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| CONSULATE HEALTHCARE OF WILLIAMSBURG | 1811 JAMESTOWN ROAD WILLIAMSBURG, VA 23185 |

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| E 000 | Initial Comments<br><br>An unannounced Emergency Preparedness survey was conducted 8/28/18 through 8/30/18. The facility was in substantial compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities. No emergency preparedness complaints were investigated during the survey. | E 000 | | |
| F 000 | INITIAL COMMENTS<br><br>An unannounced Medicare/Medicaid standard survey was conducted 8/28/18 through 8/30/18. Significant corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. Five complaints were investigated during the survey.<br><br>The census in this 90 certified bed facility was 83 at the time of the survey. The survey sample consisted of 28 current Resident reviews and 3 closed record reviews. | F 000 | | |
| F 645 SS=D | PASARR Screening for MD & ID<br>CFR(s): 483.20(k)(1)-(3)<br><br>§483.20(k) Preadmission Screening for individuals with a mental disorder and individuals with intellectual disability.<br><br>§483.20(k)(1) A nursing facility must not admit, on or after January 1, 1989, any new residents with: (i) Mental disorder as defined in paragraph (k)(3)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission, (A) That, because of the physical and mental condition of the individual, the individual requires | F 645 | 1. Resident # 62 and # 63's PASRR's have been completed and filed in medical record.<br><br>2. Admission Coordinator/Social Services conducted Quality Review of current residents to ensure the PASARR is present for each resident, new admissions and readmissions. Follow up based on findings. | |

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

M Hope | Executive Director | 9/20/18

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

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| F 645 | Continued From page 1<br>the level of services provided by a nursing facility; and<br>(B) If the individual requires such level of services, whether the individual requires specialized services; or<br>(ii) Intellectual disability, as defined in paragraph (k)(3)(ii) of this section, unless the State intellectual disability or developmental disability authority has determined prior to admission-<br>(A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and<br>(B) If the individual requires such level of services, whether the individual requires specialized services for intellectual disability.<br><br>§483.20(k)(2) Exceptions. For purposes of this section-<br>(i)The preadmission screening program under paragraph(k)(1) of this section need not provide for determinations in the case of the readmission to a nursing facility of an individual who, after being admitted to the nursing facility, was transferred for care in a hospital.<br>(ii) The State may choose not to apply the preadmission screening program under paragraph (k)(1) of this section to the admission to a nursing facility of an individual-<br>(A) Who is admitted to the facility directly from a hospital after receiving acute inpatient care at the hospital,<br>(B) Who requires nursing facility services for the condition for which the individual received care in the hospital, and<br>(C) Whose attending physician has certified, before admission to the facility that the individual is likely to require less than 30 days of nursing | F 645 | 3. Executive Director provided re-education for Admissions/Social Services on ensuring residents have PASARR on admission/ readmission and they meet the requirement.<br><br>4. Admissions Director/Social Services Director to conduct Quality Improvement Monitoring of PASARRs 5 x/ week x 8 weeks , weekly x 4 weeks, then monthly and as needed thereafter. Findings to be reviewed at monthly QAPI Committee monthly. Quality Monitoring schedule modified based on findings.<br><br>5. Allegation of Compliance: October 2, 2018 | |

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| F 645 | Continued From page 2<br>facility services.<br><br>§483.20(k)(3) Definition. For purposes of this section-<br>(i) An individual is considered to have a mental disorder if the individual has a serious mental disorder defined in 483.102(b)(1).<br>(ii) An individual is considered to have an intellectual disability if the individual has an intellectual disability as defined in §483.102(b)(3) or is a person with a related condition as described in 435.1010 of this chapter.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review and staff interview, the facility failed to ensure that the required Preadmission Screening and Resident Review(PASRR) Level I assessment was completed for 2 of 31 residents surveyed (#62, #63).<br><br>Findings include:<br><br>Resident #62 was admitted to the facility on 2/22/2017. She was discharged to the hospital on 7/27/2018, and readmitted to the facility on 8/2/2018. Her most recent comprehensive Minimum Data Set (MDS) assessment was completed 8/9/2018. Diagnoses include: vascular dementia with behavioral disturbance, bipolar disorder, cerebral infarct with hemiplegia, and diabetes. Her MDS shows a Brief Interview for Mental Status (BIMS) score of 13, showing intact cognition.<br><br>Resident #63 was admitted to the facility on 7/25/2018. On 8/1/2018 a comprehensive MDS was completed, which showed diagnoses: cerebral infarct with hemiplegia and aphasia, | F 645 | | |

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| F 645 | Continued From page 3 | F 645 | | |

dysphasia, dementia, and depression. Due to her inability to communicate, a BIMS was not completed; the provider did a staff assessment of cognition which showed severely impaired cognitive ability.

A review of the medical record showed no PASRR Level I assessment for either resident.

On 8/29/2018 at 9:30AM, a copy of these PASRRs was requested. At 2:24PM on 8/29/2018, Administration Employee C (the corporate RN consultant) stated that these two residents had come from other nursing facilities, and did not have Level I screens completed. She stated "these should have been done."

Per Medicaid.gov (located at: https://www.medicaid.gov/medicaid/ltss/institutional/pasrr/index.html)
Preadmission Screening and Resident Review (PASRR) is a federal requirement to help ensure that individuals are not inappropriately placed in nursing homes for long term care. PASRR requires that Medicaid-certified nursing facilities:
1. Evaluate all applicants for serious mental illness (SMI) and/or intellectual disability (ID)
2. Offered(sic) all applicants the most appropriate setting for their needs (in the community, a nursing facility, or acute care settings)
3. Provide all applicants the services they need in those settings
... In brief, the PASRR process requires that all applicants to Medicaid-certified nursing facilities be given a preliminary assessment to determine whether they might have SMI or ID. This is called a "Level I screen." Those individuals who test positive at Level I are then evaluated in depth,

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| F 645 | Continued From page 4<br>called "Level II" PASRR. The results of this evaluation result in a determination of need, determination of appropriate setting, and a set of recommendations for services to inform the individual's plan of care.<br><br>No further information was provided prior to exit. | F 645 | | |
| F 686 SS=G | Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii)<br><br>§483.25(b) Skin Integrity<br>§483.25(b)(1) Pressure ulcers.<br>Based on the comprehensive assessment of a resident, the facility must ensure that-<br>(i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and<br>(ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, staff interview, clinical record review and facility documentation review the facility staff failed for 1 resident (Resident #70) of 31 residents in the survey sample to identify a right heel wound prior to the development of necrotic tissue resulting in harm.<br><br>Resident #70's right heel wound was first identified on 7/18/18 and was described as "center of heel (right) necrotic 0.5 x 0.8."<br><br>The findings included: | F 686 | 1. Root Cause Analysis completed. Ad Hoc QAPI Committee Meeting conducted. Performance Improvement Plan implemented. Resident #70 reassessed by Director of Nursing and assigned Physician/Practitioner for interventions appropriate to current condition. Plan of care updated as indicated. | |

