112 N CONSTITUTION DR GRAFTON, VA 23692

(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 survey was conducted 10-12-16 through 10-14-16. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. Two complaints was investigated during the survey. The census in this 60 certified bed facility was 47 at the time of the survey. The survey sample consisted of 11 current Resident reviews (Residents #1 through #11), and 6 closed record reviews (Residents #12 through #17).	F 000		
F 225 SS=D	INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS CFR(s): 483.13(c)(1)(ii)-(iii), (c)(2) - (4) The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).	F 225		11/21/16

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

Electronically Signed | 11/03/2016

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F 225	Continued From page 1 The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility documentation review and clinical record review the facility staff failed for 1 resident (Resident #4) of 17 residents in the survey sample to report an injury of unknown origin to the state survey agency (Office of Licensure and Certification). On 9/9/16 and 9/10/16, Resident #4's nursing notes documented that bruising was observed to the right side of her neck and forearm. The bruising was not reported to the the state survey agency. The findings included: Resident #4, a 94 year old, was admitted to the facility on 10/25/14. Her diagnoses included dementia, anemia, depression, hypertension and anxiety. Resident #4's most recent Minimum Data Set	F 225	F225 1- Resident #4 was seen by the Physician on 10/21/16 and it was determined that Resident #4 has Ecchymosis. 2- The DON or Designee will review shift report and Incident and Accident report of residents for any indication of injuries of unknown origin and ensure that these incidences are reported to the State Agency appropriately. 3- The DON or designee will educate all current licensed nursing staff on the procedure to follow in reporting injuries of unknown origin to the DON or designee so that the incident can be reviewed and reported to the State Agency as applicable. 4-The DON or designee will review shift report and Incident and Accident reports for residents on a weekly basis to ensure that any injuries of unknown origin are	

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assessment was a significant change assessment with an assessment reference date of 9/19/16. She was coded with severe cognitive impairment and required extensive assistance with her activities of daily living.

Resident #4 was observed on 10/13/16 eating breakfast in her room. She received meal tray set up from facility staff and fed herself.

The bruising was documented in the following nursing notes:

9/9/16 11:20 a.m. (Written by Licensed Practical Nurse D) "Bruising was noted to rt (right) side of neck and lt (left) forearm. Resident unable to state how bruises obtained. No swelling noted to areas. No c/o (complaint of) pain voiced."

9/10/16 1:13 a.m. (Written by Licensed Practical Nurse B) "During turnover one of the CNA's (Certified Nursing Assistant) informed me and the oncoming nurse that resident had bruising noted to left lower front of arm and right side of neck. Both of us went in the room to evaluate the pt (patient), she was unable to provide a description of what happened. Increased anxiety noted with pt (patient) trying to get out of the bed. Pt (patient) brought to nurses station for monitoring."

At the end of day meeting on 10/12/16, the facility staff were asked if they investigated or reported Resident #4's bruising that was noted in the nursing notes.

On 10/14/16, the Director of Nursing (DON) provided the following written statement regarding Resident #4's bruising:
"On 9/8/16, I was alerted by staff that resident

reported to the State Agency, as applicable. Results of the audits will be presented to the quarterly Quality Assurance committee for review and recommendation.

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F 225	Continued From page 3	F 225		

had a bruise to mid neck and left arm. I went and assessed the "bruise" and found it to be a discoloration, noted it to be reddish-bluish color, diffused in size at the front neck area, and bluish color on the Lt (left) forearm, near the antecubital space related to prior lab draw on 9/6/16. Nursing did not notice discoloration to neck, prior to. I then went and looked at the Certified Nursing Assistant (CNA) assignment from the prior shift and questioned (CNA name) and (CNA name) regarding the discoloration, neither noted seeing anything on her neck. Two other CNAs (CNA name and CNA name) stated that prior to this notation of the discoloration, she was noted to have the same discoloration noted in the same area before, with no explanation. Noted a nursing note from 4/17 noting bruising to neck, arms, and hands. I requested an order for a stat (immediate) CBC (complete blood count- lab test) to evaluate any abnormalities with resident. The labs were completed and reviewed by the MD (doctor), and no new orders received. Resident does have a diagnosis of anemia, and Vit B-12 deficiency anemia, and a history of Rosacea (redness to facial skin). After interviewing staff and looking at records, it was determined that this was not a result of mistreatment, and most likely due to resident's medical condition. Resident reassessed on 9/14 and noted fading bruising to left forearm and the discoloration to the neck area was gone."

The DON was interviewed about the statement on 10/14/16 at 10:30 a.m. The DON was asked to describe the bruise. She stated the area on the neck was not a bruise, rather an area of discoloration. The DON described the color of the area as reddish with some blue. When asked if the area was still there or went away, the DON

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F 225	Continued From page 4	F 225		

stated it had gone away. It was reviewed with the DON that the conclusion of the investigation was that no mistreatment occurred for Resident #4. At this time, the DON stated that an investigation was not done, the write up provided to the survey team was a summary.

On 10/13/16 at 3:50 p.m., the Administrator was interviewed regarding the facility's abuse reporting policies. When asked what types of incidents the facility would report to the state agency, the Administrator stated abuse, misappropriation, resident to resident altercation, staff to resident altercation and injury of unknown origin. When asked what the facility considered an injury of unknown origin, the Administrator stated bruises, skin tears and broken bones.

The facility policy titled "Abuse/Neglect/Misappropriation//Crime" was reviewed.

The "Procedure" section on page 70 read "4. Any and all suspected or witnessed incidents of patient/ patient abuse, neglect, theft, and/ or exploitation or any reasonable suspicion of a crime against a patient/ patient Center brought to the attention of the Center's Administration will result in internal investigation, appropriate and timely reporting to the State Survey Agency (SSA) and other legally designated agencies, as well as corrective action."

The "Procedure" section on page 73 read "Centers must repot all alleged or reasonable suspected instances of mistreatment when Center staff is suspected of mistreatment, neglect, abuse (including injuries of unknown origin), or misappropriation of patient property."

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F 225	Continued From page 5 In addition, the "Procedure" section on page 73 read "2. Injuries of Unknown Origin should be handled the same as an allegation of mistreatment, neglect or abuse and must be reported to the State Survey Agency if there is reasonable cause to believe or suspect that an injury has been inflicted upon a patient by a nurse aide or other Center staff. The Center must establish protocol or procedure for investigating whether injuries such as skin tears, bruises, abrasions and other events occurring in the Center are abusive or neglectful or whether these occurrences are unavoidable." "The Center is not relieved of its responsibility to investigate any incident, regardless of the circumstances, and to complete a report if abuse neglect, misappropriation is alleged or suspected in the incident." On 10/14/16 at 12:30 p.m., the federal regulation regarding abuse and the facility abuse policy were reviewed with the corporate nurse. It was reviewed that all allegations of abuse must be reported to the state agency. It was reviewed that injuries of unknown origin included any injury for which the resident could not state what had happened or an injury that was not witnessed.	F 225		
F 226 SS=D	DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES CFR(s): 483.13(c) The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.	F 226		11/21/16

