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المعاشدة ال	focus survey was co 2/1/17. Corrections with the following For requirements. The bed facility was 101 The survey sample resident reviews (Re #12).	Minimum Data Set 3.0 special conducted 1/31/17 through are required for compliance ederal Long Term Care census in this 120 certified at the time of the survey. consisted of 12 current esident #1 through Resident		e e e e e e e e e e e e e e e e e e e	Preparation, submission a implementation of this place correction does not constitution admission of or agreement facts and conclusions set if survey report. Our plan of prepared and executed as continuously improve qual	an of itute an twith the forth on the corrections a means to lity of care	
SS=D	483.20(b)(1) COMP ASSESSMENTS (b) Comprehensive		F 2	(2	federal regulations. F272		
		sment Instrument. A facility		1.	Resident #10 CAA was not	ed to not	0

- must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following:
- (i) Identification and demographic information
- (ii) Customary routine.
- (iii) Cognitive patterns.
- (iv) Communication.
- (v) Vision.
- (vi) Mood and behavior patterns.
- (vii) Psychological well-being.
- (viii) Physical functioning and structural problems.
- (ix) Continence.
- (x) Disease diagnosis and health conditions.
- (xi) Dental and nutritional status.
- (xii) Skin Conditions.
- (iiix) Activity pursuit.
- (xiv) Medications.
- (xv) Special treatments and procedures.

- show specific date and location of the supporting assessment documentation in section V or in the CAA worksheet.
- 2. An audit of the CAAs completed in the last 90 days will be done, then 10% of CAAs will be audited for the next three months.
- 3. The Interdisciplinary Team will be reeducated to include the specific date, time, and location of the supporting assessment documentation for the CAA.
- 4. The Director of Nursing Services or designee will audit CAAs for location, date, and time for three months. Findings will be reported to QAPI.
- 5. February 28, 2017

BORATORY DIRECTOR'S OR PROVIDER SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Keiel Schol INHA	ARMINITRATOR	2/11/11
i euc Alice	1100000000000	4/14/17

by deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that her safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days lowing 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 ys following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued ogram participation

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BERRYVILLE, VA 22611

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PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)

(X5) COMPLETION DATE

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(xvi)

Discharge planning.

(xvii) Documentation of summary information regarding the additional assessment performed on the

care areas triggered by the completion of the Minimum Data Set (MDS).

(xviii) — Decumentation of participation in

(xviii) Documentation of participation in assessment. The assessment process must include direct

observation and communication with the resident, as well as communication with licensed and

non-licensed direct care staff members on all shifts.

The assessment process must include direct observation and communication with the resident, as well as communication with licensed and non-licensed direct care staff members on all shifts.

This REQUIREMENT is not met as evidenced by:

Based on staff interview and clinical record review it was determined that the facility staff failed to ensure complete and accurate Care Area Assessments (CAA's) for 1 of 12 Residents in the sample survey, Resident #10.

The Findings Included:

1. For Resident #10 the facility staff failed to ensure complete and accurate Care Area Assessments (CAA's) on an Admission Minimum Data Set (MDS) assessment with an Assessment Reference Date of 1/19/17. Resident #10 was a 44 year old female who was originally admitted on 10/26/16 and readmitted on 1/12/17. Admitting diagnoses included, but were

not limited to: extra dural and subdural abscess.

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obesity, major depression, anxiety and mononeuropathy right lower leg.

The most current Minimum Data Set (MDS) located in the clinical record was an Admission MDS assessment with an Assessment Reference Date (ARD) of 1/19/17. The facility staff coded that Resident #10 had a Cognitive Summary Score of 15. The facility staff also coded that Resident #10 required extensive assistance (3/3) with Activities of Daily Living (ADL's). In Section V. Care Area Assessment s (CAA's) Resident #10 "triggered" for ADL Functional Rehabilitation. Urinary Incontinence, Psychosocial Well Being, Mood State, Activities, Falls, Nutritional Status, Pressure Ulcer, Psychotropic Drug Use, Pain and Return to Community Referral. For the "triggered" areas of Psychosocial Well Being, Mood State, Activities and Return to Community Referral the facility staff documented "CAA WS" (care area assessment work sheet) dated 1/19/2017." The facility staff had not documented the specific date and location of the supporting assessment documentation for the care plan decision making.

On January 31, 2017 at 3:15 p.m. the surveyor reviewed Resident #10's clinical record. Review of the clinical record produced the CAA worksheets. Review of the CAA worksheets documented the following for the "triggered" areas of Psychosocial Well Being. Mood State, Activities and Return to Community Referral, "CAA WS dated 1/19/2017." (sic) The facility staff had not documented the specific location and dated of the supporting assessment documentation for the care plan decision making.