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| F 686 | Continued From page 5<br><br>Resident #70, an 88 year old, was admitted to the facility on 10/3/17. Diagnoses include Alzheimer's disease, major depression, anxiety, dementia, psychosis, hypertension, and congestive heart failure.<br><br>The most recent Minimum Data Set assessment was a significant change assessment with an assessment reference date of 8/13/18. Resident #70 was coded with a Brief Interview of Mental Status score of 2 indicating severe cognitive impairment and required extensive assistance with activities of daily living.<br><br>On 8/28/18 at 12:05 p.m., Resident #70 was observed seated at a table in the common area waiting for her lunch tray to be delivered.<br><br>The most current Braden scale was dated 1/13/18 and signed by the nurse on 2/9/18. Resident #70 scored a 17 which indicated she was "At Risk" for developing a pressure wound.<br><br>Resident #70's wound documentation was reviewed. Wound tracking documents were completed as electronic forms. A wound to the right heel was documented in the wound tracking. Tracking was documented as follows:<br><br>7/18/18- Weekly Skin Integrity Review form: Skin intact- no. Skin impairment described as "right heel red non-blanchable 8 x 1.5 x 0" and "center of heel (right) necrotic 0.5 x 0.8." The wound descriptions were typed into a text box on the form. The form was completed by the former Assistant Director of Nursing/ Registered Nurse.<br><br>7/18/18- Pressure Ulcer Wound Rounds form: | F 686 | 2. Director of Nursing/Designee completed a Quality Review of current facility resident's skin care evaluation/monitoring ensuring reflective of resident's current condition. Director of Nursing/Designee completed a Quality Review of current resident skin care regimen for effectiveness. Regional Director of Clinical Services/Designee validated results of Quality Review. Follow up based on findings.<br>3. Director of Nursing/Designee provided re-education for Licensed Nurses regarding stand skin/wound prevention treatment practices. | |

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| F 686 | Continued From page 6<br>Site- Right heel, Type- Pressure, Measurements-8 x 1.5 x 0, Stage- Suspected Deep Tissue Injury, Wound bed tissue- eschar, Wound bed color- black, Wound edges- Firm/ No Redness, Drainage- none. The wound descriptions were selected from a pre-populated menu on the form. The form was completed by the former Assistant Director of Nursing/ Registered Nurse.<br><br>Prior to 7/18/18, the most recent Weekly Skin Integrity Review form was dated 5/11/18. The 5/11/18 assessment documented that Resident #70 had a skin tear. Weekly skin checks were not performed during the two months between 5/11/18 and 7/18/18.<br><br>7/27/18- Pressure Ulcer Wound Rounds form: Site- Right heel, Type- Pressure, Measurements-1.2 x 1.6, Stage- Suspected Deep Tissue Injury, Wound bed tissue- eschar, Wound bed color- black, Wound edges- Firm/ No Redness, Drainage- none. This form was not signed.<br><br>7/27/18- Nursing note: IDT (interdisciplinary team) wound meeting held resident continues to have area to right heel tx (treatment) to be done as ordered, heels floated as resident allow while in bed, prostat ordered to aid in skin integrity will continue to monitor.<br><br>8/4/18- Pressure Ulcer Wound Rounds form: Site- Right heel, Type- Other, DTI, Measurements-1.2 x 3.0, Stage- Unstageable, Wound bed tissue- eschar, Wound bed color- black, Wound edges- Firm/ No Redness, Drainage- none. Signed by Licensed Practical Nurse C (LPN C), Unit Manager. | F 686 | 4. Director of Nursing/Designee to complete Quality Improvement Monitoring of skin/wound identification/treatment completed per standard 5x/week x 4 weeks, weekly x 4 weeks then monthly and as needed. Regional Director of Clinical Services/Designee to validate Quality Improvement findings monthly x 2 and as needed. Findings to be reviewed at monthly QAPI Committee Meeting. Monitoring schedule modified based on findings.<br>5. Allegation of Compliance: October 2, 2018 | |

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| F 686 | Continued From page 7<br><br>8/10/18- Pressure Ulcer Wound Rounds form: Site- Right heel, Type- Pressure, Measurements-1.4 x 1.4 x 0.1, Stage- II, Wound bed tissue- granulation, Wound bed color- pink, Wound edges- Firm/ No Redness, Drainage- none. Signed by the Unit Manager, LPN C.<br><br>8/15/18- Pressure Ulcer Wound Rounds form: Site- Right heel, Type- Pressure, Measurements-1.6 x 1.4, Stage- II, Wound bed tissue- granulation, Wound bed color- pink, Wound edges- Firm/ No Redness, Drainage- none. Signed by the Unit Manager, LPN C.<br><br>8/24/18- Pressure Ulcer Wound Rounds form: Site- Right heel, Type- Pressure, Measurements-2.0 x 1.0, Stage- II, Wound bed tissue- granulation, Wound bed color- red, Wound edges- Firm/ No Redness, Drainage- none. Signed by the Unit Manager, LPN C.<br><br>8/30/18- Pressure Ulcer Wound Rounds form: Site- Right heel, Type- Pressure, Measurements-1.0 x 1.0, Stage- Unstageable, Wound bed tissue- slough, Wound bed color- yellow, Wound edges- Firm/ No Redness, Drainage- small. Signed by the Unit Manager, LPN C.<br><br>The following treatment orders were documented in the clinical record:<br>11/4/17- Skin Prep Wipes, Apply to heels topically every day and evening shift for prevention<br>7/27/18- Skin Prep Right heel every shift for DTI. Discontinued 8/28/18<br>7/28/18- Prostat 30 milliliters twice a day for 30 days for wound healing | F 686 | | |

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| F 686 | Continued From page 8<br>8/8/18- MedPass 60 milliliters twice a day for 30 days<br>8/29/18- Cleanse right heel with normal saline pat dry and apply hydrogel and dry dressing every day<br>8/30/18- Santyl ointment apply to right heel<br><br>The following preventative measures were documented in the clinical record:<br>9/15/17- Turn and reposition every frequently (sic) and as needed<br>10/3/17- Float heels when in bed<br>10/6/17- Medpass 60 milliliter two times per day<br>10/6/17- Weekly skin checks<br><br>Activities of Daily Living (ADL) care plan dated 10/4/17 read, "has an actual ADL Self Care Performance Deficit d/t (due to) Dementia AEB (as evidenced by) unable to bathe, dress, groom, ambulate, propel self, move in bed, toilet, transfer without assistance." Interventions dated 10/4/17 included "ADL- Observe skin for redness, open areas, scratches, cuts, bruises and report to charge nurse" and "Bathing: Provide the resident with assistance to bathe daily and PRN (as needed)."<br><br>The Activities of Daily Living (ADL) tracking completed by the Certified Nursing Assistants (CNA) was reviewed for the month of July 2018. In the days prior to the identification of the right heel wound, it was documented that Resident #70 was bathed on the following occasions:<br>7/17/18, 3-11 shift: shower with total dependence on staff, 1 person physical assist.<br>7/17/18, 7-3 shift: bed bath with total dependence on staff<br>7/16/18, 7-3 shift: partial bed bath with total dependence on staff | F 686 | | |

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| F 686 | Continued From page 9<br>7/15/18, 3-11 shift: partial bed bath with total dependence on staff<br>7/13/18, 3-11 shift: bed bath with total dependence on staff<br>7/13/18, 7-3 shift: bed bath with total dependence on staff<br>7/12/18, 7-3 shift: bed bath with total dependence on staff<br><br>The CNA ADL tracking for dressing was also reviewed and documented as follows:<br>7/17/18, 3-11 shift: dressing with extensive assistance, 1 person physical assist.<br>7/17/18, 7-3 shift: dressing with total dependence on staff, 1 person physical assist.<br>7/16/18, 7-3 shift: dressing with total dependence on staff, 1 person physical assist.<br>7/15/18, 3-11 shift: dressing with extensive assistance, 1 person physical assist.<br>7/13/18, 3-11 shift: dressing with total dependence on staff, 1 person physical assist.<br>7/13/18, 7-3 shift: dressing with total dependence on staff, 1 person physical assist.<br>7/12/18, 7-3 shift: dressing with total dependence on staff, 1 person physical assist.<br><br>In the week prior to the identification of the necrotic heel wound, it was documented that staff provided assistance with dressing and bathing on 14 occasions. Bathing and dressing are opportunities for staff to monitor for and report any new skin impairment noted during care.<br><br>Resident #70's impaired skin integrity care plan dated 10/4/17 was reviewed. The "Focus" included "Pressure ulcer right heel- under TX (treatment)." Interventions included administer supplements and treatments as ordered (10/4/17), assess/ record/ monitor wound healing | F 686 | | |