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F 226	Continued From page 6 This REQUIREMENT is not met as evidenced by: Based on staff interview and facility documentation review the facility staff failed to ensure the abuse policy reflected federal abuse guidelines. 1. The facility policy regarding the reporting of injuries of unknown origin is incorrect. 2. The facility policy regarding the reporting of patient to patient altercations is incorrect. The findings included: 1. The facility policy regarding the reporting of injuries of unknown origin is incorrect. The facility policy titled "Abuse/Neglect/Misappropriation//Crime" was reviewed. The "Procedure" section on page 73 read "2. Injuries of Unknown Origin should be handled the same as an allegation of mistreatment, neglect or abuse and must be reported to the State Survey Agency if there is reasonable cause to believe or suspect that an injury has been inflicted upon a patient by a nurse aide or other Center staff. The Center must establish protocol or procedure for investigating whether injuries such as skin tears, bruises, abrasions and other events occurring in the Center are abusive or neglectful or whether these occurrences are unavoidable." "The Center is not relieved of its responsibility to investigate any incident, regardless of the	F 226	F226 1- The policy and procedure for Abuse and Neglect has been revised to reflect the federal abuse guidelines. 2- Policies are reviewed by the Corporate office annually to ensure that they meet federal abuse guidelines. 3-The Corporate Nurse Consultant or designee will educate all staff on the federal abuse guidelines and the revised facility policy regarding Abuse and Neglect. 4- The Administrator will review facility related incidents on a weekly basis to ensure that the incidents are investigated and reported as appropriate, according to the federal abuse guidelines. Results of the audits will be presented to the quarterly Quality Assurance committee for review and recommendation.	

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F 226	Continued From page 7 circumstances, and to complete a report if abuse neglect, misappropriation is alleged or suspected in the incident." On 10/14/16 at 12:30 p.m., the federal regulation regarding abuse and the facility abuse policy were reviewed with the corporate nurse. It was reviewed that injuries of unknown origin included any injury for which the resident could not state what had happened or an injury that was not witnessed. It was reviewed that if an injury is found by facility staff that was not witnessed and the resident could not say what happened, the injury should be reported to the state agency. After the injury is initially reported, then an investigation should be started to determine the cause of the injury. It was reviewed that an investigation should not occur before deciding if an incident should be reported. 2. The facility policy regarding the reporting of patient to patient altercations is incorrect. The "Procedure" section on page 73 read "3. Patient to Patient altercations may not have to be reported. Patients who are abusive to other patients must be monitored and must have a care plan that addresses the abusive behavior. Those who are victims of abuse must be protected from further injury or mental anguish." On 10/14/16 at 12:30 p.m., the federal regulation regarding abuse and the facility abuse policy were reviewed with the corporate nurse. It was reviewed that all allegations of abuse, no matter if an injury was caused or not, must be reported to the state agency.	F 226		
F 309	PROVIDE CARE/SERVICES FOR HIGHEST	F 309		11/21/16

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F 309 SS=D	Continued From page 8 WELL BEING CFR(s): 483.25 Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review and in the course of a complaint investigation the facility staff failed to ensure the highest practicable well being for 1 resident (Resident #12) of 17 residents in the survey sample. 1. On 3/4/16, Resident #12 had a urology appointment. The physician ordered Avodart and Flomax, medications for urinary retention. The medications were not started until 3/8/16. In addition, blood sugar checks were not completed per physician order. 2. Resident #4, a resident with dementia, was administered Seroquel on an as needed basis. Seroquel is not recommended for the treatment of elderly residents with dementia. 3. Resident #6 received Seroquel without a documented reason for administration, and against Registered pharmacy recommendations. The Resident had dementia, and no psychiatric diagnosis. The findings included:	F 309	F309 1- Resident #12 was discharge from the facility on 3/8/16. The Seroquel ordered for resident #4 was discontinued. The Seroquel for Resident #6 was discontinued. 2- The Unit Manager or designee will review new medication orders for residents to ensure that the medication is started timely. The UM or designee will review current residents blood sugar checks to ensure that they are completed as ordered by the physician. The DON or designee will review residents receiving Antipsychotics to ensure that they are ordered appropriately and that there is a documented reason and appropriate diagnosis for the administration of the antipsychotic. 3- The DON or designee will educate all licensed nursing staff on reviewing consult sheets for new recommendations of medications and ensuring that they are ordered timely; documentation of blood sugar checks; Antipsychotic medication	

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F 309	Continued From page 9 1. On 3/4/16, Resident #12 had a urology appointment. The physician ordered Avodart and Flomax, medications for urinary retention. The medications were not started until 3/8/16. In addition, blood sugar checks were not completed per physician order. Resident #12, an 82 year old, was admitted to the facility on 2/24/16. His diagnoses included sepsis, buttock wound stage IV, Alzheimer's disease, diabetes, and hypertension. Resident #12's most recent Minimum Data Set assessment was a 5 day assessment with an assessment reference date of 3/2/16. He was coded with severe cognitive impairment and required extensive assistance with activities of daily living. He was coded to use a catheter. The resident passed at the hospital on 3/9/16. Resident #12 had an appointment with the urologist on 3/4/16. The "Report of Consultation" read "Findings: gross hematuria and retention". The "Recommendations" read: 1) Start Avodart 0.5 mg (milligram) PO (by mouth) daily 2) Start Flomax 0.4 mg (milligram) PO (by mouth) daily According to the March 2016 Medication Administration Record, the Avodart and Flomax were not started until 3/8/16, 4 days after they were ordered. Blood sugar checks were ordered on 2/24/16. The order read: Accuchecks before meals and at bedtime. According to the March 2016 MAR, blood sugars were not documented as having	F 309	contraindication for the treatment of the elderly patients with dementia and necessary documentation and appropriate diagnosis for administration of antipsychotic medication for residents with dementia. 4-The DON or designee will review new medication orders on a weekly basis for residents to ensure that the medication is started timely. The UM or designee will review current residents blood sugar checks on a weekly basis to ensure that they are completed as ordered by the physician. The DON or designee will review residents receiving Antipsychotics to ensure that they are ordered appropriately and that there is a documented reason and appropriate diagnosis for the administration of the antipsychotic on a weekly basis. Results of the audits will be presented to the quarterly Quality Assurance committee for review and recommendation.	

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been obtained on the following dates:
3/1/16, 4:00 p.m.
3/1/16, 9:00 p.m.
3/3/16, 4:00 p.m.
3/3/16, 9:00 p.m.
3/4/16, 6:00 a.m.
3/7/16, 4:00 p.m.
3/7/16, 9:00 p.m.

On 10/14/16, the issue with the medications and accuchecks were reviewed with the Administrator and Director of Nursing (DON). The DON stated that she was not employed at the facility during the time of the issue. No further information was provided.

2. Resident #4, a resident with dementia, was administered Seroquel on an as needed basis. Seroquel is not recommended for the treatment of elderly residents with dementia.

Resident #4, a 94 year old, was admitted to the facility on 10/25/14. Her diagnoses included dementia, anemia, depression, hypertension and anxiety.

