STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495199	A. BUILDING _____ B. WING _____	C 10/12/2018

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E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 10/10/18 through 10/12/18. 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 Medicare/Medicaid standard survey was conducted 10-10-18 through 10-12-18. Significant Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. One complaint was investigated during the survey. The census in this 65 certified bed facility was 60 at the time of the survey. The survey sample consisted of 26 residents.	F 000		
F 552 SS=D	Right to be Informed/Make Treatment Decisions CFR(s): 483.10(c)(1)(4)(5) §483.10(c) Planning and Implementing Care. The resident has the right to be informed of, and participate in, his or her treatment, including: §483.10(c)(1) The right to be fully informed in language that he or she can understand of his or her total health status, including but not limited to, his or her medical condition. §483.10(c)(4) The right to be informed, in advance, of the care to be furnished and the type of care giver or professional that will furnish care. §483.10(c)(5) The right to be informed in advance, by the physician or other practitioner or professional, of the risks and benefits of proposed	F 552		11/19/18

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

Electronically Signed | 11/02/2018

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F 552	Continued From page 1 care, of treatment and treatment alternatives or treatment options and to choose the alternative or option he or she prefers. This REQUIREMENT is not met as evidenced by: Based on observation, facility staff interview, clinical record review, and facility documentation review, the facility staff failed for Resident #28 of the survey sample of 26 residents, to ensure the right to be informed of treatment risks, and alternatives of psychotropic medications. The facility staff failed to fully inform Resident #28's Responsible Party of the increased risk of death from Seroquel, and possible alternatives. The Findings included: Resident #28 was a 72 year old who was admitted to the facility on 6/12/17. Resident #28's diagnosis included Dementia with Behavioral Disturbance, Lobar pneumonia, Chronic Kidney Disease, Heart Disease, Type 2 Diabetes Mellitus with hyperglycemia, and Dependence on Renal Dialysis. The Minimum Data Set, an Annual Assessment with an Assessment Reference Date of 6/4/18, coded Resident #28 as not having any behavioral issues. On 10/12/18 a review of Resident #28's clinical record was conducted, revealing a care plan. It read, "Problem onset: 6/4/18, receives psychotropic medication due to diagnosis of psychosis." Note: Psychosis is not an official diagnosis. On 1/25/18, Resident #28 was seen by a Nurse	F 552	This plan of correction constitutes the facilities written allegation of compliance for the deficiencies cited. However, submission of this plan of correction is not an admission that deficiencies exist or that one was cited correctly. The plan of correction is submitted to meet requirements established by federal and state law. 1. Resident #28's responsible party was given printed information on the black box warnings for the antipsychotic medication ordered by the Nurse Practitioner. 2. Any other residents on psychotropic medications with black box warnings have the potential to be affected by the same practice. New consent forms with the black box warning education, will be completed by 11/12/18. 3. In-service completed for all licensed nurses regarding the consent and education for psychotropic medications with black box warning by the facility pharmacist. The education is to be completed and documented prior to the consent being signed. The medical director will send a letter to all physicians and nurse practitioners regarding the regulation and addressing pharmacy consultant recommendations for antipsychotics with black box warnings,	

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F 552	Continued From page 2 Practitioner. The report read, "Behavior agitated, oriented to self and place. Speech clear, Denies psychotic symptoms, hallucinations, etc. Disoriented to time and situation, Memory impairment. Denies suicidal and homicidal ideation. Recommendations: Seroquel 25 MG twice daily." On 10/11/18 a review was conducted of facility documentation, revealing a Psychoactive Medication Informed Consent, signed by Resident #28's Responsible Party (Daughter). It read, "1/25/18. A physician has prescribed Seroquel 25 MG 2 times daily. Possible side effects: abnormal movement of facial muscles & tongue, liver failure, muscle pain, depression." The facility failed to inform the Responsible Party of the boxed warning regarding Seroquel. The 2018 Nursing Drug Handbook listed a boxed warning regarding Seroquel. It read, "Drug isn't indicated for use in elderly patients with dementia-related psychosis because of increased risk of death from Cardiovascular Disease of infection." On 10/11/18 an interview was conducted with the Director of Nursing (Administration B). When asked about possible alternate medications or interventions, she stated that she was not aware of any. The facility Administrator (Administration A) was present. No further information was received.	F 552	and the appropriate diagnoses and use of those medication that have black box warnings. An audit of all antipsychotic medications was completed by the DON/ADON, pharmacist and medical director, for appropriate diagnoses and corrections made as needed including new consent and responsible party education. 4. The DON will review audit results in the monthly QAPI meeting and the committee with results summarized with further monitoring to be decided by the QAPI committee if thresholds are not met.	
F 645 SS=D	PASARR Screening for MD & ID CFR(s): 483.20(k)(1)-(3) §483.20(k) Preadmission Screening for individuals with a mental disorder and individuals with intellectual disability.	F 645		11/19/18