On February 1, 2017 at 8:10 a.m. the surveyor

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interviewed the Social Worker (SW). The surveyor notified the SW that Resident #10's CAA's were incomplete/inaccurate. The surveyor reviewed the Admission MDS assessment with the SW. The surveyor specifically pointed out that Section V. CAA's did not document the specific date and location of the supporting assessment documentation for Psychosocial Well Being, Mood State, Activities and Return to Community Referral. The surveyor pointed out that the facility staff had documented CAA WS dated 1/19/2017. The surveyor then reviewed the CAA worksheets for Psychosocial Well Being, Mood State, Activities and Return to Community Referral with the SW. The surveyor pointed out that the facility staff had documented CAA WS dated 1/19/2017. The surveyor notified the SW that the CAA's were incomplete and inaccurate. The surveyor notified the SW that the specific date and location of the supporting assessment documentation was not documented in Section V or in the CAA worksheets.

REGULATORY OR LSC IDENTIFYING INFORMATION:

On February 1, 2017 at 4:10 p.m. the survey team met with the Administrator (Adm), DON, ADON and MDS Coordinator. The surveyor notified the Administrative Team (AT) that Resident #10's CAA's were incomplete/inaccurate. The surveyor notified the AT that the facility staff had documented in Section V. CAA's Psychosocial Well Being, Mood State, Activities and Return to Community Referral "CAA WS dated 1/19/2017." The surveyor then informed the AT that the CAA worksheets documented "CAA WS dated 1/19/2017." The surveyor notified the AT that the facility staff had not documented the specific dated and location of the supporting assessment documentation for the care plan decision making.

F 272

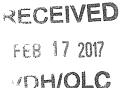
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Event ID 8DRM11

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If continuation sheet Page 4 of 26



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F 272 Continued From page 4

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

Resident #10. F 278 483.20(g)-(j) ASSESSMENT

SS=D ACCURACY/COORDINATION/CERTIFIED

F 278

F 272

- (g) Accuracy of Assessments. The assessment must accurately reflect the resident's status.
- (h) Coordination
 A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.
- (i) Certification
- (1) A registered nurse must sign and certify that the assessment is completed.
- (2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.
- (j) Penalty for Falsification
- (1) Under Medicare and Medicaid, an individual who willfully and knowingly-
- (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment; or
- (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than \$5,000 for each assessment.

F278

- Resident #11 MDS assessment was modified to reflect the treatment of the UTI reported on 2/2/17.
- 2. An audit of UTIs in the past 90 days will be conducted to ensure they are coded in the MDS assessments.
- MDS personnel will be re-educated on UTI coding according to the RAI manual.
- The ID team will review current UTIs in clinical start up to ensure they are coded correctly in the MDS. Findings will be reported to QAPI.
- 5. February 28, 2017

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Event ID 8DRM13

Facility ID: VA0210

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(2) Clinical disagreement does not constitute a material and false statement.

This REQUIREMENT is not met as evidenced

Based on staff interview and clinical record review it was determined that the facility staff failed to ensure a complete and accurate Minimum Data Set (MDS) assessment for 1 of 12 Residents in the sample survey, Resident # 11.

The Findings Included:

Resident #11 was an 88 year old female who was originally admitted on 2/8/10 and readmitted on 1/5/17. Admitting diagnoses included, but were not limited to: hypothyroidism, dehydration, cataracts, anxiety, pyelonephritis, dementia, major depression and Alzheimer's.

The most current Minimum Data Set (MDS) assessment located in the clinical record was a 5 Day Medicare and Significant Change MDS assessment with an Assessment Reference Date (ARD) of 1/12/17. The facility staff coded that Resident #11 had a Cognitive Summary Score of 6. The facility staff also coded that Resident #11 required limited (2/2) to extensive (3/3) assistance with Activities of Daily Living (ADL's). In Section I. Active Diagnoses the facility staff did not code that Resident #11 had a Urinary Tract Infection within the past 30 days.