Resident #4's most recent Minimum Data Set assessment was a significant change assessment with an assessment reference date of 9/19/16. She was coded with severe cognitive impairment and required extensive assistance with her activities of daily living.

Resident #4 was observed on 10/13/16 eating breakfast in her room. She received meal tray set up from facility staff and fed herself. She was quiet and calm at this time.

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Included in Resident #4's clinical record was an order dated 10/3/16 for Seroquel, an antipsychotic medication. The order read Seroquel tablet 25 milligram, 12.5 milligram by mouth every 12 hours prn (as needed) for agitation related to "dementia in other diseases classified elsewhere with behavioral disturbances".

According to the October 2016 Medication Administration Record (MAR), prn Seroquel was administered on 10/4/16, 10/5/16, 10/9/16, and 10/12/16.

On 10/13/16 at 3:20 p.m., Licensed Practical Nurse C (LPN C) was working the medication cart on Resident #4's hall. LPN C was asked for what behaviors she would administer the prn Seroquel. She stated that she had given it a few days ago because Resident #4 was tearful, upset, continued to state she wanted to go home and could not be redirected when attempts were made.

The following information about Seroquel (Quetiapine) was accessed on 10/17 16 at 2:02 p.m. at the website www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0011909/?report=details <http://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0011909/?report=details>
"Uses of This Medicine Quetiapine is used alone or together with other medicines to treat depression, bipolar disorder (depressive and manic episodes), and schizophrenia. This medicine should not be used to treat behavioral problems in older adult patients who have dementia or Alzheimer disease. Quetiapine is an antipsychotic medicine that works in the brain."

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F 309	Continued From page 12 On 10/14/16, an end of day meeting was held with the Administrator, Director of Nursing (DON) and Corporate Nurse. It was reviewed that Resident #4 had a prn order for Seroquel, a dosage that is not usual for Seroquel. It was also reviewed that Resident #4 had dementia and Seroquel was not recommended for use in elderly persons with dementia. The DON and corporate nurse agreed that the dosage of Seroquel was not usual. The facility staff was asked to provide Resident #4's most recent psychology evaluation. The DON thought the last psychology evaluation was completed on 9/30/16 with the psychologist. The DON stated that a copy of the consult was not available at the facility. She stated the psychologist would have recommended the Seroquel to the primary doctor for him to order. The DON reported that she had the doctor discontinue the Seroquel. COMPLAINT DEFICIENCY	F 309		

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3. Resident #6 received Seroquel without a documented reason for administration, and against Registered pharmacy recommendations. Seroquel is not recommended to be used for Residents with dementia, and without psychiatric diagnoses.

Resident #6 was admitted to the facility on 9-30-15 for a stay, and discharged. Resident #6 was readmitted on 3-8-16. Diagnoses included; Chronic respiratory failure with hypoxia, Myasthenia Gravis, hypertension, gastroesophageal reflux disease, anxiety, depression, and dementia with behaviors.

The most recent minimum data set (MDS) assessment was a significant change full assessment, with an assessment reference date (ARD) of 10-1-16. This full MDS was compared to the previous quarterly assessment with an ARD of 9-15-16. Resident #6 was coded with no cognitive impairment. Resident #6 required extensive to total assistance of one to two staff members with activities of daily living, to include bed mobility, hygiene, and transferring. The Resident was coded as having no mood or behavioral problems.

Review of Behavior and Mood Monitoring sheets located within the Medication Administration Record (MAR) for August, September, and October 2016, revealed no anxiety, mood or behavior problems for Resident #6.

Review of the nursing progress notes from August, September, and October 2016, revealed no anxiety, mood or behavior problems for

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Resident #6.

Review of Resident #6's care plan had as a "Focus" The Resident exhibits adverse behavioral symptoms, Restlessness, Yelling, increase in complaints, refusal of care. Under "Interventions" the document states "The Resident's behavior is De-escalated by 1:1 (one to one) redirect, reassure, and activities."

Review of Resident #6's clinical record revealed a signed physician's order that included, "Quetiapine (Seroquel) 37.5 mg (milligrams) by mouth at bedtime for anxiety disorder. This order first appeared for Resident #6 on 3-8-16. The dosage did not change, nor was there any Gradual dose reductions attempted for this Resident from the time of readmission until 8-29-16.

The Resident was also administered Citalopram for depression which is contraindicated while administering Seroquel. The pharmacologic drug interaction is noted to be "severe" producing "prolonged QT interval" stressing the heart muscle when co-administered with Seroquel according to
The Registered pharmacist, who documented in the progress notes.

The Registered pharmacist (RPH) "Consultation Report" dated 8-1-16 through 8-17-16, documented that the use of antipsychotic medications (Seroquel) must be used only to treat a psychiatric disorder. The document also noted that the use of this medication must be evaluated at least quarterly with documentation of appropriateness and undergo Gradual Dose

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Reduction (GDR) attempts in 2 separate quarters within the first year of the initiation of the medication, then annually. The physician signed acknowledgement of receiving the information on 8-22-16, and declined the recommendation stating in a written note, "Need more time to eval patient for indication used." Also a second "Consultation Report" dated 8-1-16 through 8-17-16, documented that the dose was unclear in the order, this was acted on by the Director of Nursing (DON) on 8-29-16 (12 days later), and it appears the order was changed to "Seroquel 12.5 mg at bedtime."

In the RPH "Consultation Summary Report", dated 9-1-16 through 9-30-16, the RPH documented Resident #6 as needing "monitoring (laboratory blood tests) for metabolic abnormalities due to antipsychotic drug use". No metabolic labs had been ordered since March of 2016.

The DON (Director of Nursing) stated that they had a new doctor, and he was getting to know the Residents. The DON also stated she would have to check to see why the Resident continued to get the medication without the necessary diagnosis, and she was made aware that no mood or behavior issues had been documented by staff. At the end of the survey, no further information was provided.

On 10-13-16 and 10-14-16 at the end of day debriefings, the Administrator, Director of Nursing, and Corporate Registered Nurse Consultant were informed of the failure of the staff to ensure unnecessary medications were not administered to Resident #6. No further information was provided by the facility.