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F 645	Continued From page 3 §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 the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services; or (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- (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 (B) If the individual requires such level of services, whether the individual requires specialized services for intellectual disability. §483.20(k)(2) Exceptions. For purposes of this section- (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. (ii) The State may choose not to apply the preadmission screening program under	F 645		

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F 645	Continued From page 4 paragraph (k)(1) of this section to the admission to a nursing facility of an individual- (A) Who is admitted to the facility directly from a hospital after receiving acute inpatient care at the hospital, (B) Who requires nursing facility services for the condition for which the individual received care in the hospital, and (C) Whose attending physician has certified, before admission to the facility that the individual is likely to require less than 30 days of nursing facility services. §483.20(k)(3) Definition. For purposes of this section- (i) An individual is considered to have a mental disorder if the individual has a serious mental disorder defined in 483.102(b)(1). (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. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and clinical record review the facility staff failed to obtain a Pre-Admission Screening and Resident Review (PASARR) prior to admission for 1 resident (Resident #53) of 26 residents in the survey sample. For Resident #53, the facility did not receive or review the PASARR prior to admission. The findings included: Resident #53, a 72 year old, was admitted to the facility on 9/24/18. Diagnoses included Vascular	F 645	This plan of correction constitutes the facilities written allegation of compliance for the deficiencies cited. However, submission of this plan of correction is not an admission that deficiencies exist or that one was cited correctly. The plan of correction is submitted to meet requirements established by federal and state law. 1. Resident #53 preadmission screening for individuals with a mental disorder and intellectual disorder (PASRR) received.	

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F 645	Continued From page 5 dementia with behaviors, delirium, hypertension and hyperlipidemia. The most recent Minimum Data Set assessment was an Admission assessment with an assessment reference date of 10/1/18. The resident had a Brief Interview of Mental Status score of 1 indicating severe cognitive impairment. On multiple occasions, Resident #53 was observed seated near the nursing station sleeping in his wheelchair. Resident #53's PASARR was not located in the clinical record. On 10/11/18, facility staff were asked to provide the document. The document was provided the following day. The PASARR included a fax date of 10/10/18. The PASARR read, "Date PAS Request Received: 9/26/18." The document was requested two days after Resident #53 was admitted to the facility. On 10/12/18 at 10:30 a.m., the Social Worker was asked if the facility had just obtained the PASARR or if it had been in the facility. She stated that it was faxed. The Social Worker was asked where the fax had come from. She stated that she thought it came from the hospital. On 10/12/18, the Administrator was asked where the PASARR had come from. She stated it came from the hospital. She stated that the residents usually come from the hospital with the PASARR, but this one did not come with Resident #53.	F 645	2. All residents currently admitted are at risk. An audit of current residents was completed for Level 1 PASRR. No additional residents were identified. 3. Education provided to the admission director and administrator of PASRR training for Virginia providers of requirement of Level 1 screen prior to admission and policy for PASRR screening process to be completed prior to admission for acceptance to facility. New PASRR request form was developed to notify discharging facility of PASRR copy of Level 1 screen for admission to facility. Admission or designee will contact discharging facility of Level 1 screen omission on admission. New hires for admission will be trained on the preadmission screening process for Virginia PASRR for providers. The DON or license nurse will review new admits during the standard clinical meeting for completion and address identified services in the plan of care. The admission director or license nurse will complete a weekly audit of residents of new admits for PASRR no less than 3 months. 4. The admission director will present the findings of the audit to the QAPI committee monthly for their review and recommendation if deemed necessary. The findings will be reported to the committee until the committee is satisfied sustainable compliance has been achieved.	

