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	49E004	A. BUILDING _____ B. WING _____	08/16/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEDFORD CO NURSING HOME	1229 COUNTY FARM ROAD BEDFORD, VA 24523

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E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 08/14/18 through 08/16/18. The facility was in substantial compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities.	E 000		
F 000	INITIAL COMMENTS An unannounced Medicaid standard survey was conducted 8/14/18 through 8/16/18. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. The census in this ninety certified bed facility was 86 at the time of the survey. The survey sample consisted of eighteen current resident reviews and two closed record reviews.	F 000		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not	F 656		9/30/18

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

Electronically Signed | 08/30/2018

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F 656	Continued From page 1 provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and clinical record review, the facility staff failed to develop a comprehensive care plan for one of 20 residents in the survey sample. Resident #79 had no care plan developed regarding care and treatment of an ulcer on her right great toe. The findings include: Resident #79 was admitted to the facility on 9/5/17 with a re-admission on 7/11/18. Diagnoses for Resident #79 included congestive heart failure, cellulitis, dementia, sleep apnea, restless leg syndrome and hyperlipidemia. The	F 656	F-656 The community will develop and implement a comprehensive person centered care plan for every resident as identified in the comprehensive assessment including objectives and time frames to meet medical, nursing, mental and psychosocial needs as evidenced by: 1. Resident #59 had an immediate correction to the care plan to include the care and treatment of the wound prior to exit of the survey team. 2. The community will identify other	

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F 656	Continued From page 2 minimum data set (MDS) dated 7/20/18 assessed Resident #79 with moderately impaired cognitive skills. Resident #79's clinical record documented the resident was assessed on 7/5/18 with an ulcer on her right great toe. A nursing note dated 7/5/18 documented, "Ulceration to the right great toe measuring 1 cm x 0.9 cm [length by width in centimeters]. Slough present in the wound bed, unable to determine depth at this time..." The clinical record documented ongoing wound assessments and physician orders for topical treatment to the right great toe starting on 7/5/18. The record documented a physician's order dated 7/11/18 stating, "No shoe right foot until healed..." The record also documented a physician's order dated 7/27/18 for the daily application of Silvadene 1% cream to the right great toe after cleansing with soap/water with application of a Band-Aid Resident #79's plan of care (revised 7/30/18) listed the resident had the potential for skin impairment but included no problems, goals and/or interventions regarding the right great toe ulcer. On 8/16/18 at 8:15 a.m., the licensed practical nurse (LPN #1) caring for Resident #79 was interviewed about a care plan for the toe ulcer. LPN #1 stated the right great toe ulcer was treated daily with Silvadene cream and a Band-Aid. LPN #1 stated the resident did not wear a shoe to prevent pressure on the toe area while it was healing. LPN #1 stated she was not responsible for updating care plans. On 8/16/18 at 9:04 a.m., the registered nurse (RN	F 656	residents with potential lack of care plan initiatives as related to changes in care and treatment on a daily basis. The MDS coordinator will be responsible to identify changes through the clinical record review daily. 3. The weekly wound report will be audited in the weekly quality assurance meeting to ensure there is an appropriate care plan for any wound. 4. The community will investigate an upgrade to Matrix software to facilitate communications of resident changes to all team members in a more timely manner. 5. The nursing team will be educated on the process.	

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F 656	Continued From page 3 #1) responsible for care plans was interviewed about Resident #79's toe ulcer. RN #1 reviewed the care plan and stated she did not see anything on the care plan about the ulcer. RN #1 reviewed the clinical record and stated the resident started with the ulcer in July 2018. RN #1 stated, "I should have added this [toe ulcer] by now." On 8/16/18 at 9:30 a.m., the director of nursing (DON) was interviewed about Resident #79's care plan for the toe ulcer. The DON stated all resident issues were supposed to be part of the comprehensive care plan. On 8/16/18 at 10:04 a.m., accompanied by LPN #1 and with the resident's permission, Resident #79's right great toe ulcer was observed. The resident had a small, circular scabbed area on the inner side of the right great toe. LPN #1 cleansed the ulcer and applied Silvadene cream and a Band-Aid as ordered by the physician. These findings were reviewed with the administrator and director of nursing during a meeting on 8/16/18 at 2:50 p.m.	F 656		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident.	F 657		9/30/18

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F 657	Continued From page 4 (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and clinical record review, facility staff failed to review and revise a comprehensive care plan (CCP) for two of 20 residents in the survey sample, Residents #59 and #25. 1. Resident #59's care plan did not have measurable interventions to address non-pharmacological interventions. 2. The facility staff failed to review and revise the comprehensive care plan for Resident # 25 in the area of psychotropic drug use. The findings included: 1. Resident #59's care plan did not have personalized measurable interventions to address non-pharmacological interventions for psychotropic drug use.	F 657	F-657 The community will develop an interdisciplinary care plan within 7 days of completion of the comprehensive assessment with measureable personalized non-pharmacological interventions for residents receiving psychotropic drugs as evidenced by 1. Residents #59 and #25 care plans were immediately revised to include measureable, personalized non-pharmacological approaches prior to the survey team exit. 2. The geriatric nurse practitioner will be permitted to conduct an assessment and make recommendations to the physician. The physician will be responsible to review the recommendations and make diagnosis and medication orders that	