On February 1, 2017 at 2 p.m. the surveyor reviewed Resident #11's clinical record. Review of the clinical record produced a physician telephone order dated 12/30/16 that read ... "UA C&S STAT (urinalysis and culture and sensitivity stat)." (sic)

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· ·	Continued review of the Peccember 2016 Med Resident #11 was discounted (MAR's). Resident Resident #11 was discounted (MAR's). Resident #11 was discounted that Resident #11 was discounted for the Peccember 2016 Med Records (MAR's). Resident #11 was orded 12/30/16 and 12/31/10 Continued review of the results of the UA Resident #11's urine 250/ul's of blood, had	f the clinical record produced ated 12/31/16 that read in part to have elevated temperature exhibiting increased confusion d chills and a headache" notes also documented that ischarged to the local hospital urned to the facility on 1/6/16 a UTI. e clinical record produced the dication Administration Review of the MAR's esident #11 received the ered by the physician on				

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On February 1, 2017 at 2:35 p.m. the surveyor reviewed Resident #11's clinical record with the 2 MDS Nurses. The surveyor reviewed the nursing progress notes that documented symptoms of a UTI, reviewed the UA C&S results dated 12/30/16 that identified a UTI, reviewed the physician orders for diagnoses and treatment of a UTI and

reviewed the December 2016 MAR's that

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	then reviewed the 5 Change MDS asses 1/12/17. The survey staff had not coded that Resident #11 ha The MDS Nurses st	Day Medicare and Significant syment with the ARD of yor pointed out that the facility in Section I. Active Diagnoses ad a UTI in the past 30 days, ated that the MDS should reflect a UTI in the past 30			
, decigner	of Nursing (DON), A (ADON) and the MD informed the Adminis Resident #11's 5 Day Change MDS assess 1/12/17 was incorrect AT that Resident #11	7 at 4:10 p.m. the survey dministrator (Adm), Director ssistant Director of Nursing S Coordinator. The surveyor strative Team (AT) that y Medicare and Significant sment with the ARD of ct. The surveyor notified the had a UTI in the look back d that the facility staff had not e MDS.	- 1 - 1 - 2 - 1 - 1 - 1 - 1 - 1 - 1 - 1		i vranciji šervažavija na a
F 315 SS=D	exiting the facility as to ensure a complete assessment for Resi	dent#11. CATHETER, PREVENT UTI,	F 3 ⁻	15	
	continent of bladder a receives services and continence unless his	ensure that resident who is and bowel on admission d assistance to maintain s or her clinical condition is t continence is not possible			

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(2) For a resident with urinary incontinence, based

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on the resident's comprehensive assessment, the facility must ensure that-

(EACH DEFICIENCY MUST BE PRECEDED BY FULL

REGULATORY OR LSC IDENTIFYING INFORMATION)

- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary;
- (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary and
- (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible.
- (3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible.

This REQUIREMENT is not met as evidenced bv:

Based on observation, staff interview, clinical record review, resident interview and facility document review it was determined that the facility staff failed to ensure proper care and treatment of a resident with an indwelling Foley catheter for 1 of 12 Residents in the sample survey, Resident # 7.

For Resident #7 the facility staff failed to keep the Foley catheter bag off of the floor, failed to anchor the indwelling Foley catheter to prevent F 315

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F 315

1. Resident #7 now has treatment orders for the Foley catheter. The Foley catheter bag has been removed from the floor.

(EACH CORRECTIVE ACTION SHOULD BE

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- 2. An audit of current residents with indwelling catheters will be created to ensure necessary orders are in place and indwelling catheter bags are kept off the floor.
- 3. Current nursing staff members will be re-educated on the policy and procedure for residents with indwelling urinary catheters.
- 4. Indwelling urinary catheters orders will be monitored daily in clinical start up for three months. Residents with indwelling catheters will be checked daily during zone rounds to ensure proper placement and positioning of indwelling catheters. Findings will be reported to QAPI.
- 5. February 28, 2017

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excess tension on the urinary meatus and failed to ensure that the physician provided necessary orders for care and treatment of an indwelling Foley catheter to include a Foley catheter size and balloon size.

The Findings Included:

Resident #7 was a 72 year old female who was originally admitted on 5/11/15 and readmitted on 10/25/15. Admitting diagnoses included, but were not limited to: major depression, hypothyroidism, hypertension, chronic obstructive pulmonary disease and osteoarthritis.

The most current Minimum Data Set (MDS) assessment located in the clinical record was a Quarterly MDS assessment with an Assessment Reference Date (ARD) of 11/9/16. The facility staff coded that Resident #7 had a Cognitive Summary Score of 14. The facility staff also coded that Resident #7 required extensive (3/2) to total nursing care (4/3) with Activities of Daily Living (ADL's). In Section H. Bladder and Bowels the facility staff coded that Resident #7 had an indwelling Foley catheter.