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F 314 SS=D	TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES CFR(s): 483.25(c) Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, Resident interview, staff interview, facility documentation review, clinical record review, and in the course of a complaint investigation, the facility staff failed to ensure care and services were provided for a stage 4 pressure injury for one resident (Resident #1) in a sample of 17 residents. For Resident #1, the facility failed to timely apply a wound vac (waste removal suction system that helps in wound healing) continuously, and failed to provided turning and repositioning on 10-12-16. The Findings included; Resident #1 was admitted to the facility on 1-30-14. Diagnoses included; High cholesterol, Quadriplegia secondary to a stroke (CVA) suffered during surgery, diabetes, congestive	F 314	F314 1- Resident #1 is currently receiving the treatment as ordered to her sacral wound. 2- The Unit Manager or designee will review current residents with wound vacs to ensure that they are applied timely and as ordered. The UM or designee will review current residents with pressure areas to ensure that they are being turned and repositioned appropriately. 3- The DON or designee will educate all licensed nursing staff on the application of wound vacs and ensuring that the wound vac is in place as ordered. The licensed nursing staff will also be educated on the provision of turning and positioning for the prevention and promotion of healing of pressure ulcers. 4- The Unit Manager or designee will	11/21/16

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F 314	Continued From page 17 heart failure, hypertension, asthma, overactive bladder, foley catheter, depression, and chronic stage 4 decubitus ulcer. All skin risk assessments revealed that Resident #1 was at risk for skin breakdown, and had one stage 4 pressure ulcer on the sacrum. The most recent minimum data set (MDS) assessment was a quarterly assessment, with an assessment reference date of 9-12-16. Resident #1 was coded with no cognitive impairment. Resident #1 required total assistance of one to two staff members with activities of daily living, to include bed mobility and transferring. The previous full MDS, which was an annual comprehensive assessment, dated 12-21-15 was reviewed. Both MDS assessments revealed an entry area M0150. The entry described Resident #1 as at risk of developing pressure ulcers, and at area M0210, the Resident was coded as having a stage 4 pressure ulcer. Review of the resident's most recent comprehensive care plan for one "stage 4 pressure ulcer (sacrum)", was initially developed and dated 8-21-16. The focus was; Wound Vac at 125 mmhg (millimeters of mercury, pressure suction setting), continuous, change Monday Wednesday, and Friday. The interventions were; 1) Administer treatments as ordered, and monitor for effectiveness. 2) Devices: Wound Vac at 125 mmhg (millimeters of mercury), change Monday Wednesday, and Friday. 3) Educate the resident/family/care givers as to causes of skin breakdown; including transfer/positioning requirements.....and frequent repositioning. 4)	F 314	review residents during weekly rounds to ensure that turning and positioning is provided appropriately and that residents with wound vacs have them in place as ordered. The results of the audits will be presented to the quarterly Quality Assurance Committee for review and recommendations.	

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Monitor nutritional status....5) Position resident every 2 hours. 6) Report dressing if not intact during care to nurse with each interaction. 7) Treat pain prior to treatment as needed to ensure the resident's comfort. No further updates or revisions were made to the skin care plan from the 8-21-16 care plan to the time of survey on 10-12-16.

Review of the weekly "Wound Record", which was the document that the wound care Nurse completed each week, describing each wound, revealed that the single sacral pressure ulcer was the only wound that Resident #2 had.

On 10-12-16 at 2:30 p.m., an interview was conducted with the Resident. Resident #1 was found in bed, laying in semi-fowler's position, supine. She was found to be alert and oriented to person, place, time, and situation. The Resident was eloquent, and able to recount long and short term history, by memory. The Resident was asked if her care had been provided that day, and she responded that she had been out to a dental appointment, and had returned at 1:30 p.m. She stated that staff had put her back to bed and had not provided incontinence care, and had not reattached her wound vac (a suction waste removal system that helps heal wounds), which had been disconnected to go out to her appointment. She said the saff told her they would be in after passing meds and reconnect it, and get her cleaned up. It was noted that the wound vac pump was sitting on a small stool close to the floor, on the window side of the bed, and was not attached to the Resident, and had no tubing connected to it.

On 10-12-16 at 3:00 p.m., the Resident was

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again interviewed and observed, and stated the nurses had not been back yet. The wound vac was still observed to be disconnected and the Resident's position had not changed.

On 10-12-16 at 3:30 p.m., the Resident was again interviewed and observed, and stated the nurses had not been back yet. The wound vac was still observed to be disconnected and the Resident's position had not changed.

On 10-12-16 at 4:00 p.m., the Resident was again interviewed and observed, and stated the nurses had not been back yet. The wound vac was still observed to be disconnected and the Resident's position had not changed.

On 10-12-16 at 4:30 p.m., the Resident was again interviewed and observed, and stated the nurses had not been back yet. The wound vac was still observed to be disconnected and the Resident's position had not changed.

On 10-12-16 at 5:00 p.m., the Resident was again interviewed and observed, and stated the nurses had not been back yet. The wound vac was still observed to be disconnected and the Resident's position had not changed.

On 10-12-16 at 5:30 p.m., the Resident was again interviewed and observed, and stated the nurses had not been back yet. The wound vac was still observed to be disconnected and the Resident's position had not changed.

From the initial interview, and for 4 hours, since the Resident returned from the dental appointment at 1:30 p.m., the wound vac had not been applied continuously, and the Resident was

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not given incontinence care or repositioned every 2 hours per doctors orders and the care plan.

The Wound Record, and weekly skin assessment sheets revealed the following;

On 8-11-16 the Resident had a stage 4 pressure ulcer to the sacrum. The measurements were 10 cm (centimeters) long x 10.5 cm wide x 6.5 cm deep, and descriptions were included.

On 9-12-16 the Resident had a stage 4 pressure ulcer to the sacrum. The measurements were 9 cm (centimeters) long x 9.5 cm wide x 5 cm deep, and descriptions were included.

On 10-13-16 during wound observations, the Resident had a stage 4 pressure ulcer to the sacrum. The measurements were 10 cm (centimeters) long x 9.2 cm wide x 5.5 cm deep, and descriptions were identified.

Weekly assessments were completed and the staging and documentation remained at a single stage 4 pressure ulcer to the sacrum. In the last 3 months, it was evident that the wound was healing slowly.

Physicians order sheets were reviewed and revealed that on 8-4-16 the wound vac was ordered and it was first applied on 8-7-16, to be on "Continuously", and the Resident was to be repositioned every 2 hours per the plan of care.

On 10-13-16 at 2:00 p.m., wound care & measurement observations were conducted by 2 surveyors, with the treatment nurse (LPN E), and her assistant (CNA C). LPN E performed the measurement, of the stage 4 sacral wound, and it

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measured 10.0 cm long x 9.2 cm wide x 5.5 cm depth, indicating slow improvement in the wound healing. The wound vac was applied after completion of the treatment, and LPN E showed good technique, and knowledge of the treatment and wound vac application. The Resident was asked if the wound vac was uncomfortable, and she stated "not really", "I want it because it helps the wound heal, mostly I don't even know it is there."

Review of nursing progress notes revealed that the wound vac order was received on 8-4-16, and the device was applied to the Resident on 8-7-16.

Facility policies for Wound care was reviewed and revealed:
- "Provide treatments as ordered."
Guidance was given, in "Medical Surgical Nursing, Vol 1, Ignatavicius and Workman, p. 123, "To maintain healthy skin, the body must have adequate food, water, oxygen intake, intact waste removal mechanisms; sensation; and functional mobility. Changes in any of these variables can lead to rapid and extensive skin breakdown. If the client cannot protect or maintain the skin, the nurse must be able to assess and plan for his or her needs. The nurse monitors the client to determine the risk of skin breakdown before it occurs." *Anytime a pressure ulcer is identified a Weekly Pressure Ulcer Record must be completed."
On 10-13-16, and 10-14-16 at the end of day conferences, the administrator, DON (Director of Nursing), and Corporate Registered nurse Consultant were informed of these concerns. No other documentation was available to be provided by the facility.