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| F 686 | Continued From page 10<br>weekly (8/10/18), Assist with turning and repositioning (10/4/17), Braden scale quarterly (10/4/17), Encourage nutrition/ hydration (10/4/17), float heels (10/4/17), monitor for and report any new skin impairment noted during care (10/4/17).<br><br>On 8/29/18 at 9:08 a.m. the survey team observed Resident #70's wound care provided by Licensed Practical Nurse H (LPN H). Upon entrance to the room, Resident #70 was lying in bed. The heels up cushion was on top of a regular pillow. Resident #70's heels were not touching the mattress. She was not wearing socks. LPN H removed the dressing and performed the wound care per physician order. Issues with hand hygiene and infection control were observed. The heel wound was observed to be approximately the size of a dime, pink in color with a thin, white center approximately 1 cm x .3 cm in size. Minimal drainage was noted in the wound. The peri-wound appeared pink. The wound edges were intact. LPN H stated the wound appeared to be healing. She stated it looked better than it did the week before.<br><br>On 8/30/18 at 10:30 a.m., the Administrator, Director of Nursing (DON) and Corporate Nurse were notified of the concern with the stage for which Resident #70's heel wound was first identified. It was reviewed that the wound was first identified with necrosis and eschar. The DON and Corporate Nurse stated that there was an issue with the Pressure Ulcer Wound Rounds form. They stated that due to a lack of wound description choices on the form, staff often chose the descriptors of black and eschar to describe a deep tissue injury because there was no appropriate choice. It was reviewed with the | F 686 | | |

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| F 686 | Continued From page 11<br>facility staff that the other form, the Weekly Skin Integrity Review form, included a text box where the nurse could free type in a description. The Registered Nurse who completed the Weekly Skin Integrity Review form for Resident #70 typed in the word "necrotic." She also choose the words eschar and black on the Pressure Ulcer Wound Rounds form. It was reviewed that the wound descriptions on both forms were the same.<br><br>The DON was asked to identify the stage of a wound that would have necrotic tissue. She referred to the facility document titled "Wound Classification Guide" and stated a wound with necrosis would be unstageable. The guide referenced the National Pressure Ulcer Advisory Panel (NPUAP) definition for Unstageable Pressure Injury, see below.<br><br>Guidance on pressure wound staging provided by the NPUAP website located at http://www.npuap.org/resources/educational-and-clinical-resources/npuap-pressure-injury-stages/ was accessed on 9/5/18 at 11:19 a.m..<br>"Unstageable Pressure Injury: Obscured full-thickness skin and tissue loss<br>Full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because it is obscured by slough or eschar. If slough or eschar is removed, a Stage 3 or Stage 4 pressure injury will be revealed. Stable eschar (i.e. dry, adherent, intact without erythema or fluctuance) on the heel or ischemic limb should not be softened or removed."<br><br>During the interview, it was also reviewed with the facility staff that no weekly skin checks had been performed for two months between 5/11/18 and | F 686 | | |

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| F 686 | Continued From page 12<br>7/18/18.<br><br>The DON was asked to explain the facility's process for monitoring skin. She stated that the weekly skin check was supposed to be completed on the Weekly Skin Integrity Review form by the nurse. The floor nurses were assigned to specific residents. If a Licensed Practical Nurse (LPN ) identified a skin issue during the weekly skin check, the LPN was supposed to report to the Registered Nurse (RN) so the RN could stage the wound. The RN would also put a treatment in place according to the facility document "Skin and Wound Care Guidelines" and the doctor. The DON stated that the facility did not use a wound care doctor. The floor nurses completed wound care treatment. The DON stated that wounds were measured weekly.<br><br>The facility staff were asked to submit any documentation they wanted to be reviewed by the survey team related to Resident #70's right heel wound.<br><br>On 8/30/18 at 3:20 p.m., the DON and Corporate Nurse stated that they had identified prior to the survey that weekly skin checks were not being done timely and wound dressings were not consistently being completed. When asked why the weekly skin checks were not being completed, the DON stated that there were a lot of new staff in the building and there were issues with the case load per nurse. They stated that they completed a 100% skin sweep on 8/24/18-8/27/18. | F 686 | | |
| F 698 SS=D | Dialysis<br>CFR(s): 483.25(l) | F 698 | | |

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| F 698 | Continued From page 13<br><br>§483.25(l) Dialysis.<br>The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview and clinical record review the facility failed to provide dialysis services consistent with professional standards for 1 Resident (Resident #18) in a survey sample of 32 Residents.<br><br>For Resident # 18 the facility failed to assess vital signs and weights before and after dialysis as care planned and ordered by physician.<br><br>The findings included;<br><br>Resident # 18 a 66 year old female with diagnoses including but not limited to End Stage Renal Disease (ESRD), dependant on dialysis, Muscle Weakness, expressive language disorder, Aphasia, Major depressive disorder, and seizures.<br><br>On 8/29/2018 a clinical record review was conducted and was found that Resident #18 a dialysis resident attended dialysis on Tuesday and Saturday. According to the (MAR) Medication Administration Record, the Resident had an order for "Dry Weights" [Weights obtained after dialysis has been performed] on Tuesdays and Saturdays.<br><br>According to the MAR these Dry Weights were not obtained on the following dates in July and | F 698 | 1. Resident #18 receives dialysis services consistent with professional standards; i.e. pre/post dialysis weights and VS obtained as indicated by physician's order and care plan.<br>2. Director of Nursing/Designee to conduct Quality Review of current facility residents receiving dialysis services consistent with professional standards; i.e. pre/post dialysis weights and VS obtained as indicated by physician's order and care plan consistent with professional standards. Follow up based on findings. | |

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| F 698 | Continued From page 14<br>August 2018:<br><br>07/13/2018<br>07/24/2018<br>07/28/2018<br>07/31/2018<br>08/28/2018<br><br>According to the MAR the Resident had an order for Vital Signs before and after dialysis to assess Residents condition. According to the MAR the vital signs were not obtained on the following dates:<br><br>07/07/2018- Prior to dialysis<br>07/17/2018 - Post dialysis<br>07/21/2018 - Prior to dialysis<br>08/25/2018 - Prior to dialysis<br>08/28/2018 - Post dialysis<br><br>A review of medical records was conducted and no further information was found on dry weights and vital signs for Resident #18.<br><br>An interview with LPN D was conducted on 08/30/2018 at 3:15 PM and she stated when a patient comes back from dialysis we check their vital signs, check their weight, and do a skin assessment then we listen for Bruit [sound of blood going through the shunt site] and feel for Thrill [feel blood going through the shunt site]. LPN D correctly demonstrated Bruit and Thrill examination.<br><br>On 8/30/2018 at 10:30 AM an interview with LPN E was conducted and she stated that the risks of not completing these assessments, of the dialysis Residents, is that we would not know if the Resident was having issues with blood pressure | F 698 | 3. Director of Nursing/Designee provided re-education for Licensed Nurses regarding dialysis services consistent with professional standards; i.e. obtaining pre/post dialysis weights and VS per physician's order and care plan.<br>4. Director of Nursing/Designee to complete Quality Improvement Monitoring to ensure dialysis services provided consistent with professional standards; i.e. pre/post dialysis weights and VS obtained as indicated with professional standards. Findings to be reviewed at monthly QAPI Committee Meeting. Monitoring schedule modified based on findings.<br>5. Allegation of Compliance: October 2, 2018 | |