On January 31, 2017 at 2:50 p.m. the surveyor observed Resident #7 lying in bed. The surveyor observed that Resident #7's urinary drainage bag was laying in the floor on the right hand side of the bed. The surveyor was exiting the room when a Licensed Practical Nurse (LPN #1) entered the room with Resident #7's medications. The surveyor pointed out that the Foley catheter bag was laying in the floor. LPN (#1) picked up the urinary drainage bag and hung it on the lower right hand side of the bed frame. The surveyor asked LPN (#1) if Resident #7's Foley was

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anchored. LPN (#1) stated "No." LPN (#1) stated that Resident #7 did not have the Foley catheter anchored "because she stooled a lot." The surveyor did not understand what LPN (#1) meant. The surveyor asked LPN (#1) and Resident #7 if the risks benefits of the Foley not being anchored were explained to Resident #7. The surveyor informed Resident #7 that if the catheter was not secured it increased the potential for infection and increased the potential of the catheter being pulled out with the bulb inflated. Resident #7 spoke up and stated, "Not that I can remember." The surveyor asked to see if Resident #7's Foley was anchored. LPN (#7) pulled down the covers and exposed Resident #7's lower legs. The surveyor observed that the Foley catheter tubing was under Resident #7's right leg. The surveyor pointed out that Resident #7 was lying on the Foley catheter tubing to LPN (#1).

SUMMARY STATEMENT OF DEFICIENCIES

(EACH DEFICIENCY MUST BE PRECEDED BY FULL

REGULATORY OR LSC IDENTIFYING INFORMATION)

On January 31, 2017 at 4 p.m. the surveyor notified the Director of Nursing (DON) and Assistant Director of Nursing (ADON) that Resident #7's Foley catheter bag was laying in the floor and that the Foley catheter was not anchored. The surveyor requested the facility policy and procedure for care and treatment of residents with Foley catheters.

On January 31, 2017 at 4:25 p.m. the ADON hand delivered the facility policy and procedure titled, "Preventing Catheter Associated UTIs (CAUTI) (urinary tract infections/catheter associated urinary tract infections)." The policy and procedure read in part ... " ... 6. Maintain unobstructed urine flow. a. Keep the catheter and tubing free of kinks. b. Secure catheter after insertion to prevent movement. c. Keep drainage

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)RM CMS-2567(02-99) Previous Versions Obsolete

Event ID 8DRM11

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F 315	Continued From page bag below the level not place the drainage.	ge 11 of the bladder at all times. Do ge bag on the floor." (sic)	F S	315	
	reviewed Resident # the clinical record pr Physician orders inc. "Monitor foley cath (c shift). Foley cath car physician orders did catheter care if the F dislodged, how often	7 at 8:10 a.m. the surveyor #7's clinical record. Review of roduced physician orders. cluded, but were not limited to: catheter) output QS (every re Q (every) shift)."(sic) The not include orders for to change the Foley er size and balloon size.	in sources	as nitrētu — entre as etc. escalabo nom etc. centratific se	nestatu ir en lastu i matro no i luvino e mmateriar das Arrico
	reviewed the clinical surveyor reviewed the DON. The surveyor pstaff did not have phy catheter size and ball change the Foley cati	at 8:30 a.m. the surveyor record with the ADON. The physician orders with the cointed out that the facility ysician orders for the Foley lloon size, how often to theter, and how to treat if the ne occluded or dislodged.			
	ADON and MDS Coo notified the Administra Resident #7's Foley of floor, the Foley cathet that the signed physic specific orders for Fol catheter size and balk	catheter bag was lying in the ter was not anchored and cian orders did not included ley catheter care and Foley loon size.			
F 329 SS=E	483.45(d) DRUG REG UNNECESSARY DRU	GIMEN IS FREE FROM UGS	F 32	29	
1	drug regimen must be	gs-General. Each resident's e free from unnecessary ary drug is any drug when			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

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F 329 Continued From page 12 used--

(1) In excessive dose (including duplicate drug therapy); or

- (2) For excessive duration; or
- (3) Without adequate monitoring; or
- (4) Without adequate indications for its use, or
- (5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or
- (6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by:

Based on staff interview and clinical record review it was determined that the facility staff failed to ensure that 6 of 12 Residents in the sample survey were free of unnecessary medications, Resident #7, Resident #8, Resident #9, Resident #10, Resident #11 and Resident #5.

The Findings Included:

1. For Resident #7 the facility staff failed to monitor for side effects, interventions, effectiveness and specific behaviors for the use of an antidepressant (Paxil and Remeron) and for an antianxiety (Xanax).