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F 323 SS=D	FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES CFR(s): 483.25(h) 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, documentation review, and clinical record review, the facility staff failed for 1 resident (Resident #2) of the survey sample of 17 residents, to provide adequate supervision to prevent 4 incidents of inappropriate sexual advances. The facility failed to prevent Resident #2 from committing 4 incidents of inappropriate sexual advances, by providing adequate supervision. All 4 incidents occurred on 6/26/16, in three different locations, during a time span of approximately 4 hours. The incidents involved three female residents, and one unidentified female visitor. The Findings included: Resident # 2 was an 85 year old who was admitted to the facility on 7/21/16. Resident #2's diagnoses included Advanced Vascular Dementia, Diabetes Mellitus, Coronary Artery Disease, Prostate Cancer, Hypertension, and	F 323	F323 1-Resident #2 discharged on 10/15/16. 2- The Unit Manager or Designee will review the shift report of current residents for any inappropriate behaviors to ensure that the incidences are handled appropriately 3- The DON or Designee will educate all licensed nursing staff on the provision of adequate supervision for any residents displaying inappropriate behaviors toward others and to notify the DON or Administrator of incidences. 4- The Unit Manager or Designee will review the shift report of current residents for any inappropriate behaviors to ensure that the incidences are handled appropriately on a weekly basis. The results of the audits will be presented to the quarterly Quality Assurance Committee for review and recommendations.	11/21/16

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Anxiety Disorder.

The Minimum Data Set, which was a Significant Change Assessment with an Assessment Reference Date of 10/3/16, coded Resident #2 as having Severely Impaired Cognitive Skills for Daily Decision Making. In addition, Resident #2 was coded as requiring a wheelchair for ambulation, which he self-propelled.

On 10/12/16 a review was conduced of facility documentation, revealing a Facility Reported Incident. On 6/26/16, Resident #2 had been sexually inappropriate with 2 female residents who were identified and placed in the survey as Resident #4 and Resident #17. In addition, another female resident was identified and put into the sample as Resident #5.

The 3 residents were as follows:

1) Resident #4, was a 94 year old who was admitted to the facility on 10/25/14. Her diagnoses included dementia, anemia, depression, hypertension and anxiety.

Resident #4's most recent Minimum Data Set was a significant change assessment with an assessment reference date of 9/19/16. She was coded with severe cognitive impairment and required extensive assistance with her activities of daily living.

2.) Resident #5 was a 69 year old, who was admitted to the facility on 9/10/14. Her diagnoses included Diabetes Mellitus.

Resident #5's most recent Minimum Data Set

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was a Quarterly assessment with an Assessment Reference Date of 9/24/16. She was coded as being independent in daily decision-making.

3.) Resident #17, was a 86 year old, who was admitted to the facility on 6/17/16. She expired at the facility on 7/12/16. Her diagnoses included Alzheimer's Dementia, Hypertension, Diabetes Mellitus, Seizure Disorder, Dysphasia, and Peripheral Vascular Disease.

Resident #17's most recent Minimum Data Set assessment was a significant change assessment with an assessment reference date of 6/23/16. She was coded with severe cognitive impairment and required extensive assistance with her activities of daily living.

On 10/13/16 at 3:50 P.M. an interview was conducted with the facility Administrator (Administration A). He stated that he conducted the investigations of the incidents. The sequence of events were as follows:

1. On 6/26/16, Resident #2 was found in Resident #4's room. He had been in there for an undetermined amount of time between 3:00 P.M. and 4:30 P.M. He was found at 4:30 P.M. sitting at her bedside with his pants down, and his hand underneath her bed sheet. He was removed from the room and put into his room. He refused to remain in his room and was put at the nurse's station within reach of other female residents. He was not put on 1:1 and there was no evidence that 15 minute checks had been done by staff. At 4:45 P.M. the Administrator had been notified of the incidents. Resident #4 received a full skin

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assessment by a facility nurse, resulting in no signs of injury from the event.

2. On 6/26/16 sometime prior to 4:45 P.M. Resident #2 was sitting unattended at the nurse's station, within reach of other female residents and visitors. Resident #2 propelled himself to Resident #17, and put his hand underneath the covering that was on her lap. Resident #17 received a full skin assessment by a facility nurse, resulting in no signs of injury from the event. Resident #2 was not removed from the Nurse's station. He was not put on 1:1 and there was no evidence that 15 minute checks had been done by staff.

3. On 10/13/16 at 4:00 P.M. an interview was conducted with Certified Nursing Assistant (CNA B) via telephone. She stated that Resident #2 was at the Nurse's Station on 6/26/16 at 4:45 P.M. He was unattended by a staff member, and he was not on 1:1 monitoring. There was no evidence that 15 minute checks had been conducted by any staff member. CNA B stated that she happened to walk up to the Nurse's Station to document another resident's vitals. She stated that Resident #2 "grabbed the breasts of a visitor." There was no documented intervention by staff.

4. On 6/26/16 at dinner time in the Dining Room, Resident #2 made a sexually inappropriate comment to Resident #5. Resident #5 was Independent in Daily Decision Making, and she confirmed her written statement dated 6/26/16. Her statement read, "He told me earlier to come sit beside him, then he asked me if I like to play with myself cause he does while he was doing an up and down hand gestures."

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F 323	Continued From page 26 Prior to 6/26/16, Resident had not exhibited any inappropriate sexual behaviors. In addition, he had not been identified as a Registered Sex Offender according to the the Virginia State Police. Resident #2 was transported to the hospital for an evaluation on 6/26/16 at approximately 9:00 P.M. He returned the next day. He returned to the facility on 6/27/16 with a diagnosis of Urinary Tract Infection and received antibiotic medication. There have not been any additional incidents. Resident #2's overall health has declined significantly, and as a result he was bed bound. During the survey he was observed on 10/12/16 at 4:30 P.M., 10/13/16 at 10:30 A.M., and 10/14/16 at 2:00 P.M.. During each observation, he was in bed. The facility policy titled "Abuse/Neglect/Misappropriation//Crime" was reviewed (undated). The "Procedure" section on page 73 read "3. Patient to Patient altercations may not have to be reported. Patients who are abusive to other patients must be monitored and must have a care plan that addresses the abusive behavior. Those who are victims of abuse must be protected from further injury or mental anguish." On 10/14/16 at 10:00 A.M. the Administrator was notified of the findings. No further information was received.	F 323		
F 329 SS=E	DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS	F 329		11/21/16

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F 329	Continued From page 27 CFR(s): 483.25(l) Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a 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 review, and in the course of a complaint investigation the facility staff failed for 3 residents (Resident #9, #3 and #1) of 17 residents in the survey sample to ensure residents were free from unnecessary medications. 1. For Resident #9, the facility staff failed to hold Coreg (for atrial fibrillation) according to physician	F 329	F329 1- Resident #9 is receiving Coreg as ordered. Resident #3 is receiving medications as ordered. Resident #1 is receiving medications as ordered. 2- The Unit Manager or Designee will review the medication administration records for current residents receiving hypertension medications to ensure that	