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| F 698 | Continued From page 15<br>or bleeding from the shunt or if the shunt was clogged and no blood flow was going through. These are all necessary for assessing the health and effectiveness of dialysis.<br><br>On 8/30/2018 at 10:45 AM the DON was notified about concerns and she stated that the nurses were aware of the protocol and they must have forgotten to sign off on the MAR.<br><br>On 8/30/2018 at an end of day conference the Administration was made aware and no new information was provided. | F 698 | | |
| F 755 SS=D | COMPLAINT DEFICIENCY<br>Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3)<br><br>§483.45 Pharmacy Services<br>The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.<br><br>§483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.<br><br>§483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-<br><br>§483.45(b)(1) Provides consultation on all | F 755 | 1. Root Cause Analysis completed. Resident # 127 no longer resides in the facility.<br><br>2. Director of Nursing / Designee completed a Quality Review of antibiotics for timely refill/availability for administration. Regional Director to validate results of Quality Review. Follow up based on findings. | |

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| F 755 | Continued From page 16<br>aspects of the provision of pharmacy services in the facility.<br><br>§483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and<br><br>§483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, staff interview, clinical record review and facility documentation review the facility staff failed to ensure medications were available for administration for 1 resident (Resident #127) of 31 residents in the survey sample.<br><br>Resident #127 was admitted to the facility from the hospital on 8/27/18 for treatment of an infection with the antibiotic Vancomycin. The antibiotic was unavailable from the pharmacy on 8/28/18. The antibiotic was not administered until on 8/29/18 at 6:00 p.m.<br><br>The findings included:<br><br>Resident #127, an 88 year old, was admitted to the facility on 8/27/18. Diagnoses included C. Diff (infection), spondylosis, hypertension, heart disease, diabetes, end stage renal disease, anemia, and arthritis.<br><br>As the resident was new to the facility, a Minimum Data Set assessment had not been completed. | F 755 | 3. Director of Nursing/Designee provided re-education for Licensed Nurses regarding ensuring medication refilled/administered as ordered by physician. Director of Nursing/Designee to met with hospital discharge planner to discuss coordination of resident care.<br><br>4. Director of Nursing /Designee to conduct Quality Improvement monitoring of resident medications for timely refill/available (in stock)/administered per physician's order 5 x/week x 4 weeks, weekly x 4 weeks. Quality improvement Monitoring, Findings to be reviewed at monthly QAPI Committee Meeting. Monitoring schedule modified based on findings.<br><br>5. Allegation of Compliance: October 2, 2018 | |

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| F 755 | Continued From page 17<br>On 8/28/18 at 2:30 p.m., personal protective equipment was observed in a plastic set of drawers outside of Resident.#127's room. The resident was not in the room at this time.<br><br>According to Resident #127's clinical record, contact precautions were in place for Resident #127 due to a C. Diff infection.<br><br>The "After Visit Summary" from the hospital was included in Resident #127's clinical record. The summary read, "You were discharged on : August 27, 2018." Included in the summary was the "Final Medication List At Discharge." The list included an antibiotic order for Vancomycin take 1 cap (125 milligrams) by mouth every 6 hours for 5 days.<br><br>A handwritten note on the hospital medication list read, "Verified t.o. (telephone order)." It was signed with the facility nurse's name and the date of 8/27/18.<br><br>According to Resident #127's computerized facility orders, the order date for the Vancomycin was 8/27/18. The start date was documented as 8/28/18 and the end date was 8/28/18. The "order status" read, "Discontinued." The order was discontinued at 12:39 a.m. and the "Reason for Discontinue" read, "medicine will be delivery on 8/28/2018 in the afternoon."<br><br>The 8/27/18 Vancomycin order was included on the August 2018 Medication Administration Record (MAR). The MAR entry for 8/28/18 at 0000 (12 a.m.) included the nurse initials and the number 9. According to the "chart codes" a 9 indicated that a nursing note had been written. Other medications with an administration time of | F 755 | | |

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| F 755 | Continued From page 18<br>9:00 a.m. were administered on 8/28/18.<br><br>On 8/28/18 at 2:00 a.m., a Nursing Progress Note was written. The note read, "Vancomycin HCL Capsule 125 mg (milligram) Give 1 capsule by mouth every 6 hours for CDIFF for 5 Days until finished called pharmacy, medication will be delivery tomorrow afternoon (8/28/2018). Reschedule medicine."<br><br>On 8/28/18 at 9:09 a.m., a Nursing Progress Note was written. The note read, "Called pharmacy for medication: Vancomycin HCL capsule 125 mg. Pharmacy told writer that it will be in the afternoon. Rescheduled it. (Husband name), aware On call doctor, aware."<br><br>A new order for Vancomycin with an order date of 8/28/18 was included in Resident #127's orders. The start date was documented as 8/28/18 and the end date was 9/3/18. The "order status" read, "Active." The new order was include on the August 2018 MAR. The first dose of Vancomycin was scheduled to start 8/29/18 at 6:00 p.m.<br><br>On 8/30/18 at 1:30 p.m., Licensed Practical Nurse K (LPN K) was asked to describe the pharmacy delivery schedule. LPN K stated that the pharmacy was located in Portsmouth. She stated that the pharmacy delivered medications twice daily Monday- Saturday. The delivery times were between 3-4 p.m. and midnight. On Sunday there was one delivery run at midnight. A stat medication delivery would arrive within 2-4 hours. LPN K pointed to a "Pharmacy Information" sheet taped to the nursing station. When asked if she knew why Resident #127's Vancomycin was not delivered on the midnight run on 8/28/18, LPN K stated that she did not | F 755 | | |

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| F 755 | Continued From page 19<br>know why.<br><br>The Pharmacy Information sheet included the pharmacy order timelines for admissions. The sheet read, Monday- Friday medications ordered by 11:00 a.m. had a delivery window of 12:00 p.m. and medications ordered by 10:00 p.m. had a delivery window of 12:00 a.m.<br><br>On 8/30/18 at 1:50 p.m., an interview was conducted with the Director of Nursing (DON) regarding Resident #127's Vancomycin. The DON stated that Resident #127 arrived at the facility on 8/27/18 at 5:30 p.m. and the medications were put in with the pharmacy on 8/27/18 evening. She stated that the facility staff were told the Vancomycin would come on the 8/28/18 midnight run. She stated that medications for new admissions were top priority. The DON stated that the Vancomycin did not come on the midnight run. She asked that the survey team speak with the Unit Manager, Licensed Practical Nurse C (LPN C), as LPN C was involved with the situation.<br><br>On 8/30/18 at 2:00 p.m., LPN C was asked how the pharmacy received orders from the facility. LPN C stated that when a nurse entered an order into the computer system, the order was sent to the pharmacy automatically. LPN C stated that Resident #127's orders went to the pharmacy on 8/27/18. LPN C stated that she called the pharmacy on 8/28/18 and asked about the Vancomycin. LPN C stated the pharmacy would stat the medication. She stated that the medication was delivered on 8/28/18. LPN C was asked to provide the pharmacy phone number. She provided the phone number and the pharmacy contact, Other A. | F 755 | | |

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| F 755 | Continued From page 20<br><br>On 8/30/18 at 2:15 p.m., a call was placed to the pharmacy. Other A answered the phone and was asked to provide medication order information for Resident #127. Other A stated that the pharmacy received the order for the Vancomycin on 8/27/18 at 8:17 p.m. Other A stated that the medication should have gone out on the midnight delivery on 8/28/18. She did not know why it did not go on the midnight delivery. Other A stated the Vancomycin was sent out on 8/28/18 on the noon delivery run. She stated that the Vancomycin delivery was signed by Licensed Practical Nurse G (LPN G) at the facility on 8/28/18 at 2:30 p.m.<br><br>On 8/30/18 at 2:35 p.m., LPN G was asked if she signed for Resident #127's Vancomycin. LPN G stated that she worked from 7:00 a.m. until 4:45 p.m. on 8/28/18 and did remember signing for the Vancomycin. She stated that she signed a hard copy and an electronic copy of the receipt. LPN G stated that the paper copy was placed in a basket at the nursing station. She looked through the basket during the interview and could not locate the receipt.<br><br>The "Proof of Delivery" shipment summary was provided by the facility staff. LPN G signed for the medication on 8/28/18 at 2:30 p.m.<br><br>On 8/30/18 at 3:02 p.m., the DON was asked why the original Vancomycin order was discontinued. The DON stated that the Vancomycin did not arrive from the pharmacy on the midnight run. The on-call doctor was called and a new order was written.<br><br>The DON was asked why the Vancomycin delivered on 8/28/18 at 2:30 p.m. was not | F 755 | | |