Resident #7 was a 72 year old female who was originally admitted on 5/11/15 and readmitted on 10/25/15. Admitting diagnoses included, but were not limited to: major depression, hypothyroidism, hypertension, chronic obstructive pulmonary

F 329

F 329

- Resident #7, 8, 9, 10, 11, and 5 have been noted to have no documentation of potential side effects, or interventions, from psychotropic medications.
- 2. An audit of patients currently prescribed psychotropic medications will be created to ensure a monitoring tool for side effects is being utilized.
- Current licensed nursing staff members will be re-educated on utilizing a monitoring tool after administering psychotropic medications.
- The Director of Nursing Services will monitoring new psychotropic med orders to ensure monitoring tool is in place. Findings will be reported to QAPI.
- 5. February 28, 2017

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F 329 Continued From page 13 disease and osteoarthritis.

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The most current Minimum Data Set (MDS) assessment located in the clinical record was a Quarterly MDS assessment with an Assessment Reference Date (ARD) of 11/9/16. The facility staff coded that Resident #7 had a Cognitive Summary Score of 14. The facility staff also coded that Resident #7 required extensive (3/2) to total nursing care (4/3) with Activities of Daily Living (ADL's). In Section N. Medications the facility staff coded that Resident #7 received 7 days of an antidepressant medication and 7 days of an antianxiety medication.

On February 1, 2017 at 8:10 a.m. the surveyor reviewed Resident #7's clinical record. Review of the clinical record produced physician orders. Physician orders included, but were not limited to: "Remeron Tablet 15 MG (Mirtazapine) Give 1 tablet by mouth at bedtime for Depression, Paroxetine HCl Tablet 40 MG Give 1 tablet by mouth one time a day for Depression, Xanax Tablet 0.25 MG (ALPRAZolam) Give 0.25 tablet by mouth two times a day for anxiety 1 tab (tablet) at lunch and 1 tab at HS (bedtime)." (sic)

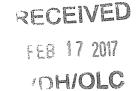
Continued review of the clinical record produced the January and February 2017 Medication Administration Records (MAR's). Review of the MAR's documented that the facility were administering the Paxil, Remeron and Xanax as ordered by the physician. Further review of the clinical record produced the Comprehensive Care Plan (CCP). The CCP identified the following "Focus, Goal and Interventions." "Focus I sometimes have behaviors which included Crying; non-compliance with diuretic administering orders non-compliance

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with orders for daily weights, and non-compliance with taking medications ... Goal My behavior will stop with staff intervention Interventions Attempt interventions before my behaviors begin. Goal Potential for drug related complications associated with psychotropic medications related to: Anti-Depressant medication, AntiAnxiety Goal Will be free of psychotropic drug related complications. Interventions ... Monitor for side effects and report to physician: Anti-anxiety/Hypnotic medications, drowsiness, morning, hang over, ataxia, dry mouth, constipation, blurred vision, urinary retention, headache, vertigo, nausea, hypotension, tachycardia, weakness, sedation, lethargy, confusion, memory loss and dependence. Monitor for side effects and report to physician:

(EACH DEFICIENCY MUST BE PRECEDED BY FULL

REGULATORY OR LSC IDENTIFYING INFORMATION)

Continued review of the clinical record failed to produce documentation of monitoring for specific behaviors of depression and antianxiety. effectiveness of the antidepressant and antianxiety medications, interventions and side effects of the antidepressant and antianxiety medications.

Antidepressant-Sedation. drowsiness, dry mouth, blurred vision, urinary retention, tachycardia, muscle tremor, agitation, headache, skin rash, photo sensitivity and excess weight gain." (sic)

On February 1, 2017 at 4:10 p.m. the survey team met with the Administrator (Adm), DON, ADON and MDS Coordinator. The surveyor notified the Administrative Team (AT) that Resident #7 was receiving Paxil, Remeron and Xanax. The surveyor notified the AT that specific behaviors of depression and antianxiety, effectiveness of the antidepressant and antianxiety medications, interventions and side

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F 329 Continued From page 15

effects of the antidepressant and antianxiety medications could not be located in the clinical record.

No additional information was provided prior to exiting the facility as to why the facility staff failed to ensure that Resident #7 was free of unnecessary medications.

2. For Resident #8 the facility staff failed to monitor for side effects, interventions, effectiveness and specific behaviors for the use of an antidepressant (Zoloft) and a hypnotic (Temazepam).

Resident #8 was a 77 year old male who was originally admitted on 3/16/15 and readmitted on 6/10/16. Admitting diagnoses included, but were not limited to: pneumonia, gout, diabetes mellitus, major depression, penile implant, chronic kidney disease, stage IV, urinary tract infection and sepsis.