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F 657	Continued From page 5 Resident #59 was originally admitted to the facility on 12/18/2017 and readmitted on 06/07/2018 with diagnoses including congestive heart failure, acute bronchitis, cirrhosis of liver, muscle weakness, chronic kidney disease (stage 3), diabetes type 2, recurrent depressive disorder vitamin D deficiency, hyperlipidemia, and dementia without behavioral disturbance. The minimum data set (MDS) dated 06/29/2018 assessed Resident #59 as cognitively intact. Resident #59's CCP was reviewed on 08/16/18 at 11:00 a.m. Under the category: "Psychotropic Drug Use", the following approach was noted "try non-pharmacological interventions." There was nothing personalized specific to Resident #59. RN #1 (registered nurse) was interviewed on 08/16/18 at 2 p.m., regarding the care plans. RN #1 stated the resident does not display behaviors so she was not sure what to write for specific interventions. She continued and stated the resident and or her family reports she is having hallucinations or dreams, however the reports are made well after the event had taken place and are generally unwitnessed by staff. RN #1 stated she believes Resident #59 has more anxiety than actual behaviors. RN #1 reviewed Resident #59's clinical notes and stated the care plan should have personalized interventions based on the clinical notes. These findings were reviewed with the administrator and director of nursing during a meeting on 08/16/18 at approximately 2:45 p.m. No further information was received by the survey team prior to the exit conference on 08/16/18.	F 657	meet state and federal regulations. The clinical team and pharmacist will also review recommendations. Other types of medications and non pharmacological interventions must be attempted prior to starting any antipsychotic medication. Any resident on a psychotropic medication will have a specific behavior care plan. 3. Target behaviors for residents on antipsychotic medicine will be reviewed and revised. This will ensure behaviors are appropriate. This will be monitored every shift by the nurse and CNA. 4. Residents on antipsychotic medicine will have behavioral logs reviewed weekly in the quality assurance meeting for responses to medication. 5. The geriatric nurse practitioner, physician and the pharmacist will be educated on the new process.	

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F 657	Continued From page 6	F 657		

2. Resident # 25 was admitted to the facility on 05/25/18. Diagnoses for Resident # 25 included, but were not limited to: COPD (chronic obstructive pulmonary disease), hypokalemia, hypothyroidism, restless leg syndrome, hypercalcemia, dementia with behavioral disturbance, personality disorder, mood disorder, and schizophrenia.

The most current full MDS (minimum data set) was a 14 day admission assessment dated, 06/01/18. This MDS assessed the resident with a cognitive score of 13, indicating the resident was cognitively intact for daily decision making skills. The resident was also assessed as requiring limited assistance with at least one person physical assistance for most all ADL's (activities of daily living). This MDS did not identify the resident as having a serious mental illness in section A1500. The resident triggered for ADL's (activities of daily living), falls, nutrition, pressure, and psych drug use in the CAAS (care area assessment section) of this MDS.

The resident's clinical record was reviewed. The physician's orders for Resident # 25 were reviewed from admission to present (08/16/18). The resident had an order for Seroquel 12.5 mg (milligrams) at bedtime; this medication was started one day after admission (05/26/18) for the diagnosis of "unspecified mood disorder."

The medication Seroquel was discontinued on 06/04/18. There was no physician documentation found in the resident's clinical record regarding the discontinuation. It was documented in the nursing notes that the resident had refused this medication on several occasions in this nine day period.

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F 657	Continued From page 7	F 657		

The resident's behavioral log was reviewed for this time period and did not evidence the resident had any type of behaviors.

A nursing note dated 07/30/18 2:07 p.m. - "...she has become increasingly paranoid and often refuses to take her medication. Contacted [name of] NP [nurse practitioner] with psychiatry. Orders for Seroquel 12.5 mg BID [twice daily] for Bipolar disorder received. Faxed new orders to...pharmacy...signature of nurse."

A nursing note dated 07/30/18 8:09 p.m. - "MD responded to communication about placing resident on Seroquel 12.5 mg bid, stated to start qday [everyday] dose for paranoia...signature of nurse."

The resident's physician's orders were reviewed. An order dated 07/31/18 for Seroquel 12.5 mg every day at 5 pm was ordered for personality disorder.

A nursing note dated 08/14/18 at 1:06 p.m. documented: "NP saw resident today and recommended to D/C [discontinue] Seroquel 12.5 mg Q [every] 5 pm, Start Seroquel 25 mg QAM, 25 mg Q5pm, and 25 mg Qhs [bedtime]- delusional disorder...signature of nurse."

A physician's note (MD # 2) dated 08/15/18 at 12:21 p.m. documented: "delusional thinking, meds being adjusted by psych and is improved...alert not oriented and is confused...thyroid labs reviewed and will repeat now that dose is changed...signature of MD # 2."

The resident's physician's orders were reviewed

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and documented an order dated 08/16/18 for Seroquel 12.5 mg every morning for Schizophrenia and an order for Seroquel 12.5 mg every evening for Schizophrenia.

The resident's behavioral log was reviewed 07/18/18 through present (08/16/18) and did not document any behaviors all.

The resident's CCP (comprehensive care plan) was reviewed and documented, "...Start date: 06/07/18...Psychotropic drug use...resident will be free from signs of drug related side effects...administer medications per MD order...attempt gradual dose reduction [if not contraindicated]...attempt non pharmacological interventions such as distraction and redirection as indicated...Keep MD informed of increase in symptoms or any possible side effects...Labs per MD...observe for and report over sedation, falls and new onset of tremors...Observe mood/behaviors and assess response to medication...MRR [medication regimen review] monthly and as needed..."