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| F 755 | Continued From page 21<br>administered to Resident #127 until 8/29/18 at 6:00 p.m. The DON stated she did not know why the Vancomycin was put into the computer to start on 8/29/18 at 6:00 p.m. It was reviewed with the DON that Resident #127 did not receive the antibiotic until 48 hours after admission.<br><br>At the end of day meeting on 8/30/18, the Administrator, DON and Corporate Nurse were notified of the issue. They were asked to provide all information pertaining to the issue. | F 755 | | |
| F 757 SS=D | Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6)<br><br>§483.45(d) Unnecessary Drugs-General.<br>Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used-<br><br>§483.45(d)(1) In excessive dose (including duplicate drug therapy); or<br><br>§483.45(d)(2) For excessive duration; or<br><br>§483.45(d)(3) Without adequate monitoring; or<br><br>§483.45(d)(4) Without adequate indications for its use; or<br><br>§483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or<br><br>§483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section.<br>This REQUIREMENT is not met as evidenced by: | F 757 | 1. Resident #16 currently resident in facility. Psychiatric Nurse Practitioner reviewed psychotropic medications on 9/7/18 and 9/18/18. Tegretol was discontinued. Resident didn't experience any adverse affects from receiving medication.<br>2. Quality Review of current residents in facility receiving Tegretol to ensure the diagnosis is appropriate to support the use of the medication. Follow up based on findings. | |

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| F 757 | Continued From page 22<br>Based on observation, staff interview and clinical record review the facility staff failed to ensure 1 resident (Resident #16) of 31 residents in the survey sample were free from unnecessary meds.<br><br>For Resident # 16 the facility failed to ensure that Resident #16 had an appropriate diagnosis for receiving Tegretol (a seizure medication).<br><br>The findings include:<br><br>Resident # 16 was a 80 year old female admitted to the facility on 7/10/2018 with diagnoses of but not limited to Cerebral infarction (stroke) Dementia (present before stroke) Diabetes, Hypertension, Reflux and Insomnia. Resident #16's most recent Minimum Data Set (MDS) coded as a significant change with an Assessment Reference Date (ARD) of 6/25/18 coded the resident's Brief Interview of Mental Status at a 3, indicating severe cognitive impairment.<br><br>On 8/29/2018, a review of the clinical record was conducted. The review showed an order for 1 tablet of Tegretol 400 (mg) milligrams extended release to be given by mouth at bedtime for Dementia in other diseases classified elsewhere without behavioral disturbance.<br><br>According to the physicians orders, history and physical, and most recent MDS dated 6/25/2018 under section I (active diagnoses) Resident # 16 had no diagnosis of Seizure Disorder.<br><br>The following was obtained from the FDA website:<br>TEGRETOL® and TEGRETOL®-XR (Teg-ret-ol) | F 757 | 3. Licensed Nurses re-educated by DON/Designee on ensuring diagnosis is accurate for medication prescribed. DON/Designee re-educated Licensed nurses on ensuring proper diagnosis is present upon admission.<br>4. Quality Monitoring of current residents with psychoactive medications, new admissions, readmissions weekly x 8 weeks, and every 2 weeks x 4 weeks. Findings to be reported to QAPI committee monthly. Quality monitoring based on findings.<br>5. Alleged date of compliance: October 2, 2018. | |

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| F 757 | Continued From page 23<br>(carbamazepine)<br>Tablets, Suspension, Chewable Tablets, Extended-Release Tablets<br><br>TEGRETOL is a prescription medicine used to treat:<br>Certain types of seizures (partial, tonic-clonic, mixed)<br>Certain types of nerve pain (trigeminal and glossopharyngeal neuralgia)<br>TEGRETOL is not a regular pain medicine and should not be used for aches or pains<br><br>Do not use TEGRETOL for a condition for which it was not prescribed. Do not give TEGRETOL to other people, even if they have the same symptoms that you have. It may harm them.<br>This Medication Guide summarizes the most important information about TEGRETOL. If you would like more information, talk with your healthcare provider. You can ask your pharmacist or healthcare provider for the full prescribing information about TEGRETOL that is written for health professionals.<br><br>On 8/30/18, at 3:45 pm, an interview was conducted with the DON. The DON stated she was aware of that Tegretol was an antiseizure medication and that the Resident had no such diagnosis. She stated it was prescribed when Resident #16 went to her Psych consult.<br><br>The Administration was made aware of these findings and no further information was provided. | F 757 | | |
| F 758 SS=E | Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5)<br><br>§483.45(e) Psychotropic Drugs. | F 758 | | |

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| F 758 | Continued From page 24<br>§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:<br>(i) Anti-psychotic;<br>(ii) Anti-depressant;<br>(iii) Anti-anxiety; and<br>(iv) Hypnotic<br><br>Based on a comprehensive assessment of a resident, the facility must ensure that---<br><br>§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;<br><br>§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;<br><br>§483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and<br><br>§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 | F 758 | 1. Residents # 16, 63 and 69 prescribed psychotropic medications were reviewed for diagnosis, medical and behavioral needs. Plan of care updated as indicated.<br><br>2. Director of Nursing/Designee conducted a Quality Review of current facility residents with prescribed psychotropic medications for diagnosis, medical and behavioral indicators. Consultant pharmacist conducted a focused Quality Review of current facility residents with prescribed psychotropic, medications for diagnosis, medical and behavioral indicators. Follow up based on findings.<br><br>3. Director of Nursing/Designee provided re-education for licensed nurses regarding ensuring psychotropic medications have appropriate diagnosis, medical and behavioral indicators. | |

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| F 758 | Continued From page 25<br>indicate the duration for the PRN order.<br><br>§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.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, clinical record review, staff interview and facility documentation review the facility staff failed to ensure that 3 residents (#63, #16, and #69) of 31 residents in the survey sample were free from unnecessary psychotropic medications.<br><br>1. For Resident # 63, the provider failed to ensure the resident had medical and behavioral needs for an antipsychotic medication.<br><br>2. For Resident # 16 the facility failed to ensure that Resident #16 had (A) an appropriate diagnosis for receiving Anti-psychotic medications in combination with Prozac (antidepressant) and (B) having a PRN psychotropic for longer than 2 weeks.<br><br>3. For Resident #69 the facility administered Depakote Sprinkles (for seizures or mood disorder) without an appropriate diagnosis.<br><br>Findings included:<br><br>1. For Resident # 63, the provider failed to ensure the resident had medical and behavioral needs for an antipsychotic medication.<br><br>Resident #63 was admitted to the facility on 7/25/2018 from another nursing facility. Her | F 758 | 4. Director of Nursing/Designee to complete Quality Improvement Monitoring of residents with prescribed psychotropic medications for diagnosis, medical and behavioral indicators 5x/week x 4 weeks, weekly x 4 weeks, then monthly and as needed thereafter. Findings to be reviewed at monthly QAPI Committee Meeting. Follow up based on findings.<br><br>5. Allegation of Compliance: October 2, 2018 | |