The most current Minimum Data Set (MDS) assessment located in the clinical record was a Quarterly MDS assessment with an Assessment Reference Date 9ARD of 10/24/16. The facility staff coded that Resident # had a Cognitive Summary Score of 9. The facility staff also coded that Resident #8 required extensive (3/3) to total nursing care (4/3) with Activities of Daily Living (ADL's). In Section N. Medications the facility staff coded that Resident #8 received 7 days of an antidepressant and 7 days of a hypnotic.

On February 1, 2017 at 1 p.m. the surveyor reviewed Resident #8's clinical record. Review of the clinical record produced physician orders. Physician orders included, but were not limited to:

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"Sertraline HCL (Zoloft) 100 MG give 1 tablet by mouth one time a day for depression, Temazepam Capsules 15 MG give 15 mg by mouth at bedtime Insomnia (Hospice will cover)." (sic)

REGULATORY OR LSC IDENTIFYING INFORMATION)

Continued review of the clinical record produced the January and February 2017 Medication Administration Records (MAR's). The MAR's documented that the facility staff were administering the Zoloft and Temazepam as ordered by the physician.

Further review of the clinical record failed to produce documentation of monitoring for specific behaviors related to the antidepressant drug use and the hypnotic (Zoloft and Temazepam), interventions, side effects of the antidepressant and hypnotic drug use and effectiveness of the antidepressant and hypnotic.

Continued review of the clinical record produced the Comprehensive Care Plan (CCP). The CCP identified the following "Focus, Goal and Interventions." "Focus Potential for drug related complications associated with psychotropic medications related to: Anti-Depressant medication, AntiAnxiety medication, and hypnotic use. Goal Will be free of psychotropic drug related complications. Interventions ... Monitor for side effects and report to physician: Anti-anxiety/Hypnotic medications, drowsiness, morning, hang over, ataxia, dry mouth, constipation, blurred vision, urinary retention, headache, vertigo, nausea, hypotension, tachycardia, weakness, sedation, lethargy, confusion, memory loss and dependence. Monitor for side effects and report to physician: Antidepressant-Sedation, drowsiness, dry mouth,

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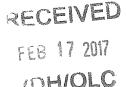
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F 329	Continued From pa	ge 17	F3	29	
.esasi r	photo sensitivity and for side effects and Antipsychotic medic dry mouth, constipal weight gain, edema sweating, loss of appoint of the MDS Nurse record failed to proof the Zoloft and Tema MDS Nurse reviewer record. The MDS Nurse record. The MDS Nurse reviewer record. The MDS Nurse record. The MDS Nurse recor	cations-sedation, drowsiness, ation, blurred vision, EPS, postural hypotension, petite, urinary retention." (sic) 7 at 1:30 p.m. the surveyor area that review of the clinical duce monitoring for the use of azepam. The surveyor and ad Resident #8's clinical area was unable to find use of the Zoloft and ade specific behaviors, affects and effectiveness. 7 at 4:10 p.m. the survey dministrator (Adm), DON, nordinator. The surveyor trative Team (AT) that	es a ville da	นอกระ (นอกระกอน กับกับอากา นับ (- 2) นัก (กับอะตรณ์) (- การกับ) ใก	in the King the region of the last the control of

No additional information was provided prior to exiting the facility as to why the facility staff failed to ensure that Resident #8 was free of unnecessary medications.

specific behaviors of depression and insomnia, effectiveness of the antidepressant and hypnotic medications, interventions and side effects of the antidepressant and hypnotic medications could

not be located in the clinical record.

3. For Resident #9 the facility staff failed to monitor for the use of an antidepressant, Zoloft.

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F 329	admitted on 9/18/13 included, but were r	76 year old male who was 3. Admitting diagnoses not limited to: major	F3	329	-		
	mellitus, hypertension	ner's, gout seizures, diabetes on, chronic obstructive atrial fibrillation, retention of sorder.					
s s s s s	assessment located Quarterly MDS asse Reference Date (AR staff coded that Res (3/2) to total nursing Daily Living (ADL's)	inimum Data Set (MDS) In the clinical record was a ressment with an Assessment RD) of 12/14/16. The facility ident #9 required extensive care (4/2) with Activities of In Section N. Medications at that Resident #9 received 7 researt.	a Linear	gar ar	general general Menamblane (p. 1920). Para di se		e agreement datum a timbaa ti T
	reviewed Resident # the clinical record pr Physician orders inc	7 at 9:15 a.m. the surveyor 9's clinical record. Review of oduced physician orders. luded, but were not limited to: G Give 100 mg by mouth at ion." (sic)					
	the January and Feb Administration Reco MAR's documented	the clinical record produced bruary 2017 Medication rds (MAR's). Review of the that the facility staff were loft as order by the physician.					
	produce monitoring ouse, Zoloft, to include	clinical record failed to of the antidepressant drug e specific behaviors, fects and effectiveness.					