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F 329	Continued From page 28 ordered parameters and failed to measure heart rate as indicated in the parameters. 2. The facility failed to hold blood pressure medications for blood pressures outside of physician ordered parameters for Resident #3. 3. Resident #1 received Carvedilol on 9-17-16, against physician's orders for administration related to blood pressure parameters The findings included: 1. For Resident #9, the facility staff failed to hold Coreg (blood pressure medication) according to physician ordered parameters and failed to measure heart rate as indicated in the parameters. Resident #9, an 89 year old, was admitted to the facility 12/2/15. Her diagnoses included congestive heart failure, atrial fibrillation, chronic kidney disease, dementia, reflux, and anemia. Resident #9's most recent Minimum Data Set assessment was a significant change assessment with an assessment reference date of 10/4/16. She was coded with a Brief Interview of Mental Status score of 15 indicating no cognitive impairment. She required assistance with her activities of daily living. Resident #9 had a physician order dated 9/29/16 for Coreg. The order read Coreg tablet 1.25 milligram give 1 tablet by mouth two times per day. Hold for systolic blood pressure less than 110 or heart rate less than 60. The October 2016 Medication Administration	F 329	they are administered and documented appropriately and as ordered. 3- The DON or Designee will educate all licensed nursing staff on following physician ordered parameters with the administration of hypertension medication and documenting the administration or findings appropriately on the medication administration record. 4- The Unit Manager or designee will review the medication administration records for current residents receiving hypertension medications to ensure that they are administered and documented appropriately and as ordered on a weekly basis. The results of the audits will be presented to the quarterly Quality Assurance Committee for review and recommendations	

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Record (MAR) was reviewed. On 10/2/16 at 6:00 p.m., Resident #9's blood pressure was 103/68. The medication was administered. The medication should have been held according to the parameters.

At the time of the October 2016 MAR review, Coreg was administered 21 times. Out of the 21 times Coreg was administered, Resident #9's heart rate was only measured 3 times as follows:
10/1/16, 9:19 p.m.: 74
10/2/16, 9:30 p.m.: 71
10/4/16, 10:18 a.m.: 75

Coreg was administered 18 times without staff knowing if the heart rate was within physician ordered parameters.

On 10/14/16 at the end of day meeting, the Administrator, Director of Nursing and Corporate Nurse were notified of the issue with Resident #9's Coreg administration. No further information was provided.

COMPLAINT DEFICIENCY

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2. The facility failed to hold blood pressure medications for blood pressures outside of physician ordered parameters for Resident #3.

Resident #3, was initially admitted to the facility on 8/17/14 and was readmitted on 8/11/16. Diagnoses included high blood pressure, paraplegia and depression.

Resident #3's most recent MDS (minimum data set) with an ARD (assessment reference date) of 9/1/16 was coded as a significant change in status assessment. He was coded as having a BIMS (brief interview of mental status) of "15" out of a possible 15, or no cognitive impairment. Resident #3 was also coded as requiring limited to extensive to total assistance of one to two staff members to perform activities of daily living.

Review of the Resident #3's MAR (medication administration record) for October and September, 2016 revealed the following physician order: Norvasc (blood pressure medication) 5 mg (milligrams) once daily. Hold for SBP (systolic blood pressure) less than 120 (dated 8/13/16). On the following dates, the medication was documented as given:

10/2/16: BP 112/71
10/8/16: BP 114/78
10/10/16: BP 113/75

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10/11/16: BP 117/84
9/8/16: BP 119/80
9/14/16: BP 119/70
9/16/16: BP 113/74
9/28/16: BP 118/75

Saunders Nursing Drug Handbook, 2011, pp 754-755, include the following: "Overdose may produce profound bradycardia (low heart rate) , hypotension. (low blood pressure).

On 10/13/16 at the end of the day exit, the DON (director of nursing) stated, "The drug should not be given." The Administrator and DON were notified of above findings.

3. Resident #1 received Carvedilol on 9-17-16, against physician's orders for administration related to blood pressure parameters.

Resident #1 was admitted to the facility on 1-30-14. Diagnoses included; High Cholesterol, Quadriplegia secondary to a stroke (CVA) suffered during surgery, diabetes, congestive heart failure, hypertension, asthma, overactive bladder, Foley catheter, depression, and chronic stage 4 sacral decubitus ulcer.

The most recent minimum data set (MDS) assessment was a quarterly assessment, with an assessment reference date of 9-12-16. Resident #1 was coded with no cognitive impairment. Resident #1 required total assistance of one to two staff members with activities of daily living, to include bed mobility and transferring.

Review of Resident #1's clinical record revealed a signed physician's order that included, "Carvedilol tablet 3.125 mg (milligrams) by mouth two times

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F 329	Continued From page 32 per day for heart failure. Hold for systolic blood pressure less than 110, or heart rate less than 55 beats per minute. An entry was placed on the MAR (medication administration record) with nurses initials indicating the medication had been administered on 9-17-16. Documentation on the MAR revealed that the Resident's blood pressure at the time of administration was 109 Millimeters of mercury- systolic. The medication should not have been administered. The DON (Director of Nursing) stated that staff should not have administered the medication. As of the end of the survey, no further information was provided. On 10-13-16 and 10-14-16 at the end of day debriefings, the Administrator, Director of Nursing, and Corporate Registered Nurse Consultant were informed of the failure of the staff to ensure unnecessary medications were not administered to Resident #1. No further information was provided by the facility. COMPLAINT DEFICIENCY.	F 329		
F 333 SS=D	RESIDENTS FREE OF SIGNIFICANT MED ERRORS CFR(s): 483.25(m)(2) The facility must ensure that residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, clinical record review, and in the course of a complaint investigation the facility staff failed for 1 resident	F 333	F333 1- Resident #9 is receiving medications as ordered.	11/21/16

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F 333	Continued From page 33 (Resident #9) of 17 residents in the survey sample to ensure resident was free from significant medications error. 1. For Resident #9, the facility staff failed to hold Coreg (for atrial fibrillation) according to physician ordered parameters. The findings included: 1. For Resident #9, the facility staff failed to hold Coreg (blood pressure medication) according to physician ordered parameters. Resident #9, an 89 year old, was admitted to the facility 12/2/15. Her diagnoses included congestive heart failure, atrial fibrillation, chronic kidney disease, dementia, reflux, and anemia. Resident #9's most recent Minimum Data Set assessment was a significant change assessment with an assessment reference date of 10/4/16. She was coded with a Brief Interview of Mental Status score of 15 indicating no cognitive impairment. She required assistance with her activities of daily living. Resident #9 had a physician order dated 9/29/16 for Coreg. The order read Coreg tablet 1.25 milligram give 1 tablet by mouth two times per day. Hold for systolic blood pressure less than 110 or heart rate less than 60. The October 2016 Medication Administration Record (MAR) was reviewed. On 10/2/16 at 6:00 p.m., Resident #9's blood pressure was 103/68 millimeter of mercury. The medication was administered. The medication should have been held according to the parameters.	F 333	2- The Unit Manager or Designee will review current residents receiving hypertension medications to ensure that they are administered correctly and that any ordered parameters for hypertension medications are followed correctly. 3- The DON or Designee will educate all licensed nursing staff on following physician ordered parameters with the administration of hypertension medication and documenting the administration or findings appropriately on the medication administration record 4- The Unit Manager or designee will review the medication administration records for current residents receiving hypertension medications to ensure that they are administered and documented appropriately and as ordered on a weekly basis. The results of the audits will be presented to the quarterly Quality Assurance Committee for review and recommendations	