The CCP did not list the specific rationale for administering an antipsychotic medication to Resident # 25, nor did the CCP list specific nonpharmalogical interventions prior to the administration of an antipsychotic mediation for Resident # 25. There was no documentation and/or monitoring of the resident's behaviors and/or specific interventions attempted with or without success to evidence nonpharmacological interventions were unsuccessful.

On 08/15/18 at 3:39 PM, the survey team met for an end of day meeting with the administrator and director of nursing (DON). The DON and

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F 657	Continued From page 9 administrator were made aware of concerns regarding Resident # 25. The administrator and DON were made aware that Resident # 25 was admitted to this facility on 05/25/18 and was started on Seroquel the day after admission and although the medication was discontinued on 06/04/18, it was started again on 07/31/18 without first implementing specific, nonpharmacological interventions. The administrator and DON were made aware of concerns that the resident had no documentation of any type of behaviors on the behavior logs and that nonpharmacological interventions were not specific and were not documented as implemented for this resident. No further information and/or documentation was presented prior to the exit conference on 08/16/18 at 4:00 p.m. to evidence that that this resident was provided nonpharmacological interventions, that were specific and documented.	F 657		
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and	F 688		9/30/18

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F 688	Continued From page 10 assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on family interview, staff interview and clinical record review, the facility staff failed to ensure one of 20 residents (Resident # 10) received restorative nursing services. Findings include: Resident # 10 was admitted to the facility on 06/07/17. Diagnoses for this resident included, but were not limited to: dementia, blepharitis, constipation, glaucoma, scoliosis, DM (diabetes mellitus), high blood pressure, edema, and pain. The most current MDS (minimum data set) was an annual assessment with dated 05/18/18. The resident was assessed with a cognitive score of 11, indicating the resident had moderate impairment in daily decision making skills. The resident was also assessed as requiring extensive assistance from at least one staff (two staff at times) for most all ADL's (activities of daily living). The resident was not coded on this MDS as receiving restorative nursing services. On 08/15/18 at 10:56 AM, the resident's daughter was interviewed via phone and stated that the resident is supposed to be getting restorative nursing, but hasn't been getting it. The resident's daughter stated that she (the resident) has been sedated and goes through periods of "sleep mode", but staff are not providing the restorative nursing. At approximately 11:20 a.m., the resident was	F 688	F-688 The community will ensure that a resident with limited range of motion receives appropriate treatment and services to prevent further decline as evidenced by: 1. Resident #10 had range of motion and appropriate documentation implemented prior to survey team exit. 2. All residents will be evaluated by therapy on admission and quarterly or with a decline in function. Residents will be transitioned to a restorative program as appropriate. Restorative service will begin within 24 hours of transition from therapy. Restorative care will be documented daily. A resident's refusal or inability to tolerate restorative therapy will be reported to the Restorative RN to assess. The responsible party will be notified. 3. A new restorative manual will be adopted. The Restorative RN will instruct the Restorative CNA on competencies and trainings to be done. The results of daily restorative documentation will be audited and will be reported weekly at the Quality Assurance meeting. The caseload will be reviewed for residents' responses to the program at the same meeting.	

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observed sitting in a w/c (wheelchair) with the bedside table in front of her. The resident was asleep.

Resident # 10's clinical record was reviewed and revealed that the resident had been participating in OT (occupation therapy) and had reached maximum potential with a referral for restorative nursing.

The OT discharge summary documented that the resident was being discharged from OT on 07/27/18, due to reaching maximum capacity for improvement. The resident was recommended for restorative nursing on this discharge summary.

The resident's physician's orders were then reviewed and included an order for, but not limited to: "Restorative Nursing Care per Protocol [start date: 06/07/17-Open Ended]."

The resident's CCP (comprehensive care plan) was then reviewed and documented, "...potential for decline in ADL's...participate in ADL care...encourage exercise and ambulation...may use stand to lift as needed for transfers...consult with restorative and therapy services as needed [05/24/18]..."

The resident's restorative records were reviewed and documented the resident had restorative one time since being discharged from OT on 07/27/18.

On 08/16/18 at approximately 8:40 a.m., the DON (director of nursing) was asked where staff document restorative nursing. The DON stated that they document in the computer. The DON

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asked who performs the restorative nursing. The DON stated that she wished she could have all the CNA's (certified nursing assistants) cross trained to do restorative, but as of right now she has three CNA's who complete all the restorative. The DON was asked for the names of the restorative aides. The DON was asked how often is restorative done. The DON stated that it is done 7 days a week.

On 08/16/18 at 02:00 PM, the DON presented a log of residents that are currently on restorative. Resident # 10 was on the list for a start date of 08/06/18 and to d/c (discontinue) on 11/06/18. It was documented, Resident # 10 is to receive restorative for 30 minutes (each day) for ROM (15 minutes on each part of the body-upper/lower for active/passive ROM (range of motion). The DON stated, "We have three CNA's that are doing the restorative, but only one is assigned each day." The DON was made aware that this resident is not getting restorative. The DON stated that, "we don't really have anyone overseeing this at this time", then stated..."well me and RN # 4" and stated that they (the facility) are trying to "revamp" and get it [restorative] back on track.