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Continued review of the clinical record produced the Comprehensive Care Plan (CCP). Review of the CCP identified the following "Focus, Gola and

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Interventions." "Focus Potential for drug related complications associated with psychotropic medications related to: Anti-Depressant medication. Goal Will be free of psychotropic drug related complications. Interventions ... Monitor for side effects and report to physician: Antidepressant-Sedation drowsiness, dry mouth, blurred vision, urinary retention, tachycardia, muscle tremor, agitation, headache, skin rash, photo sensitivity and excess weight gain." (sic)

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On February 1, 2017 at 10:10 a.m. the surveyor notified the Director of Nursing (DON) that Resident #9 was receiving Zoloft and that monitoring for the use of the antidepressant was not located in the clinical record. The surveyor notified the DON that specific behaviors of depression, side effects of the antidepressant, effectiveness of the antidepressant and interventions need to be documented. The surveyor and Don reviewed the clinical record. The DON was unable to locate documentation of the monitoring of the use of the antidepressant drug use, Zoloft.

On February 1, 2017 at 4:10 p.m. the survey team met with the Administrator (Adm), DON, ADON and MDS Coordinator. The surveyor notified the Administrative Team (AT) that Resident #9 was receiving Zoloft. The surveyor notified the AT that specific behaviors of depression, effectiveness of the antidepressant medication, interventions and side effects of the antidepressant medication could not be located in the clinical record.

No additional information was provided prior to exiting the facility as to why the facility staff failed to ensure that Resident #9 was free of F 329

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F 329 Continued From page 20 unnecessary medications.

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4. For Resident #10 the facility staff failed to monitor for the use of an antidepressant, Cymbalta, and an antianxiety, Ativan.

Resident #10 was a 44 year old female who was originally admitted on 10/26/16 and readmitted on 1/12/17. Admitting diagnoses included, but were not limited to: extra dural and subdural abscess, obesity, major depression, anxiety and mononeuropathy right lower leg.

The most current Minimum Data Set (MDS) located in the clinical record was an Admission MDS assessment with an Assessment Reference Date (ARD) of 1/19/17. The facility staff coded that Resident #10 had a Cognitive Summary Score of 15. The facility staff also coded that Resident #10 required extensive assistance (3/3) with Activities of Daily Living (ADL's). In Section N. Medications the facility staff coded that Resident #10 received 7 days of an antidepressant and 7 days of an antianxiety medication.

On January 31, 2017 at 3:15 p.m. the surveyor reviewed Resident #10's clinical record. Review of the clinical record produced physician orders. Physician orders included, but were not limited to: "Lorazepam Tablet (Ativan) 1 MG Give 1 tablet by mouth every 6 hours as needed for anxiety related to GENERALIZED ANXIETY DISORDER, DULoxetine HCI (Cymbalta) Capsule Delayed Release Particles 30 MG Give 1 capsule by mouth two times a day related to DEPRESSIVE DISORDER, SINGLE EPISODE. UNSPECIFIED." (sic)

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Continued review of the clinical record produced the January 2017 Medication Administration Records (MAR's). Review of the MAR's documented that the facility staff were administering the Cymbalta twice a day as ordered by the physician. The MAR's also documented that Resident #10 received the Ativan twice on 1/26/17, once on 1/27/17, once on 1/28/17, once on 1/29/17 and once on 1/30/17.

(EACH DEFICIENCY MUST BE PRECEDED BY FULL

REGULATORY OR LSC IDENTIFYING INFORMATION)

Further review of the clinical record failed to produce documentation of monitoring for the Ativan and Cymbalta drug use to include specific behaviors, side effects of the medications. effectiveness of the medication uses and interventions.

On February 1, 2017 at 8:05 a.m. the surveyor notified the Assistant Director of Nursing (ADON) that Resident #10 was receiving Ativan and Cymbalta. The surveyor notified the ADON that specific behaviors, effectiveness, interventions and side effects for the use of the Ativan and Cymbalta could not be located in the clinical record. The surveyor reviewed the clinical record with the ADON. The ADON stated that the facility did not monitor for the use of antidepressants and antianxiety medications. The ADON stated that the facility staff only monitored for psychotropic drug use.

On February 1, 2017 at 4:10 p.m. the survey team met with the Administrator (Adm), DON, ADON and MDS Coordinator. The surveyor notified the Administrative Team (AT) that Resident #10 was receiving Cymbalta and Ativan. The surveyor notified the AT that specific behaviors of depression and anxiety,

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effectiveness of the antidepressant and antianxiety medications, interventions and side effects of the antidepressant and antianxiety medications could not be located in the clinical record.