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| F 758 | Continued From page 26<br>diagnoses included: cerebral infarct with aphasia, hemiplegia, and dysphasia, dementia without behavior disturbance, insomnia, major depressive disorder, and diabetes.<br><br>On 8/1/2018, the provider completed a Minimum Data Set (MDS) assessment which showed that Resident #63 could not understand staff or be understood. This MDS also showed that the resident had severely impaired cognition, no behavioral symptoms, and needed total nursing assistance for her activities of daily living. The resident was coded in D0500C as not having trouble falling asleep or staying asleep.<br><br>On 8/29/2018 at 1PM, a clinical record review occurred that showed the following:<br>-On admission to the facility, the Nurse Practitioner (NP) ordered Seroquel 0.25mg (one-half tablet) at bedtime for insomnia. No clinical notes by nursing staff or the NP were found on record review that stated the resident had problems falling asleep or staying asleep. Per the Admission History Note, "Patient is on melatonin for insomnia".<br><br>NP progress note dated 8/3/2018 stated:<br>History of present illness: "She has had crying spells. Patient does have expressive aphasia. Staff states usually she cries when she is alone in her room by herself. When she is around people she is fine."<br><br>Plan: Encourage staff to keep patient around others. May benefit from psych consult. Sometimes her symptoms appear to be pseudobulbar affect however crying spells are not random and may be more related to anxiety. | F 758 | | |

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| F 758 | Continued From page 27<br>NP Progress note dated 8/21/2018 stated: History of present illness: "She has been having increase in the crying spells. She does have cognitive deficit and significant agitation issues."<br><br>On 8/21/2018 Resident #63's Seroquel dosage was doubled to Seroquel 0.25mg (one-half tablet) twice a day for dementia in other diseases classified elsewhere without behavior disturbance.<br><br>Resident # 63's care plan included:<br>1. *Focus* Ms. (Resident #63's name) has an alteration in sleep/wake cycles r/t CVA, new environment<br>*Goal* the resident will maintain sleep patterns WNL (e.g. at least 8 hours a night)<br>*Interventions* - provide comfort measures as needed: pain medication, back rub, etc.<br><br>2. *Focus* Psychoactive Medication use/Antipsychotic medication in use for dx of dementia<br>*Goal* No side effects x90 days<br>The interventions listed no behaviors or staff response/treatment for behaviors. The clinical notes and care plan listed no assessments for crying, to include the possibility of pain, discomfort, anxiety, loneliness, or difficulties adjusting to a new environment.<br><br>At 1:45PM on 8/29/2018, an interview was held with LPN C (acting unit manager for Resident #63's unit). When asked if Resident #63 had any behaviors, LPN C reviewed the computer database and replied "No, she hasn't had any documented and I haven't seen any." When asked if the resident had pain, LPN C replied "Sometimes. She gets a little fussy when she is in | F 758 | | |

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| F 758 | Continued From page 28<br>pain."<br><br>On 8/30/2018 at 10:40, an interview was held with Administration B (the director of nursing) and Administration C (the corporate nurse consultant). When asked what the facility's practice was for tracking behaviors, Administration B said "Behavior tracking is supposed to be part of the MAR (medication administration record)." Administration B and C were asked to review Resident #63's MAR in hard copy and in the software, and asked directly if this resident had any documented behaviors. Administration B replied "No." When asked if antipsychotic medications should be administered for insomnia or if the resident had no diagnosis or behaviors to require it, Administration C replied "No."<br><br>On 8/30/2018 at 2:45, Resident #63's responsible party was brought to the surveyor by Administration B. The resident's responsible party stated she was pleased with the care provided her relative. She volunteered that "she communicates with crying- crying could mean she needs to be repositioned, or she could be wet." When asked if she was informed of the black box warning on the medication prescribed, she stated she was "made aware that she was on it, but not how risky it was."<br><br>On 8/30/2018 at 3:30, the NP was brought to the surveyor by Administration B. When asked if Seroquel was appropriate for residents with a primary diagnosis of dementia without behaviors, the NP did not answer the question. When asked again, she replied "No."<br><br>A review of the Provider's Policy for Medication | F 758 | | |

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| F 758 | Continued From page 29<br>Management-Psychotropic (N-1255) shows:<br>POLICY: Residents who have not used psychotropic medications are not given these medications unless the medications is necessary to treat a specific condition as diagnosed, documented in the clinical record, and per physician order.<br>1. Resident receiving psychotropic medication should have specific condition documented indications in the medical record<br>4. Monitor behavior and side effects every shift utilizing the Behavior Monitoring Flow Record or electronic equivalent.<br>5. Resident centered non-pharmacological interventions should be initiated as indicated.<br>No further information was provided prior to exit.<br><br>2. For Resident # 16 the facility failed to ensure that Resident #16 had (A) an appropriate diagnosis for receiving Anti-psychotic medications in combination with Prozac (antidepressant) and (B) having a PRN psychotropic for longer than 2 weeks.<br><br>(A)<br>Resident # 16 is a 80 year old female admitted to the facility on 7/10/2018 with diagnoses of but not limited to Cerebral infarction (stroke) Dementia (present before stroke) Diabetes, Hypertension, Reflux and Insomnia. Resident #16's most recent Minimum Data Set (MDS) coded as a significant change with an Assessment Reference Date (ARD) of 6/25/18 Resident had a Brief Interview of Mental Status of 3 indicating severe cognitive impairment. MDS.<br><br>According to the most recent (MDS) Minimum data set (an assessment tool) dated 6/25/2018 a (GDR) Gradual Dose Reduction had not been | F 758 | | |

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| F 758 | Continued From page 30<br>attempted and had not been documented as clinically contraindicated. MDS section E for behaviors Psychosis E-0100 asks the question is does the resident have Hallucinations or Delusion the box is checked (z) none of the above.<br><br>Under section E 0200 behavioral symptoms presence and frequency resident was coded as 0 having not exhibited any behaviors such as physical aggression towards others (hitting, kicking punching pushing ) also coded as not having any Verbal behaviors such as threatening screaming or cursing at others. No other behaviors not directed at others (hitting self, yelling out, pacing, rummaging, and sexual acts in public areas)<br><br>On 8/29/2018 a review of clinical record was conducted and it was found that Resident #16 had an order dated 3/31/2018 for Seroquel (anti psychotic) 50 (milligrams) mg give 1 tablet by mouth one time a day related to Dementia in other diseases classified elsewhere. On 4/27/2018 an order was added to give Seroquel 100 mg one time per day and 150 mg at bedtime for a total of 250 mg per day. Seroquel was Discontinued on 5/10/2018.<br><br>During review of clinical record it was found that Resident #16 had a psychiatric consult dated 5/3/2018 that listed her Primary Diagnosis of Dementia diagnosed prior to the stroke (Stroke was on 3/18/18). She had no diagnosis for depression or other mental illness.<br><br>The Seroquel manufacturer instructions stated:<br><br>WARNING!<br>INCREASED MORTALITY IN ELDERLY | F 758 | | |

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| F 758 | Continued From page 31<br>PATIENTS WITH DEMENTIA-RELATED PSYCHOSIS; and SUICIDAL THOUGHTS AND BEHAVIORS<br><br>Increased Mortality in Elderly Patients with Dementia-Related Psychosis<br>Elderly patients with dementia-related psychosis treated with antipsychotic drugs are at an increased risk of death [see WARNINGS AND PRECAUTIONS]. SEROQUEL is NOT approved for the treatment of patients with dementia-related psychosis [see WARNINGS AND PRECAUTIONS].<br><br>According to the FDA:<br><br>SEROQUEL may cause serious side effects, including:<br><br>1. Risk of death in the elderly with dementia. Medicines like SEROQUEL can increase the risk of death in elderly people who have memory loss (dementia). SEROQUEL is not for treating psychosis in the elderly with dementia.<br>2. Risk of suicidal thoughts or actions (antidepressant medicines, depression and other serious mental illnesses, and suicidal thoughts or actions).<br><br>Resident #16 was also prescribed Zyprexa (anti psychotic) which was started on 5/16/2018 and Prozac (an Antidepressant) beginning on 5/17/2018.<br><br>The manufactures of Zyprexa (olanzapine) warn:<br><br>HIGHLIGHTS OF PRESCRIBING INFORMATION | F 758 | | |