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F 656	Continued From page 6	F 656		
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 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	F 656		11/19/18

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F 656	Continued From page 7 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 failed, for one resident (Resident #35) in a survey sample of 26 residents, to complete a comprehensive care plan. 1. For Resident #35, the facility failed to devise a plan for patient-centered activities pertaining to the potential for sensory deprivation and isolation. The findings include: Resident #35, a 94 year old male, was admitted to the facility on 11/01/2016. Diagnoses include hypertension, dementia, gastroesophageal reflux, dysphagia, contractures, and hypothyroidism. Resident #35 has bilateral above-the-knee amputations and receives tube feedings via gastrostomy tube. Resident # 35's most recent quarterly Minimum Data Set (MDS) had an Assessment Reference Date (ARD) of 09/10/2018. Resident #35 did not have a Brief Interview of Mental Status (BIMS) score recorded but cognitive skills for daily decision-making were coded as severely impaired. Hearing ability was coded minimally difficult and vision was coded as severely impaired because eyes do not appear to follow objects. Functional status for mobility was coded as total dependence on staff for performance and support. Activity preferences were not coded.	F 656	This plan of correction constitutes the facilities written allegation of compliance for the deficiencies cited. However, submission of this plan of correction is not an admission that deficiencies exist or that one was cited correctly. The plan of correction is submitted to meet requirements established by federal and state law. 1. Resident #35's activity care plan was developed by the activity director of individualized person-centered activities of his preferences and choices that are important to him. 2. All residents who are dependent on staff for ADL's and activities of interest have the potential to be affected by the practice and care plans will be developed or reviewed/updated following the MDS calendar. 3. Education provided to the activity director of development of person-centered care plan includes measurable objectives and timeframes for all residents with dementia or inability to make needs known, and interviews with family/responsible parties to be completed using the activity assessment form that includes preferences, past hobbies and	

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F 656	Continued From page 8 On 10/10/2018 at 1:40 PM, Resident #35 was observed awake in bed, lying on his back and the head of the bed was elevated approximately 45 degrees. On 10/10/2018 at 4:00 PM, the Resident was observed awake in bed, lying on his back and the head of the bed was elevated approximately 45 degrees. On 10/11/2018 at 8:35 AM, the Resident was observed awake in bed, lying on his back and the head of the bed was elevated approximately 45 degrees. On 10/11/2018 at 11:15 AM, the Resident was observed awake in bed, lying on his back and the head of the bed was elevated approximately 45 degrees. On 10/12/2018 at 8:30 AM, the Resident was observed awake in bed, lying on his back and the head of the bed was elevated approximately 45 degrees. On 10/12/2018 10:00 AM, Registered Nurse (RN) B and two surveyors entered the Resident's room. It was a semi-private room and the Resident's bed was positioned near the window. The privacy curtain was partially drawn which blocked the view of the hallway from the Resident's visual field. The Resident did not have a television or a CD player at his bedside. At no time throughout the survey was the Resident observed out of bed or outside of his room.	F 656	choices of former lifestyle will be utilized to complete a person-centered plan of care. The activity director will complete a weekly audit of care plan development of activity care plans per MDS calendar no less than 3 months. 4. The activity director will present the findings of the audit to the QAPI committee monthly for their review and recommendation if deemed necessary. The findings will be reported to the committee until the committee is satisfied sustainable compliance has been achieved.	

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On 10/12/2018 at approximately 10:45 AM, RN C stated that Resident #35 gets up to the geri-chair "three times a week."

On 10/12/2018 at 2:15 PM, an interview with the Activities Director was conducted. When asked about his activities schedule, the Activities Director stated that the Resident "does not respond to much" and will read to the Resident at times, talk to him and massage his hands. When asked about interventions initiated for in-room activities, the Activities Director stated that she could provide a CD player for him and stated, "I think he likes jazz."