On 08/16/18 at 2:33 PM, RN (registered nurse) # 2 and CNA # 3 were interviewed regarding restorative nursing for Resident # 10. The CNA stated that she was the restorative aide for today. The CNA stated that she is just doing restorative today. RN # 2 stated that for Resident # 10, the restorative program picked her up on 8/6/18. The RN was asked why it was started on 8/6/18, when the resident was discharged from OT with the restorative recommendation on 07/27/18. The RN stated, "The 27th was a Friday." The RN was

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made aware that did not make sense, when the following Monday was July 30th and further didn't make sense, when the DON had stated that resident's get restorative seven days a week. The RN and the CNA presented restorative records on paper. According to the documentation the resident didn't start restorative until 8/8/18 (12 days later). It was documented that the resident refused on 08/08/18. The CNA was asked if the resident actually refused by saying that she did not want to participate. The CNA stated that she had worked that day and the resident was so sleepy that she did not participate.

The documentation was reviewed further and documented on 8/11/18 that the resident did not receive the restorative. CNA # 3 stated that it did not get done because she (CNA #3) got pulled to the floor to work, so she didn't get the restorative done and Resident # 10 did not have it that day. The resident was documented on 08/11/18 as not being done, because the CNA (#3) was pulled to unit 2 to work as a CNA, not a restorative aide. The resident was documented to receive restorative for 15 minutes on 08/13/18. Then on August 15, it was again documented that the resident did not get restorative and the CNA stated that was because she (CNA # 3) was on transport that day with another resident and wasn't able to get the restorative done and when she got back from transport she did not have time to complete the resident before the end of her shift.

The CNA was asked if she normally reports to anyone that the restorative wasn't completed. The CNA stated that she doesn't normally report it that day, but will report it the next day or during

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F 688	Continued From page 14 the weekly meeting that it didn't get done, and that she will report to the DON. No further information and/or documentation was presented prior to the exit conference on 08/16/18 at 4:00 p.m., to evidence that Resident # 10 was receiving restorative services and recommended by OT.	F 688		
F 758 SS=E	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive	F 758		9/30/18

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F 758	Continued From page 15 psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on clinical record review and staff interview, the facility failed to ensure residents were free from unnecessary medications for three of 20 residents in the survey sample. Residents #59, #25, and #74. 1. Resident #59 had an order for the antipsychotic medication, Seroquel that was ordered on 08/03/2018 without a documented clinical rationale. 2. The facility staff failed to ensure Resident # 25 was free of an unnecessary medication and failed to provide a specific diagnoses and documentation in the resident's clinical record. 3. The facility failed to ensure Resident # 74 was free of unnecessary medications, including	F 758	F758 The community will ensure residents are free from psychotropic drugs and PRN use based on a comprehensive assessment as evidenced by: 1. Residents #59, #25 & #74 were reviewed by the physician and given proper specific diagnosis for psychoactive and anti-Alzheimer's medication prior to the exit of the survey team. 2. All residents on psychotropic medication will be audited for proper diagnosis and behaviors to ensure compliance with state and federal regulations. This will be reviewed weekly	

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F 758	Continued From page 16 Exelon without a diagnosis and at a non-therapeutic level, Namenda without a diagnosis, and Trazodone without a diagnosis The findings included: 1. Resident #59 was originally admitted to the facility on 12/18/2017 and readmitted on 06/07/2018 with diagnoses including congestive heart failure, acute bronchitis, cirrhosis of liver, muscle weakness, chronic kidney disease (stage 3), diabetes type 2, recurrent depressive disorder vitamin d deficiency, hyperlipidemia, and dementia without behavioral disturbance. The minimum data set (MDS) dated 06/29/2018 assessed Resident #59 as cognitively intact. The clinical record was reviewed on 08/16/18 at 10 a.m. The following clinical note was observed: Dated 08/03/2018 at 13:25 (1:25 p.m.) "Resident lying in bed. Resident hallucinating about seeing people in room not there, specifically her husband. Stating she's not breathing, arms and feet shaking. Resident does have her O2 and O2 sat is 95% on 2L/min. Spoke with (Name), NP (Nurse Practitioner) Psych and received order for Seroquel 25 mg BID." RN #2 (registered nurse) was interviewed on 08/16/18 at 10:42 a.m., regarding the above note and order. She stated on 08/03/18 she called the Psych NP because Resident #59 was having hallucinations. She stated the Psych NP gave her a telephone order for the Seroquel with the diagnosis of Schizophrenia. RN #2 stated Resident #59 had a history of Schizophrenia and this was the reason for the diagnosis. A review of the clinical record did not reflect any	F 758	in the quality assurance meeting. 3. The geriatric nurse practitioner will only be permitted to assess residents and make recommendations to the physician. The physician will be responsible to review and make diagnosis and prescribe medicine. A best practice workflow will be developed. An in-service will be conducted for all nurses, physicians, nurse practitioner and pharmacist. Pharmacy reviews will be conducted monthly by the pharmacist for proper diagnosis, dosing, side effects and labs with recommendations to the physician. Residents on psychotropic drugs will have behavior care plans to include non-pharmacological interventions. 4. The geriatric nurse practitioner must make consult notes available within 72 hours of any visit.	

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documentation noting Resident #59 had a history of Schizophrenia prior to the start of the Seroquel on 08/03/2018.

On 08/16/18 at 11:07 a.m., LPN #2 (licensed practical nurse) who routinely provides care for Resident #59 was interviewed regarding Resident #59's behaviors. She stated she did not consider Resident #59 to have hallucinations rather more anxiety and wanting more help with her ADL (activities of daily living care). She stated recently Resident #59 has had more complaints of leg pain possibly related to therapy and she had been asking for more assistance with dressing, going to bathroom, etc.

On 08/16/18 at 2 p.m., CNA #1 (certified nursing assistant) who routinely provides care for Resident #59 was interviewed regarding Resident #59's behaviors. CNA #1 stated she has worked with Resident #59 for several months and she has not observed her having hallucinations.