No additional information was provided prior to exiting the facility as to why the facility staff failed to ensure that Resident #10 was free of unnecessary medications.

5. For Resident #11 the facility staff failed to monitor for the use of an antidepressant, Lexapro.

Resident #11 was an 88 year old female who was originally admitted on 2/8/10 and readmitted on 1/5/17. Admitting diagnoses included, but were not limited to: hypothyroidism, dehydration, cataracts, anxiety, pyelonephritis, dementia, major depression and Alzheimer's.

The most current Minimum Data Set (MDS) assessment located in the clinical record was a 5 Day Medicare and Significant Change MDS assessment with an Assessment Reference Date (ARD) of 1/12/17. The facility staff coded that Resident #11 had a Cognitive Summary Score of 6. The facility staff also coded that Resident #11 required limited (2/2) to extensive (3/3) assistance with Activities of Daily Living (ADL's). In Section N. Medications the facility staff coded that Resident #11 received 7 days of an antidepressant.

On February 1, 2017 at 2 p.m. the surveyor reviewed Resident #11's clinical record. Review of the clinical record produced physician orders. Physician orders included, but were not limited to:

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"Lexapro Tablet (Escitalopram Oxalate) Give 15 mg by mouth one time a day related to MAJOR DEPRESSIVE DISORDER, SINGLE EPISODE, UNSPECIFIED."(sic)

Continued review of the clinical record produced the January and February 2017 Medication Administration Records (MAR's). Review of the MAR's documented that the facility staff were administering the Lexapro as ordered by the physician.

Further review of the clinical record failed to produce documentation of monitoring for the Lexapro drug use to include specific behaviors, side effects of the medications, effectiveness of the medication uses and interventions.

Continued review of the clinical record produced the Comprehensive Care Plan (CCP). The CCP identified the following "Focus, Goals and Interventions," "Focus Potential for drug related complications associated with psychotropic medications related to: Anti-Depressant medication. Goal Will be free of psychotropic drug related complications. Interventions ... Monitor for side effects and report to physician: Antidepressant-Sedation drowsiness, dry mouth, blurred vision, urinary retention, tachycardia, muscle tremor, agitation, headache, skin rash, photo sensitivity and excess weight gain." (sic)

On February 1, 2017 at 2:35 p.m. the surveyor notified two MDS Nurses that review of the clinical record failed to produce monitoring for the use of the Lexapro. The surveyor and MDS Nurse reviewed Resident 10's clinical record. The MDS Nurses were unable to find monitoring for the use of the Lexapro to include specific

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behaviors, interventions, side effects and effectiveness.

On February 1, 2017 at 4:10 p.m. the survey team met with the Administrator (Adm), Director of Nursing (DON), Assistant Director of Nursing (ADON) and the MDS Coordinator. The surveyor informed the Administrative Team (AT) that Resident #10 was receiving Lexapro. The surveyor notified the AT that specific behaviors of depression, effectiveness of the antidepressant medication, interventions and side effects of the antidepressant medication could not be located in the clinical record.

No additional information was provided prior to exiting the facility as to why the facility staff failed to ensure that Resident #10 was free from unnecessary medications.

6. For Resident #5, facility staff failed to monitor the resident for effectiveness of antipsychotic medications.

Resident #5 was admitted to the facility on 10/24/15 with diagnoses including dementia with behavior, depression, hypertension, and cerebrovascular disease. On the minimum data set (MDS) assessment with assessment reference date 1/4/2017, the resident scored 9/15 on the brief interview for mental status and was assessed as without signs of delirium, psychosis, or behaviors affecting others.

Clinical record review revealed an physician orders for the antipsychotic medication Risperdal. The first order was for Risperdal .25 (milligram) 2 times per day for bipolar disorder written 12/29/2016 and the second order for Risperdal .5 mg 2 times per day for r/o (rule out) bipolar

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BERRYVILLE, VA 22611

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disorder written 1/20/2017.

The medication administration record documented the resident received the medication two times per day every day during January 2017. A nursing order for behavior monitoring was entered in the record starting 1/20/2017. The specific behaviors for which the resident was being treated were not documented. The first behavior monitoring entry was entered on 1/31/2017 (indicating no behaviors noted) after the surveyors entered the facility on 1/31/17.

SUMMARY STATEMENT OF DEFICIENCIES

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The surveyors discussed the concerns with monitoring with the assistant director of nursing on 2/1/2017.

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