On 10/12/2018, physician's orders were reviewed. There were no current orders pertaining to activities.

The care plan was reviewed. The following includes some problems that were identified for Resident #35:

Resident has "dx (diagnosis) of dementia w/cognitive loss; he is unable to answer questions. (Resident) hollers & yells out at intervals, uses foul language - he is unaware of his actions"

Resident is "dependent on staff for all ADLs (Activities of Daily Living). Complete blindness."

The potential problems of sensory deprivation and isolation related to dependence on staff were not addressed on the care plan. Interventions to provide patient-centered activities in and out of resident's room were not listed on the care plan.

The ADL flow records for September and October

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F 656	Continued From page 10 2018 were reviewed. Transfers (how Resident moves between surfaces including to/from bed and chair) were coded as an "8" (meaning the activity did not occur) on all three shifts in the month of September with the exception of 5 days where the flowchart was blank from lack of documentation. All three shifts in the month of October from 10/01/2018 to 10/11/2018 also coded transfers as an "8". On 10/12/2018, the findings were shared with Administrator and she presented facility activity sheets with dates between 07/02/2018 through 08/12/2018 and documented Resident #35 attended two church services, a bible study, and two exercise sessions in that time frame. No further documentation was offered.	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. (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	F 657		11/19/18

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F 657	Continued From page 11 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 and clinical record review the facility staff failed to revise the care plan for 3 residents (Resident #56, #6, and #13) of 26 residents in the survey sample. 1. Resident #56's care plan did not address pain management. 2. The facility failed to revise the care plan and provide a bed alarm as ordered for Resident # 6. 3. For Resident #13, the facility failed to revise the care plan when the antipsychotic medication was initiated on 09/10/2018. The findings included: 1. Resident #56's care plan did not address pain management. Resident #56, a 91 year old, was re-admitted to the facility on 9/25/18. Diagnoses included hip and rib fracture, osteoarthritis, depression, diabetes, and hypertension. The most recent Minimum Data Set assessment was a quarterly assessment with an assessment	F 657	This plan of correction constitutes the facilities written allegation of compliance for the deficiencies cited. However, submission of this plan of correction is not an admission that deficiencies exist or that one was cited correctly. The plan of correction is submitted to meet requirements established by federal and state law. 1. Resident #56, pain care plan was reviewed and updated with involvement of resident for a person-centered care plan of specific areas of pain and a pain management program including non-pharmacological interventions to manage her pain/discomfort. 2. All residents are at risk for the same practice. All residents with pain medication and coded with pain on the MDS will be audited for person-centered pain care plan. All residents with order for alarming device will be audited for care plan intervention, residents identified will have care plan updated with current physician order. All residents on antipsychotic medications with	