The Nursing 2017 Drug Handbook on page 1232 describes Seroquel as an antipsychotic used for the treatment of schizophrenia, bipolar disorder, depression associated with bipolar disorder and as adjunctive therapy for major depressive disorder. Page 1234 of this reference states Seroquel has a, "Black Box Warning Drug isn't indicated for use in elderly patients with dementia-related psychosis because of increased risk of death from CV [cardiovascular] disease or infection." (1)

These findings were reviewed with the administrator and director of nursing during a meeting on 08/16/18 at approximately 2:45 p.m.

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No further information was received by the survey team prior to the exit conference on 08/16/18.

(1) Rader, Janet, Dorothy Terry and Leigh Ann Trujillo. Nursing 2017 Drug Handbook. Philadelphia: Wolters Kluwer, 2017.

2. Resident # 25 was admitted to the facility on 05/25/18. Diagnoses for Resident # 25 included, but were not limited to: COPD (chronic obstructive pulmonary disease), hypokalemia, hypothyroidism, restless leg syndrome, hypercalcemia, dementia with behavioral disturbance, personality disorder, mood disorder, and schizophrenia.

The most current full MDS (minimum data set) was a 14 day admission assessment dated, 06/01/18. This MDS assessed the resident with a cognitive score of 13, indicating the resident was cognitively intact for daily decision making skills. The resident was also assessed as requiring limited assistance with at least one person physical assistance for most all ADL's (activities of daily living). This MDS did not identify the resident as having a serious mental illness in section A1500. The resident triggered for ADL's (activities of daily living), falls, nutrition, pressure, and psych drug use in the CAAS (care area assessment section) of this MDS.

The resident's clinical record was reviewed. The physician's orders for Resident # 25 were reviewed from admission to present (08/16/18). The resident had an order for Seroquel 12.5 mg (milligrams) at bedtime; this medication was started one day after admission (05/26/18) for the diagnosis of "unspecified mood disorder."

All physician's progress notes were reviewed

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from admission to present (08/16/18) and documented the following:

A physician's progress note dated 05/30/18 at 11:46 a.m. documented: "...seen for admission evaluation from (name of neighboring nursing home) where she had been admitted after (initials of hospital) admission for confusion, possible sepsis and hyponatremia...pt (patient) is alert, conversant, a good historian and makes good eye contact. She is in no distress...reports nocturnal discomfort from RLS (restless leg syndrome) and neuropathy...reports history of paralyzed diaphragm status post remote axial load injury as a child...wearing O2 (oxygen)...LE (lower extremity) edema...labs...signature of PA (physician's assistant) # 1..."

This PA note did not document any information regarding the resident having dementia with behavioral disturbances, personality disorder, mood disorder, and/or schizophrenia and did not mention the resident was receiving or had received Seroquel currently and/or in the past.

The medication Seroquel was discontinued on 06/04/18. There was no physician documentation found in the resident's clinical record regarding the starting of and/or discontinuation of Seroquel for Resident # 25. It was documented in the nursing notes that the resident had refused this medication on several occasions in this nine day period.

The resident's behavioral log was reviewed for this time period and did not evidence the resident had any type of behaviors.

A physician's progress note dated 06/13/18 at

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10:56 a.m. documented: "...asks to stop Brovana (slow acting bronchodialator for COPD) due to hoarseness...she cannot stop Brovana due to severe lung DZ (disease)...Will check on reclast which she has previously used for osteoporosis...recheck tsh, T4, T3 for f/u...signature of MD (medical doctor # 1).

A nursing note dated 06/14/18 at 10:02 p.m.: "...resident complained about meds...stated that she had a med twice this shift...reeducated resident that she had all her meds for this shift. Resident wanted to argue...nurse and staff left the room...no sign/symptoms of distress...signature of nurse."

A nursing note dated 06/15/18 at 9:10 p.m.: "...resident complained to this nurse about her morning meds, stated that she had already taken meds prior...making it twice this shift...resident wanted to argue....after breakfast went back to check on resident, resident in good mood and when asked resident stated she only had meds one time today by this nurse...signature of nurse."

A nursing note dated 06/20/18 at 5:51 p.m.: "... (name of MD # 2) in today...aware resident continues to frequently refuse Bovana...no new orders...signature of nurse."

A nursing note dated 06/25/18 at 10:39 a.m.: "...resident refused Brovana X 3...states it makes her hoarse and she does not want it today....signature of nurse."

A nursing note dated 06/25/18 at 12:29 a.m.: "...resident refused to come to dining room X 3...also noted making repetitive anxious statements regarding her health...resident unable

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to be redirected at this time...signature of nurse."

A nursing note dated 0627/18 at 3:29 p.m.: "(name of PA # 1) in to see resident today for recert...no concerns noted...signature of nurse."

A physician's progress note dated 07/11/18 at 10:29 a.m. documented - "...Seen for c/o (complaints of) vertigo; also pain L (left) great toe...mild nystagmus...complains of vertigo when turning head or changing position...try meclizine...signature of MD # 1.

A nursing note dated 07/13/18 at 10:41 p.m.: "...refused shower this shift, stated she was too tired and requested on given Saturday if possible."