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| F 758 | Continued From page 32<br><br>ZYPREXA (olanzapine) Tablet for Oral use<br><br>WARNING: INCREASED MORTALITY IN ELDERLY PATIENTS<br>WITH DEMENTIA-RELATED PSYCHOSIS<br>See full prescribing information for complete boxed warning.<br>Elderly patients with dementia-related psychosis treated with antipsychotic drugs are at an increased risk of death.<br>ZYPREXA is not approved for the treatment of patients with dementia-related psychosis. (5.1, 5.14, 17.2)<br><br>When using ZYPREXA (olanzapine) and PROZAC (fluoxetine) in combination, also refer to the Boxed Warning section of the package insert from Symbyax.(Symbyax is a combination of ZYPREXA and PROZAC)<br><br>The Boxed Warning from the Symbyax manufacturer state:<br>SYMBYAX® (SIM-be-ax)<br>(olanzapine and fluoxetine hydrochloride)<br><br>Possible serious risks:<br><br>Increased risk of death and increased incidence of stroke or "mini-strokes" called transient ischemic attacks (TIAs) in elderly people with psychosis related to dementia (a braindisorder that lessens the ability to remember, think, and reason). SYMBYAX is not approved for these patients.<br><br>The FDA Warnings on Zyprexa are as follows: | F 758 | | |

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| F 758 | Continued From page 33<br><br>ZYPREXA may cause serious side effects, including:<br>1. Increased risk of death in elderly people who are confused, have memory loss and have lost touch with reality (dementia-related psychosis).<br>2. High blood sugar (hyperglycemia).<br><br>These serious side effects are described below.<br><br>1. Increased risk of death in elderly people who are confused, have memory loss and have lost touch with reality (dementia-related psychosis). ZYPREXA is not approved for treating psychosis in elderly people with dementia.<br>2. High blood sugar (hyperglycemia). High blood sugar can happen if you have diabetes already or if you have never had diabetes<br><br>(B)<br>Resident #16 also had an order dated 04/02/2018 ending 4/30/2018 for Ativan 0.5 mg (anti-anxiety) give 0.5 mg. every 8 hours (as needed) PRN for restlessness. She received the Ativan on 20 separate occasions during that time period.<br><br>On 8/30/18 an interview was conducted with the DON and she stated she was aware of the black box warnings regarding antipsychotics and Elderly Dementia patients and she stated she was also aware that PRN psychotropics should be limited to 14 days.<br><br>The Administration was made aware of these findings and no further information was provided.<br><br>3. For Resident #69 the facility administered Depakote Sprinkles (for seizures or mood disorder) without an appropriate diagnosis. | F 758 | | |

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| F 758 | Continued From page 34<br><br>Resident #69, a 91 year old, was admitted to the facility on 6/30/17. Her diagnoses included insomnia, anxiety, dementia with behavioral disturbance, major depression, psychosis, hypothyroidism, elevated lipids, and diabetes.<br><br>The most recent Minimum Data Set assessment was a quarterly assessment with an assessment reference date of 8/13/18. Resident #69 was coded with a Brief Interview of Mental Status score of 4 indicating severe cognitive impairment and required extensive assistance with activities of daily living.<br><br>On 8/28/18 at 11:30 a.m., Resident #69 was observed in the locked unit. She was seated in a chair outside of her room. She repeatedly asked staff for her money because she needed to pay her bills.<br><br>She was observed again on 8/29/18 seated at a table finishing her lunch meal. She was observed to walk from the table to her room with a walker.<br><br>Resident #69 had a physician order dated 3/19/18 for Depakote Sprinkles 125 milligram cap, 1 cap by mouth two times per day for dementia with behavioral disturbances.<br><br>Resident #69's care plan was reviewed. The behavior care plan dated 7/3/17 read "(Resident name) exhibits S/S (signs/symptoms) of BPSD (Behavioral and Psychological Symptoms of Dementia) or behaviors related to Depressive D/O(disorder) and Anxiety D/O: Agitation, attempting to hit others, refuses medication/ meals at times, exit seeking at times, goes in and out of bed frequently (messes up hair frequently) | F 758 | | |

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| F 758 | Continued From page 35<br>threatened to hit roommate, blocking doorway of room, smacking staffs hands away, pushing staff, throwing items out of room, HX (history) of accusations of abuse at this facility, lying in others beds, yelling out, will wear more than one pull up at a time, called 911 (8/13/17) Will wear pajamas frequently."<br><br>The following interventions dated 7/3/17 were included on the behavior care plan: assess for underlying medical issues, assess for psychosocial and environment changes, assess for pain, consistent caregivers, determine precipitating factors and alleviate, attend group, encourage responsible party to assist with refusal, evaluate elimination needs, evaluate hunger/thirst, explain procedure before providing care, report all abuse accusations to supervisor and follow protocol, introduce self when providing care, medications as ordered, independent self-directed activities, positive feedback, psych eval, redirect inappropriate behaviors, remove distractions.<br><br>The following product information about Depakote and Depakote Sprinkles was accessed on 9/4/18 at 1:38 p.m. at the website https://www.depakote.com/<br>"Depakote can be used for the treatment of multiple conditions as described below.<br>What is Depakote used for?<br>Depakote comes in different dosage forms. Depakote® (divalproex sodium) tablets, for oral use, and Depakote® ER (divalproex sodium) extended-release tablets, for oral use, are prescription medications used:<br>· to treat manic episodes associated with bipolar disorder<br>· alone or with other medicines to treat: - | F 758 | | |

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| F 758 | Continued From page 36<br>complex partial seizures in adults and children 10 years of age and older<br>- simple and complex absence seizures, with or without other seizure types<br>· to prevent migraine headaches<br><br>Depakote® Sprinkle Capsules (divalproex sodium delayed release capsules), for oral use, is a prescription medicine used alone or with other medicines to treat:<br>· complex partial seizures in adults and children 10 years of age and older<br>· simple and complex absence seizures, with or without other seizure types"<br><br>According to the physician order, Resident #69 was prescribed Depakote Sprinkles for dementia with behavioral disturbances. The product information for Depakote and Depakote Sprinkles does not indicate dementia with behavioral disturbances as an indication for use.<br><br>At the end of day meeting on 8/29/18, it was reviewed with the Administrator, Director of Nursing and Corporate Nurse that Resident #69 was taking a psychotropic medication for which she did not have an appropriate diagnosis to support it's use. | F 758 | | |
| F 842 SS=D | Resident Records - Identifiable Information<br>CFR(s): 483.20(f)(5), 483.70(i)(1)-(5)<br><br>§483.20(f)(5) Resident-identifiable information.<br>(i) A facility may not release information that is resident-identifiable to the public.<br>(ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information | F 842 | | |

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| F 842 | Continued From page 37<br>except to the extent the facility itself is permitted to do so.<br><br>§483.70(i) Medical records.<br>§483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are-<br>(i) Complete;<br>(ii) Accurately documented;<br>(iii) Readily accessible; and<br>(iv) Systematically organized<br><br>§483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is-<br>(i) To the individual, or their resident representative where permitted by applicable law;<br>(ii) Required by Law;<br>(iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;<br>(iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.<br><br>§483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.<br><br>§483.70(i)(4) Medical records must be retained for- | F 842 | 1. Resident # 73's medical record contains correct diet slip. Identified misfiled diet slip removed from resident record.<br><br>2. Director of nursing/Designee conducted a Quality Review of current resident's charts to ensure contents were specific to resident. Follow up based on findings.<br><br>3. Director of Nursing provided re-education for Licensed nurses and Director of Medical Records regarding the Policy and Procedure of clinical/medical records.<br><br>4. Medical Records Coordinator/Designee to complete random Quality Monitoring of resident records to ensure information filed correctly 5x/ week x 4 weeks , 2x/ week x 4 weeks then monthly and as needed. Findings to be reported at monthly QAPI Committee Meeting. Monitoring schedule modified based on findings.<br><br>5. Allegation of Compliance: October 2, 2018 | |