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F 657	Continued From page 12 reference date of 10/2/18. The resident was coded with a Brief Interview of Mental Status score of 13 indicating no cognitive impairment. She was coded to have frequent pain making it hard to sleep and limiting daily activities. On 9/21/18, Resident #56 fell and broke her hip and ribs. She returned to the facility after a four day hospital stay. On 10/10/18 at 1:15 p.m., an interview was conducted with Resident #56. She stated that she fell trying to transfer herself from the recliner to her bed. She stated that she broke her hip. She expressed that she had some pain and that she can not turn herself while in bed. When asked if the staff give her any medication for pain, Resident #56 stated "they give me lots of pills." Resident #56's medication orders were reviewed. The following pain medications were included: 1. (9/25/18) Lidocaine 5% patch apply to rib daily for 14 days. Discontinue 10/10/18. 2. (9/26/18) Oxycodone 5 milligram, take 2.5 milligram by mouth as needed every 6 hours for 5 days for pain. Discontinue 10/1/18. 3. (9/25/18) Tylenol 325 milligram tablet, take 650 milligram by mouth three times a day for 7 days for pelvic pain. Stop 10/2/18. On 10/4/18, the physician assessed Resident #56. The progress note read, "Pt (patient) reports still with pain in pelvis but is better." The assessment/ plan section read, "Pelvis fx (fracture)- pt (patient) is slowly improving. Cont (continue) present meds for pain control." As of the physician assessment on 10/4/18, the pain medications to treat the pelvic fracture had	F 657	psychotropic care plan will be reviewed and care plan updated of current treatment with targeted behaviors and individualize treatment plan including non-pharmacological interventions. 3. Education provided to the interdisciplinary team by certified resident care coordinator of responsibility of development of the plan of care within 7 days of a comprehensive assessment and after each assessment, including both comprehensive and quarterly with resident centered care approaches. Will identify targeted behaviors with non-pharmacological interventions based on resident/responsible party interviews, and prior interests, preferences and behaviors and resolutions per the MDS calendar. Changes to resident's treatment plan will be reviewed during the clinical meeting and care plans updated by the IDT to reflect the changes. MDS staff member or license nurse will audit weekly timely care plan revision of plan care per the Rai guidelines no less than 3 months. 4. The MDS coordinator will present the audit findings to the QAPI committee monthly for the review and recommendation if deemed necessary. The findings will be reported to the committee until the committee is satisfied sustainable compliance has been achieved.	

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been discontinued two days prior. The only pain medication Resident #56 was receiving was a lidocaine patch to her broken rib. A lidocaine patch treats the specific area to which it is applied. The lidocaine patch would not provide pain relief to the pelvic area.

The October 2018 Medication Administration Record (MAR) was reviewed. Pain assessment was documented on the MAR. On 10/1/18, 8:00 a.m., pain was documented as 6. The as needed pain medication was not administered. On 10/4/18, 12:00 a.m., a pain rating of 8 was documented. No pain medication was administered as there was no ordered medications to give. It does not appear that this pain was addressed by facility staff. While a defined pain scale was not documented on the MAR or in the physician orders, pain is usually measured on a scale from 1-10, with 10 indicating the worst pain ever experienced. No further pain was documented on the MAR.

On 10/11/18 at 9:29 a.m., Certified Nursing Assistant A (CNA A) was interviewed. She was assigned to care for Resident #56. When asked if Resident #56 ever complained for pain, CNA A stated that Resident #56 would express being sore after therapy.

Resident #56's physician orders included a therapy order dated 9/26/18: PT (physical therapy) to evaluate and treat as indicated/ PT (physical therapy) services 5 times a week for 14 weeks for therapy exercise/ therapy functional mobility/ gait training with pt (patient) and caregiver education. OT (occupational therapy) to evaluate and seen 5 times a week x 12 weeks for therapy education; therapy activities/

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F 657	Continued From page 14 wheelchair management." Resident #56's care plan was reviewed. The care plan did not address pain management. On 10/12/18 at the end of day meeting, the Administrator and Director of Nursing were notified of the concerns regarding Resident #56's care plan. 2. The facility failed to revise the care plan and provide a bed alarm as ordered for Resident # 6. Resident #6, an 88 year old male was admitted to the facility on 03/27/2018. Diagnoses include coronary artery disease, heart failure, hypertension, peripheral vascular disease, diabetes, dementia, and depression. Resident # 6's most recent quarterly Minimum Data Set (MDS) had an Assessment Reference Date (ARD) of 07/12/2018. Resident #6 did not have a Brief Interview of Mental Status (BIMS) score recorded but cognitive skills for daily decision-making were coded as severely impaired. Functional status for mobility and transfers was coded as total dependence on staff for performance and support. Surface-to-surface transfers were coded as unsteady and only able to stabilize with human assistance. 10/10/2018 4:00 PM The Resident was observed in bed in supine position and the head of the bed was elevated approximately 15 degrees. There were no mats on the floor by the Resident's bed	F 657		

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F 657	Continued From page 15	F 657		

and a bed alarm was not visualized.

10/11/2018 8:40 AM The Resident was observed in bed and there were no mats on the floor by the Resident's bed and a bed alarm was not visualized.