A physician's progress note dated 07/18/18 at 9:50 a.m. documented: "...Seen for concerns about decreased appetite. Started levothyroxine 112 mcg (micrograms) for TSH (thyroid stimulating hormone) 5.66 6/1/18. Recent c/o vertigo...states she does not have a loss of appetite, but can only eat small amounts at a time...love a fresh fruit snack daily...vertigo is better per pt report but overall strength is low... PT (physical therapy) for strengthening and conditioning...please give one fresh fruit snack daily...defer xolair (an injection for allergic Asthma and/or idiopathic hives) to (initials of MD # 1) on her next visit...signature of PA # 1.

A nursing note dated 07/21/18 at 8:26 p.m.: "...resident refused nebulizer this shift, stating it makes her throat sore. Education provided for benefits with use of nebulizer, but resident continues to refuse...signature of nurse."

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A nursing note dated 07/30/18 at 2:07 p.m.: "...she has become increasingly paranoid and often refuses to take her medication. Contacted (name of) NP (nurse practitioner) with psychiatry. Orders for Seroquel 12.5 mg BID (twice daily) for Bipolar disorder received. Faxed new orders to...pharmacy...signature of nurse."

A nursing note dated 07/30/18 at 8:09 p.m.: "MD responded to communication about placing resident on Seroquel 12.5 mg bid, stated to start qday (everyday) dose for paranoia...signature of nurse."

The resident's physician's orders were reviewed. An order dated 07/31/18 for Seroquel 12.5 mg every day at 5 pm was ordered for personality disorder.

A nursing note dated 08/10/18 at 8:25 a.m.: "Resident stated, "You are ruining my breakfast", as this nurse was giving her morning meds. Resident stated, "What is this? Reeducated her that they were her morning meds...signature of nurse."

A SW (social worker) note dated 08/10/18 at 11:04 a.m.: "...reported to social services department resident was upset had concerns that her family...was taking her money...I'm being kicked out...my bill has not been paid...people don't like me...I hear them talking about (last name of resident)...signature of SW."

A nursing note dated 08/12/18 at 5:16 p.m.: "...Resident stated "I know my daughter is dead and you all are trying to hide it from me...contact daughter and assured resident that her daughter was not dead...resident ate dinner without any

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issues, accepted medications with a lot of encouragement...calmer when not around a large group of people. Daughter to the facility around 1800 to spend time with resident...appeared to be in much better spirits when seeing daughter...signature of nurse."

A nursing note dated 08/13/18 at 10:36 a.m.: "...resident took all meds without problems this shift...no change in behaviors...signature of nurse."

A nursing note dated 08/14/18 at 1:06 p.m.: "NP saw resident today and recommended to D/C (discontinue) Seroquel 12.5 mg Q (every) 5 pm, Start Seroquel 25 mg QAM, 25 mg Q5pm, and 25 mg Qhs (bedtime)- delusional disorder...signature of nurse."

A physician's note (MD # 2) dated 08/15/18 at 12:21 p.m.: "delusional thinking, meds being adjusted by psych and is improved...alert not oriented and is confused...thyroid labs reviewed and will repeat now that dose is changed...signature of MD # 2."

The resident's physician's orders were reviewed and documented an order dated 08/16/18 for Seroquel 12.5 mg every morning for Schizophrenia and an order for Seroquel 12.5 mg every evening for Schizophrenia.

The resident's behavioral log was reviewed 07/18/18 through present (08/16/18) and did not document any behaviors all. The above documentation was the only documentation of the resident's behavior.

The resident's CCP (comprehensive care plan)

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was reviewed and documented, "...Start date: 06/07/18...Psychotropic drug use...resident will be free from signs of drug related side effects...administer medications per MD order...attempt gradual dose reduction [if not contraindicated]...attempt non pharmacological interventions such as distraction and redirection as indicated...Keep MD informed of increase in symptoms or any possible side effects...Labs per MD...observe for and report over sedation, falls and new onset of tremors...Observe mood/behaviors and assess response to medication...MRR (medication regimen review) monthly and as needed..."

On 08/15/18 at 3:39 PM, the survey team met for an end of day meeting with the administrator and director of nursing (DON). The DON and administrator were made aware of concerns regarding Resident # 25. The administrator and DON were made aware that Resident # 25 was admitted to this facility on 05/25/18 and had been at the facility less than three months and already had 5 diagnoses related to mental health/illness that were not evident prior to admission. The DON and administrator were made aware that it was documented throughout the resident's clinical record that the resident had the following diagnoses, "dementia with behavioral disturbance, personality disorder, mood disorder, schizophrenia, bipolar disorder and delusional disorder." The administrator and DON were made aware of concerns that the resident was prescribed an antipsychotic medication, the day after admission, with no documentation of any type of behaviors and was documented as having a cognitive score of 13, and was assessed by the PA as having no distress. The DON and administrator were made aware of that after

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admission the resident's status appeared to decline according to the progress notes. The DON and administrator were made aware that the resident was given the medication without a specific diagnosis, without the implementation of specific nonpharmacological interventions, without specific documentation from the physician to support the clinical justification for starting the resident on Seroquel. The DON and administrator were made aware of concerns regarding this resident being started on Seroquel on 07/31/18 and was not physically assessed/examined by a physician, NP or PA until 08/14/18 (two weeks later).

The DON agreed with the above information and stated that she did not know why Resident # 25 was given multiple diagnoses for one medication, or why the medication was started initially because the resident was documented as stable and additionally agree that there did not appear to be any documentation from the physician and/or NP regarding the rationale for the above, but would look for documentation to provide clinical justification for the use of the medication and/or diagnoses.