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F 333	Continued From page 34 On 10/14/16 at the end of day meeting, the Administrator, Director of Nursing and Corporate Nurse were notified of the issue with Resident #9's Coreg administration. No further information was provided.	F 333		
F 425 SS=D	COMPLAINT DEFICIENCY PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH CFR(s): 483.60(a),(b) The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. This REQUIREMENT is not met as evidenced by: Based on Resident interview, staff interview, facility record review, clinical record review, and	F 425	F425 1- Resident #1 is receiving medications as	11/21/16

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F 425	Continued From page 35 in the course of a complaint investigation, the facility staff failed to ensure medications were available for administration for two Residents (Residents' #1 and #6) in a survey sample of 17 Residents. 1. For Resident #1 Atorvastatin (high blood cholesterol lowering agent) was not available for administration. 2. For Resident #6, Seroquel (psychotropic medication) was not available for administration. The findings included: 1. Resident #1 was admitted to the facility on 1-30-14. Diagnoses included; High Cholesterol, Quadriplegia secondary to a stroke (CVA) suffered during surgery, diabetes, congestive heart failure, hypertension, asthma, overactive bladder, Foley catheter, depression, and chronic stage 4 sacral decubitus ulcer. The most recent minimum data set (MDS) assessment was a quarterly assessment, with an assessment reference date of 9-12-16. Resident #1 was coded with no cognitive impairment. Resident #1 required total assistance of one to two staff members with activities of daily living, to include bed mobility and transferring. Review of Resident #1's clinical record revealed a signed physician's order that included, "Atorvastatin Calcium tablet 40 mg (milligrams) by mouth at bedtime for hyperlipidemia. An entry was placed on the MAR (medication administration record) with nurses initials indicating the medication had not been administered on 9-10-16. Documentation on the	F 425	ordered. Resident #6 is receiving medications as ordered. 2- The Unit Manager or designee will review the medication administration records for current residents to ensure that they have medications available for administration. An audit of the medication carts will be conducted by the Unit Manager or designee to ensure that all ordered medications are available for administration. 3- The DON or Designee will educate all licensed nursing staff on the process of ordering and refilling medications. 4- The Unit Manager or designee will review the medication administration records and shift reports for current residents on a weekly basis to ensure that medications are available for administration. The medication carts will be checked on a weekly basis by the UM or designee to ensure that ordered medications are available for administration. The results of the audits will be presented to the quarterly Quality Assurance Committee for review and recommendations	

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nursing progress notes revealed that the medication was not administered during the day noted as it was not available from the pharmacy.

The Pharmacy "Shipment Details" report revealed that the medication was ordered on 9-9-16, however, was not delivered until 11:23 p.m. on 9-10-16. The medication was not administered.

The DON (Director of Nursing) stated that staff should contact the pharmacy to have medication delivered stat (immediately) when it has run out. The DON also stated she would have to check to see why the staff failed to administer the medication when it arrived. As of the end of the survey, no further information was provided.

On 10-13-16 and 10-14-16 at the end of day debriefings, the Administrator, Director of Nursing, and Corporate Registered Nurse Consultant were informed of the failure of the staff to ensure medications were available for administration to Resident #1. No further information was provided by the facility.

COMPLAINT DEFICIENCY

2. Resident #6 was admitted to the facility on 9-30-15. Diagnoses included; Chronic respiratory failure with hypoxia, Myasthenia Gravis, hypertension, gastroesophageal reflux disease, anxiety, depression, and dementia with behaviors.

The most recent minimum data set (MDS) assessment was a significant change full assessment, with an assessment reference date of 10-1-16. Resident #6 was coded with no

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cognitive impairment. Resident #6 required extensive to total assistance of one to two staff members with activities of daily living, to include bed mobility, hygiene and transferring.

Review of Resident #6's clinical record revealed a signed physician's order that included, "Quetiapine (Seroquel) 37.5 mg (milligrams) by mouth at bedtime for anxiety disorder. An entry was placed on the MAR (medication administration record) with nurses initials indicating the medication had not been administered on 9-23-16. Documentation on the nursing progress notes revealed that the medication was not administered as it was not available from the pharmacy (on order).

No Pharmacy "Shipment Details" report could be found for this Resident's medication order or delivery. The medication was not administered.

The DON (Director of Nursing) stated that staff should contact the pharmacy to have medication delivered stat (immediately) when it has run out. The DON also stated she would have to check to see why the staff failed to administer the medication. As of the end of the survey, no further information was provided.

On 10-13-16 and 10-14-16 at the end of day debriefings, the Administrator, Director of Nursing, and Corporate Registered Nurse Consultant were informed of the failure of the staff to ensure medications were available for administration to Resident #6. No further information was provided by the facility.

COMPLAINT DEFICIENCY

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F 428 SS=D	DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON CFR(s): 483.60(c) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility documentation review, and clinical record review, the Registered Pharmacist (RPH) Consultant's recommendations were not followed, or addressed for two Residents (Resident #6 and #3) in a survey sample of 17 residents. 1. For Resident #6, monthly pharmacy recommendations were not followed. 2. Resident #3's pharmacy recommendation for 8/25/16 regarding holding blood pressure medication for low blood pressures was not addressed. The findings included: 1. Resident #6 was admitted to the facility on 9-30-15 for a stay, and discharged. Resident #6 was readmitted on 3-8-16. Diagnoses included; Chronic respiratory failure with hypoxia,	F 428	F 428 1-The most recent pharmacy recommendations have been reviewed by the physician. 2 □ The DON or designee will review current pharmacy recommendations to ensure that they were reviewed and addressed by the physician in a timely manner. 3 □ The DON or designee will educate all licensed nursing staff on ensuring that physician orders are transcribed from pharmacy recommendations. 4 □ The DON or designee will review the pharmacy recommendation report on a monthly basis to ensure that they are reviewed and addressed by the physician in a timely manner. The results of the audits will be presented to the quarterly Quality Assurance Committee for review and recommendations.	11/21/16

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Myasthenia Gravis, hypertension, gastroesophageal reflux disease, anxiety, depression, and dementia with behaviors.

The most recent minimum data set (MDS) assessment was a significant change full assessment, with an assessment reference date (ARD) of 10-1-16. This full MDS was compared to the previous quarterly assessment with an ARD of 9-15-16. Resident #6 was coded with no cognitive impairment. Resident #6 required extensive to total assistance of one to two staff members with activities of daily living, to include bed mobility, hygiene, and transferring. The Resident was coded as having no mood or behavioral problems.

Review of Behavior and Mood Monitoring sheets located within the Medication Administration Record (MAR) for August, September, and October 2016, revealed no anxiety, mood or behavior problems for Resident #6.