10/11/2018 9:30 AM The Resident was observed in bed sleeping in the supine position and the head of the bed was elevated to approximately 45 degrees. There were no mats on the floor by the Resident's bed and a bed alarm was not visualized.

On 10/11/2018 at approximately 10:30 AM, Admin B, RN B, and two surveyors entered the Resident's room to perform a skin assessment. When Admin B was asked if a bed alarm was on the bed, she inspected the bed, looked under the Resident, felt the sheets under Resident, and stated that there was not a bed alarm on the bed.

On 10/11/2019, physician's orders were reviewed. An order written on 09/13/2018 at 4:30 PM states, "Bed alarm (pressure) Pad floor on Resident's left side when pad available". An order dated 10/02/2018 stated "Bed alarm at all times. Check function every shift. "

The care plan was reviewed. Resident was identified as at risk for falls and injury secondary to dependence on others for mobility. The care plan was not revised to include bed alarm at all times.

Nurse's notes were reviewed. All entries on the nurse's notes from 10/02/2018 through 10/10/2018 did not document that Resident had a bed alarm in place.

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On 10/12/2018, the Administrator and the DON were notified and they offered no further information.

3. For Resident #13, the facility failed to revise the care plan when the antipsychotic medication was initiated on 09/10/2018.

Resident #13, an 80 year old female, was admitted to the facility on 04/28/2018. Diagnoses include hypertension, dementia, depression, mixed anxiety disorders, and psychotic disorder (other than schizophrenia).

Resident #13's most recent quarterly Minimum Data Set (MDS) had an Assessment Reference Date (ARD) of 08/02/2018. Resident #13 was coded with a Brief Interview of Mental Status (BIMS) score of 3 out of 15 indicative of severely impaired cognitive skills. Behaviors such as hallucinations and delusions were coded as not occurring. Physical and verbal behaviors toward others were coded as not being exhibited. Functional status for mobility and transfers was coded as total dependence on staff.

The physician's orders were reviewed. The Resident has an order for Risperdal 1 mg twice a day for "psychosis, anxiety, and delusion paranoid". The order was initiated 09/10/2018.

The care plan dated 08/09/2018 was reviewed. There were no targeted behaviors addressed on the care plan. The care plan did not have any non-pharmacological interventions for behaviors of yelling. An entry dated 06/07/2018 states

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F 657	Continued From page 17 "Severe aggitation (sic) + anxiety" was crossed out. An entry dated 06/08/2018 stated "Dr. Anderson D/C medication and ordered antipsychotic to help with aggitation (sic) and anxiety." An entry dated 06/24/2018 states, "Resident continues to holler + agitate other residents" was crossed out and stated "Resolved" and dated 08/09/2018. On 10/12/2018 at 11:50 AM in an interview with the DON, she stated that facility staff wants to meet quarterly to review information on all residents receiving psychoactive medications. On 10/12/2018, the Administrator and DON were notified of concerns and they offered no further documentation or information.	F 657		
F 679 SS=D	Activities Meet Interest/Needs Each Resident CFR(s): 483.24(c)(1) §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, record reviews, and facility documentation, the facility failed to assess and provide on-going resident-centered activities for one Resident (Resident #35) out of a sample of 26 residents.	F 679	This plan of correction constitutes the facilities written allegation of compliance for the deficiencies cited. However, submission of this plan of correction is not an admission that deficiencies exist or	11/19/18