On 08/16/18 at 10:42 AM, RN (registered nurse) # 2 was interviewed and stated that she (RN # 2) makes rounds with the NP (psych) and that the diagnoses for schizophrenia was put in (the computer), in error for Resident # 25. The RN stated, "This resident does not have schizophrenia, she actually has delusional disorder." The RN was asked where the documentation was for this diagnosis and was made aware that there was no assessment information or physician documentation to evidence that the resident has a specific

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diagnosis for the use of Seroquel. The RN was made aware that the resident also has a diagnoses for personality disorder, mood disorder, bipolar disorder and delusional disorder and all of these were added since the resident was admitted to the facility and all are for the same medication. The RN was asked to provide assistance in locating any physician/NP/PA documentation to provide evidence and clinical justification for the use of Seroquel, based upon an assessment of the resident's condition and therapeutic goals and consistent with manufacturer's recommendations and/or clinical practice guidelines and clinical standards of practice.

On 08/16/18 at 02:19 PM, RN # 2 stated that the resident was given this diagnoses by accident (schizophrenia), but did not provide any information regarding the other diagnoses and stated that the NP would document why the resident was on the medication. The RN was asked why the NP had not written in the resident's chart regarding all of the above. The RN stated that she did not know, but the NP was supposed to be faxing a progress note today for Resident # 25.

At approximately 3:40 p.m., the RN presented a faxed progress note for Resident # 25 by the NP. The progress note documented, "....family history...unobtainable from any source...patient is unable to provide the information, family is not available, and prior charts do not include family history. Nursing staff unable to provide...past psychiatric admission: information unknown...past psychiatric outpatient treatment: Information unknown...Past use of Psychotropic medications: Information unknown...Family

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psychiatric history: Information unknown...DOS (date of service) 08/14/18 initial evaluation...stabilization of paranoid delusions, and hallucinations, depression, and disorganized thinking...84 year old female...mood disorder...she is being seen for assessment of psychotropic medication as described below and per nursing staff request..."

The administrator and DON were again made aware of the serious concerns regarding the NP prescribing an antipsychotic medication without a specific diagnosis and the fact that the resident gained additional psychiatric diagnoses without any substantiating evidence. The medication was prescribed prior to the resident even being seen by the NP and or physician. The DON and administrator were asked how do you give a resident all of these diagnoses without the appropriate documentation and/or monitoring to ensure the diagnoses is accurate. The DON agreed and stated that she did not understand it. The DON and administrator were made aware that there was a lack of assessment information, lack of documentation, lack of nonpharmacological interventions, lack of consistent monitoring and communication from the resident's physicians.

No further information and/or documentation was presented prior to the exit conference on 08/16/18 at 4:00 p.m. to evidence that that this resident was assessed and provided a specific, and accurate diagnoses prior to the use of an antipsychotic medication.

3. Resident # 74 in the survey sample, was admitted to the facility on 1/14/16, and most recently readmitted on 12/1/17 with diagnoses that included unspecified dementia with

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behavioral disturbance, gastroesophageal reflux disease, chronic obstructive pulmonary disease, diabetes mellitus, hypertension, Vitamin-D deficiency, chronic kidney disease, benign prostate hyperplasia, hyperlipidemia, mood disorder due to known physiological condition (unspecified), and major depressive disorder (single episode, unspecified). According to the most recent Minimum Data Set (MDS), a Quarterly with an Assessment Reference Date (ARD) of 7/13/18, the resident was assessed under Section C (Cognitive Patterns) as being severely cognitively impaired, with a Summary Score of 3 out of 15.

Review of the Electronic Medication Administration Record (EMAR), contained in the resident's Electronic Health Record (EHR) revealed the following were included on the EMAR list of diagnoses; unspecified dementia with behavioral disturbance, mood disorder due to known physiological condition (unspecified), and major depressive disorder (single episode, unspecified).

The EMAR for the month of August 2018 included the following medication, ordered on 12/1/17: Exelon capsule, 1.5 mg. (milligram), 1 by mouth two times a day. The reason for the Exelon was listed on the EMAR as "Unspecified dementia with behavioral disturbance."

(Exelon is classed as an Anti-Alzheimer's agent and is used for mild to severe Alzheimer's dementia, and mild to moderate Parkinson's dementia. Unlabeled uses include vascular dementia, dementia with Lewy bodies, and Pick's disease. Ref. Mosby's 2017 Nursing Drug Reference, 30th Edition, page 1048.)

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On 7/31/18, the consulting pharmacist forwarded a "Note To Attending Physician/Prescriber" that noted the following: "This 83 y/o (year-old) resident is receiving Exelon 1.5 mg BID (two times a day)....Therapeutic dose of the Exelon capsules is 6 mg/day given in divided doses, 3 mg BID. Review of progress notes and face sheet does not show a diagnosis of Alzheimer's Disease...Please assess effectiveness and benefits of Exelon. If this medication remains necessary, please document benefits versus risks."

The response to the pharmacist's recommendation was, "Pt (patient) has benefit from Exelon, improvement in cognitive functioning, will document." The response, dated 8/3/18, was signed by the Psychiatric Nurse Practitioner.

Further review of the diagnoses listed on the Face Sheet of the EHR, the diagnoses listed under Section I (Active Diagnoses) of the 7/13/18 Quarterly MDS, and the diagnoses listed on the EMAR, failed to find Alzheimer's Disease listed as a diagnosis for Resident # 74.

The Progress (Nurses) Notes in the resident's EHR included the following entry:

8/7/18 - 3:21 p.m. "Pharmacy recommendation to assess Exelon. (Name of Psychiatric Nurse Practitioner) agreed resident does need it, improvement in cognitive functioning. MD to review tomorrow."