Review of the nursing progress notes from August, September, and October 2016, revealed no anxiety, mood or behavior problems for Resident #6.

Review of Resident #6's care plan had as a "Focus" The Resident exhibits adverse behavioral symptoms, Restlessness, Yelling, increase in complaints, refusal of care. Under "Interventions" the document read, "The Resident's behavior is De-escalated by 1:1 (one to one) redirect, reassure, and activities." If the care plan is correct, there is no need for the Seroquel, as non-pharmacologic interventions are successful.

Review of Resident #6's clinical record revealed a

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signed physician's order that included, "Quetiapine (Seroquel) 37.5 mg (milligrams) by mouth at bedtime for anxiety disorder. This order first appeared for Resident #6 on 3-8-16. The dosage did not change, nor was there any Gradual dose reductions attempted for this Resident from the time of readmission until 8-29-16.

The Resident was also administered Citalopram for depression which is contraindicated while administering Seroquel. The pharmacologic drug interaction is noted to be "severe" producing "prolonged QT interval" stressing the heart muscle when coadministered with Seroquel.

The Registered pharmacist (RPH) "Consultation Report" dated 8-1-16 through 8-17-16, documented that the use of antipsychotic medications (Seroquel) must be used only to treat a psychiatric disorder. The document also noted that the use of this medication must be evaluated at least quarterly with documentation of appropriateness and undergo Gradual Dose Reduction (GDR) attempts in 2 separate quarters within the first year of the initiation of the medication, then annually. The physician signed acknowledgement of receiving the information on 8-22-16, and declined the recommendation stating in a written note, "Need more time to eval patient for indication used." Also a second "Consultation Report" dated 8-1-16 through 8-17-16, documented that the dose was unclear in the order, this was acted on by the Director of Nursing (DON) on 8-29-16 (12 days later), and it appears the order was changed to "Seroquel 12.5 mg at bedtime."

In the RPH "Consultation Summary Report",

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dated 9-1-16 through 9-30-16, the RPH documented Resident #6 as needing "monitoring (laboratory blood tests) for metabolic abnormalities due to antipsychotic drug use". No metabolic labs had been ordered since March of 2016.

The DON (Director of Nursing) stated that they had a new doctor, and he was getting to know the Residents. The DON also stated she would have to check to see why the Resident continued to get the medication without the necessary diagnosis, and she was made aware that no mood or behavior issues had been documented by staff. At the end of the survey, no further information was provided.

On 10-13-16 and 10-14-16 at the end of day debriefings, the Administrator, Director of Nursing, and Corporate Registered Nurse Consultant were informed of the failure of the staff to follow, and timely act on the RPH recommendations for Resident #6. No further information was provided by the facility.

2. Resident #3's pharmacy recommendation for 8/25/16 regarding holding blood pressure medication for low blood pressures was not addressed.

Resident #3, was initially admitted to the facility on 8/17/14 and was readmitted on 8/11/16.. Diagnoses included high blood pressure, paraplegia and depression.

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Resident #3's most recent MDS (minimum data set) with an ARD (assessment reference date) of 9/1/16 was coded as a significant change in status assessment. He was coded as having a BIMS (brief interview of mental status) of "15" out of a possible 15, or no cognitive impairment. Resident #3 was also coded as requiring limited to extensive to total assistance of one to two staff members to perform activities of daily living.

Review of Resident #3's clinical record revealed a pharmacy consultant report dated 8/25/16. It contained the following: "(____) name of resident has orders to hold Norvasc when SBP (systolic blood pressure) < (less than) 120. SBP was 117 on 8/15/16 and 112 on 8/16/16 and the medication was given based on the MAR (medication administration record).

Review of the Resident #3's MAR (medication administration record) for October and September, 2016 revealed the following physician order: Norvasc (blood pressure medication) 5 mg (milligrams) once daily. Hold for SBP (systolic blood pressure) less than 120 (dated 8/13/16). On the following dates, the medication was documented as given:

10/2/16: BP 112/71
10/8/16: BP 114/78
10/10/16: BP 113/75
10/11/16: BP 117/84
9/8/16: BP 119/80
9/14/16: BP 119/70
9/16/16: BP 113/74
9/28/16: BP 118/75

Saunders Nursing Drug Handbook, 2011, pp

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F 428	Continued From page 43 754-755, include the following: "Overdose may produce profound bradycardia (low heart rate) , hypotension. (low blood pressure). On 10/13/16 at the end of the day exit, the DON (director of nursing) stated, "The drug should not be given." The Administrator and DON were notified of above findings.	F 428		
F 441 SS=D	INFECTION CONTROL, PREVENT SPREAD, LINENS CFR(s): 483.65 The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their	F 441		11/21/16

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F 441	Continued From page 44 hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility documentation review, and clinical record review, the facility staff failed to ensure an effective infection control program was implemented for one resident, Resident # 8 in a survey sample of 16 residents. The medication nurse failed to clean the glucometer before or after a blood glucose check. The findings included: Resident #8 was admitted to the facility on 9/27/16. Resident #8's diagnoses included hip replacement, diabetes and osteoarthritis. The resident did not have a completed MDS (minimum data set) completed as she was a new admission. The resident was documented as being alert and oriented to time, place and person. On 10/13/16 at 8:15 AM, Resident #8 was observed during the medication pass. LPN (licensed practical nurse) C stated, "I am going to check (name of resident)'s blood sugar." LPN (C)	F 441	F 441 -The glucometer is being cleaned appropriately for resident #8 when checking blood sugars. 2-The Staff Development Coordinator will observe all licensed nursing staff when using the glucometer to check blood sugars to ensure that they are cleaning the glucometer per policy. 3-The DON will educate all licensed nursing staff on the appropriate way to clean the glucometer when used for resident blood sugar checks. 4-The Unit Manager or designee will observe licensed nursing staff on a monthly basis to ensure that the nurse cleans the glucometer appropriately before and after each use for the resident blood sugar checks. The results of the audits will be presented to the quarterly Quality Assurance Committee for review and recommendations. 5 – Completion date 11/21/16.	

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obtained the glucometer which was located in a basket containing the glucometer, lancets and alcohol wipes. LPN (C) removed the glucometer from the basket and placed it on the night stand in Resident #8's room. The glucometer was used for other residents. The glucometer was not cleaned prior to use. The blood sugar was obtained and the glucometer was placed back into the basket and then back into the medication cart without cleaning it.

On 10/13/16 at 8:50 AM, LPN (C) was questioned as to when the glucometer should be cleaned. LPN (C) stated, "I will clean it now. It should be cleaned because of infection control."

Review of the facility's policy on cleaning and disinfecting the glucometer was done. It stated, "Cleaning and disinfecting can be completed by using a commercially available EPA (Enviromental Protection Agency) -registered disinfectant detergent or germicide wipe." "We suggest cleaning and disinfecting the meter between patient use."

On 10/14/16 at approximately 10:00 AM, the infection control program was reviewed. The DON (director of nursing) stated, "We have had some new nurses. We should be cleaning between patients."

On 10/14/16 at the end of the day exit, the Administrator and DON were notified of above findings.