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| F 842 | Continued From page 38<br>(i) The period of time required by State law; or<br>(ii) Five years from the date of discharge when there is no requirement in State law; or<br>(iii) For a minor, 3 years after a resident reaches legal age under State law.<br><br>§483.70(i)(5) The medical record must contain-<br>(i) Sufficient information to identify the resident;<br>(ii) A record of the resident's assessments;<br>(iii) The comprehensive plan of care and services provided;<br>(iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State;<br>(v) Physician's, nurse's, and other licensed professional's progress notes; and<br>(vi) Laboratory, radiology and other diagnostic services reports as required under §483.50.<br>This REQUIREMENT is not met as evidenced by:<br>Based on Staff Interview and Clinical Record Review, the facility failed to maintain an accurate clinical record for 1 Resident, Resident #73, in a sample of 31 Residents.<br><br>1. For Resident #73, a diet order for a different resident was found inside Resident #73's chart.<br><br>The Findings included:<br><br>Resident #73 was admitted on 8/5/2018, with his most recent Minimum Data Set (MDS) Assessment being a Medicare 14-Day assessment with an Assessment Review Date (ARD) of 8/17/2018. The Brief Interview for Mental Status (BIMS) scored Resident #73 at 15, indicating no impairment. Resident #73's diagnoses included Osteomyelitis, HIV, Paraplegia, Sacral Pressure Ulcer Stage 4, | F 842 | | |

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| F 842 | Continued From page 39<br>Neurogenic Bladder, Hypertension, Diabetes Mellitus Type II, Pyoderma, and Major Depressive Disorder. Resident #73 required setup assistance for eating, limited assistance of 1 person for transfers, and extensive assistance of 2 or more persons for toileting, personal hygiene, and bed mobility. Ambulation did not occur during the lookback period.<br><br>On 8/29/2018 at 2:15p.m., a review of Resident #73's paper chart was conducted. Upon reviewing the paper chart, several papers titled "DIET ORDER AND COMMUNICATION" were found in the chart. Two of the three papers found had Resident #73's name on them. The 3rd paper had a different name in the "Resident Name" field. When this surveyor asked to speak with the manager for Resident #73's unit, LPN F, the MDS Nurse, stated that the unit did not have a specific manager, but that she would be happy to assist. LPN F was shown Resident #73's chart and the Diet Order sheets inside it. When LPN F was shown the Diet Order that did not have Resident #73's name on it, she stated "that shouldn't be there". This surveyor requested and was given photocopies of all 3 Diet Order sheets.<br><br>The Administrator and Director of Nursing were informed of the findings at the end of day meeting on 8/29/2018. No further information was obtained. | F 842 | | |
| F 880 SS=D | Infection Prevention & Control<br>CFR(s): 483.80(a)(1)(2)(4)(e)(f)<br><br>§483.80 Infection Control<br>The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and | F 880 | | |

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| F 880 | Continued From page 40<br>comfortable environment and to help prevent the development and transmission of communicable diseases and infections.<br><br>§483.80(a) Infection prevention and control program.<br>The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:<br><br>§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;<br><br>§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:<br>(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;<br>(ii) When and to whom possible incidents of communicable disease or infections should be reported;<br>(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;<br>(iv)When and how isolation should be used for a resident; including but not limited to:<br>(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and<br>(B) A requirement that the isolation should be the least restrictive possible for the resident under the | F 880 | 1. Resident # 70 was reassessed by Director of Nursing; identified treatment removed, reapplied utilizing technique to include handwashing practices per standards. Identified LPN H has not returned to facility.<br><br>2. Director of /Designee completed Quality Review observations of licensed nurses provision of treatment utilizing infection control practices per standard, including but not limited to hand washing practices. Follow up based on findings.<br><br>3. Director of Nursing/Designee provided re-education, including competency demonstration for licensed nurses regarding provision of treatment utilizing infection control practices per current standard; i.e. handwashing practices. | |

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| F 880 | Continued From page 41<br>circumstances.<br>(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<br>(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.<br><br>§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.<br><br>§483.80(e) Linens.<br>Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.<br><br>§483.80(f) Annual review.<br>The facility will conduct an annual review of its IPCP and update their program, as necessary.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation and facility documentation review the facility staff failed to implement an effective infection control program for 1 resident (Resident #70) of 31 residents in the survey sample.<br><br>For Resident #70 the nurse failed to clean hands and change gloves during wound care.<br><br>The findings included:<br><br>Resident #70, an 88 year old, was admitted to the facility on 10/3/17. Diagnoses include Alzheimer's disease, major depression, anxiety, dementia, psychosis, hypertension, and congestive heart failure. | F 880 | 4 Director of Nursing/Designee to complete random Quality Improvement Monitoring of licensed nurse provision of resident treatment utilizing infection control practices/handwashing per standard 3x/week x 4 weeks, weekly x weeks then monthly and as needed. Findings to be reviewed at monthly QAPI Committee Meeting. Follow up based on findings.<br><br>5. Allegation of Compliance: October 2, 2018 | |

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| F 880 | Continued From page 42<br><br>The most recent Minimum Data Set assessment was a significant change assessment with an assessment reference date of 8/13/18. Resident #70 was coded with a Brief Interview of Mental Status score of 2 indicating severe cognitive impairment and required extensive assistance with activities of daily living.<br><br>On 8/29/18 at 9:08 a.m. the survey team observed Resident #70's wound care provided by Licensed Practical Nurse H (LPN H). LPN H began by assessing Resident #70's pain level. She cleaned the over bed table. She washed her hands using appropriate technique. She touched the door to the room twice, removed supplies from the treatment cart and placed them on the overbed table and then pulled the curtain around Resident #70's bed.<br><br>LPN H donned a pair of gloves. Her hands were not washed or sanitized prior to putting on the gloves. She positioned Resident #70's foot to remove the bandage. Prior to the bandage removal, LPN H scooted a small trash can with her foot from near the door to the bed side. She pulled the trash bag out of the trash can and put it on the bed. She rolled down the edges of the trash bag. The bag contained a small amount of trash. LPN H removed her gloves, applied hand sanitizer and donned a new pair of gloves. LPN H removed the bandage from the right heel.<br><br>LPN H did not change her gloves between removing the bandage and cleaning the wound. LPN H sprayed the wound with simple saline spray. She pat and wiped the wound with a piece of gauze. She removed her gloves. She did not clean her hands before donning a new pair of | F 880 | | |

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| F 880 | Continued From page 43<br>gloves. She applied skin prep. She removed her gloves. She did not clean her hands before donning a new pair of gloves. LPN H applied hydrogel using 2 swabs. She removed her gloves. She did not clean her hands before donning a new pair of gloves. She signed and dated the bandage and then affixed the bandage over the wound. At the conclusion of the wound care, LPN H washed her hands using appropriate technique.<br><br>On 8/30/18 at 10:30 a.m., the Administrator, Director of Nursing and Corporate Nurse were notified of the hand hygiene issues observed during wound care. They were asked to provide their handwashing policy.<br><br>The policy titled "Hand Hygiene" dated 9/6/16 was reviewed. The overview of the policy read, "The CDC (Centers for Disease Control) defines hand hygiene as cleaning your hands by using either handwashing (washing with soap and water), antiseptic hand wash, or antiseptic hand rubs (i.e. alcohol based sanitizer including foam or gel).<br><br>The purpose of the policy read, "To reduce the spread of germs in the healthcare setting." The process read, "Hand hygiene should be performed:" and included Before initiating a clean procedure, After contact with blood, body fluids, or excretions, mucous membranes, non-intake skin, or wound dressing, After contact with inanimate objects (including medical equipment) in the immediate patient vicinity, After glove removal. | F 880 | | |