A thorough review of the resident's EHR failed to reveal any documentation that the MD had

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reviewed the Nurse's Note or the pharmacy recommendation.

Review of the three most recent MDS assessments following the resident's readmission on 12/1/17, revealed the following regarding his cognitive status and his "...improvement in cognitive functioning..." as noted by the Psychiatric Nurse Practitioner in her response to the pharmacy recommendation.

Quarterly MDS with an ARD of 2/2/18 - the resident was assessed under Section C (Cognitive Patterns) as being severely cognitively impaired, with a Summary Score of 2 out of 15.

Annual MDS with an ARD of 4/27/18 - the resident was assessed under Section C (Cognitive Patterns) as being severely cognitively impaired, with a Summary Score of 2 out of 15.

Quarterly MDS with an ARD of 7/13/18 - the resident was assessed under Section C (Cognitive Patterns) as being severely cognitively impaired, with a Summary Score of 3 out of 15.

Also included on Resident # 74's EMAR for August 2018 was the following medication, ordered on 12/1/17: Namenda XR (extended release) capsule, 21 mg., 1 by mouth once a day. The reason for the Namenda was listed on the EMAR as "Unspecified dementia with behavioral disturbance."

(Namenda is classed as an Anti-Alzheimer's agent and is used for moderate to severe dementia in Alzheimer's disease. Unlabeled uses include vascular dementia, and acquired pendular nystagmus. Ref. Mosby's 2017 Nursing Drug

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F 758	Continued From page 31 Reference, 30th Edition, page 748.) As noted with the use of Exelon, Resident # 74 did not have a diagnosis of Alzheimer's disease. Resident # 74's EMAR for August 2018 also included the following medication, ordered on 12/1/17: Trazodone tablet, 100 mg. 1 by mouth at bed time. The reason listed for the use of Trazodone on the EMAR was, "Mood disorder due to known physiological condition, unspecified." (Trazodone is classed as an Antidepressant and is used to treat depression. Unlabeled uses include alcoholism, anxiety, panic disorder, insomnia. Ref. Mosby's 2017 Nursing Drug Reference, 30th Edition, page 1189.) The Trazodone order did not list depression as the reason for its use, and the resident did not have diagnoses of alcoholism, anxiety, panic disorder, or insomnia. The resident's drug regimen, and specifically the use of Exelon without an diagnosis and at a non-therapeutic level was discussed during a meeting at 3:00 p.m. on 8/16/18 that included the Administrator, Director of Nursing, and the survey team.	F 758		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the	F 880		9/30/18

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development and transmission of communicable diseases and infections.

§483.80(a) Infection prevention and control program.
The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:

§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.

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F 880	Continued From page 33 (v) The circumstances under which 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; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: The facility staff failed to ensure proper infection control practices during a medication pass an pour observation on one of three units, Unit 1 (Parkview). LPN # 2 dropped a medication on the top of the medication cart twice and handled the medication with her bare hand twice. Findings include: During a medication pass and pour observation on 08/15/18 at 8:35 a.m., LPN # 2 was preparing medications to be administered. LPN # 2 removed a medication card for the medication Coreg 6.25 mg (milligrams). The LPN attempted to pop one pill through the bubble pack into the	F 880	F0880 The community will establish and maintain an infection control program to ensure a safe, sanitary environment to prevent development and transmission of communicable diseases and infections as evidenced by: 1. The nurse LPN#2 was given an immediate inservice and medication pass audit competency prior to the exit of the survey team. 2. All nurses will be involved in an in-service in medication policy and proper infection control practices.	

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F 880	Continued From page 34 plastic dispensing cup, but missed the cup and the pill fell on top of the medication cart. The top of medication cart was observed with small particles of debris and contained multiple items, such as the medication book, ink pens, medication cards, and various medication administration supplies. The LPN picked the pill up off of the medication cart with her bare hand and attempted to place the pill into the plastic medication cup, but dropped the pill again on top of the medication cart. The LPN again, picked up the pill with her bare hand and successfully put the pill into the plastic dispensing cup. The LPN then administered the medications. At approximately 08/15/18 08:44 AM LPN # 2 was interviewed regarding the medication observation and was asked if that was normal practice to pick up a pill that had been dropped and administer the medication. The LPN stated, "The educator said as long as it's on top of the cart it's ok to pick up, as long as it isn't on the floor." On 08/15/18 at 3:45 PM, the DON (director of nursing) and RN (registered nurse) # 4, also known as the educator were made aware of the above information in a meeting with the survey team. RN # 4 stated that if the top of medication cart is clean, I think it would be ok to pick up the pill, but it is never ok to touch a pill with bare hands. The DON stated that the expectation is to never pick up a pill if it has been dropped. A policy was requested at that time. On 08/16/18 at approximately 8:30 a.m. a policy was presented and reviewed. The policy documented, "...hands are washed with soap and water or alcohol gel [and examination gloves	F 880	3. Every nurse will be monitored by a quarterly medication pass audit to insure ongoing competency. 4. Medication pass audit reports will be reported weekly in the quality assurance meeting.	

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F 880	Continued From page 35 worn] prior to handling tablets and examination gloves must worn to prevent touching of tablets...pour or push the correct number of tablets or capsules into the souffle' cup, taking care to avoid touching the tablet or capsule, unless wearing gloves..." No further information and/or documentation was provided prior to the exit conference on 08/16/18 at 4:00 p.m.	F 880		