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F 679	Continued From page 18 Resident #35 was observed to be in his room for 3 days without getting out of bed and with no meaningful activities provided. In addition, between 07/02/2018 through 08/12/2018 the resident only attended two church services, a bible study, and two exercise sessions. The findings included: Resident #35, a 94 year old male, was admitted to the facility on 11/01/2016. Diagnoses include hypertension, dementia, gastroesophageal reflux, dysphagia, contractures, and hypothyroidism. Resident #35 has bilateral above-the-knee amputations and receives tube feedings via gastrostomy tube. Resident # 35's most recent quarterly Minimum Data Set (MDS) had an Assessment Reference Date (ARD) of 09/10/2018. Resident #35 did not have a Brief Interview of Mental Status (BIMS) score recorded but cognitive skills for daily decision-making were coded as severely impaired. Hearing ability was coded minimally difficult and vision was coded as severely impaired because eyes do not appear to follow objects. Functional status for mobility was coded as total dependence on staff for performance and support. Activity preferences were not coded. On 10/10/2018 at 1:40 PM, Resident #35 was observed awake in bed in supine position and the head of the bed was elevated approximately 45 degrees. On 10/10/2018 at 4:00 PM, Resident #35 was observed in bed.	F 679	that one was cited correctly. The plan of correction is submitted to meet requirements established by federal and state law. 1. The activity director completed a new assessment for resident #35 that addresses his preferences and choices in areas of interest that are important to him. 2. All residents who are dependent on staff for ADL's and activities of interest have the potential to be affected by the practice and new assessments will be completed following the MDS calendar. 3. An audit was completed by the activities director and social services director for all residents with dementia or inability to make needs known, and interviews with family/responsible parties to be completed using the activity assessment form that includes preferences, past hobbies and choices of former lifestyle. 4. The activity director will review audit results in the monthly QAPI meeting, and the committee to discuss/review for ongoing audits if thresholds are not met.	

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F 679	Continued From page 19 On 10/11/2018 at 8:35 AM, Resident #35 was observed awake in bed in the supine position and the head of the bed was elevated approximately 45 degrees. On 10/11/2018 at 11:15 AM, Resident #35 was observed in bed. On 10/12/2018 at 8:30 AM, Resident #35 was observed awake in bed in supine position and the head of the bed elevated approximately 45 degrees. At no time throughout the survey was the Resident observed outside of his room. On 10/12/2018 at 2:15 PM, an interview with the Activities Director was conducted. When asked about his activities schedule, the Activities Director stated that the Resident "does not respond to much" and will read to the Resident at times, talk to him and massage his hands. When asked about interventions initiated for in-room activities, the Activities Director stated that she could provide a CD player for him and stated, "I think he likes jazz." The care plan was reviewed. Needs pertaining to activities were not specifically addressed. On 10/12/2018, the findings were shared with Administrator and she presented facility activity sheets with dates between 07/02/2018 through 08/12/2018 and documented Resident #35 attended two church services, a bible study, and two exercise sessions in that time frame. No further documentation was offered.	F 679		
F 684	Quality of Care	F 684		11/19/18

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F 684 SS=D	Continued From page 20 CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility documentation and clinical record review, the facility staff failed to ensure the highest practicable well being for 1 resident (Resident #25) in a survey sample of 26 residents. Resident #25 did not have on her physician ordered TEDS (clot preventing/treatment of edema) stockings during the days of survey. The findings included: Resident # 25 was admitted to the facility 8-14-17. Her diagnoses included but were not limited to: high blood pressure, dementia and arthritis. Resident #25's most recent MDS (minimum data set) with an ARD (assessment reference date) of 8-21-18 was coded as an admission assessment. Resident #25 was coded as having a BIMS (Brief Interview for Memory Status) Score of "2" out of 15 indicating severe cognitive impairment. She was coded as needing extensive to total assistance of one staff member to perform her activities of daily living.	F 684	This plan of correction constitutes the facilities written allegation of compliance for the deficiencies cited. However, submission of this plan of correction is not an admission that deficiencies exist or that one was cited correctly. The plan of correction is submitted to meet requirements established by federal and state law. 1. Resident #25's TED stockings were ordered and applied per MD order. 2. MD orders were reviewed for any other residents with TED stockings ordered to ensure compliance. All warfarin residents were also audited for any other special needs to ensure compliance. 3. Each new MD order will be reviewed in the daily morning meeting for transcription and application of the new special need on the MAR. Risk manager will audit equipment/treatment needs three times per week for 30 days to ensure compliance with new orders. An in-service	

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F 684	Continued From page 21 On 10/10/18 at 12:58 PM: Resident #25 was observed in the dining room. There were no TED stockings in place. Review of the active physician's order dated 10-26-17 revealed the following order: "Apply TED hose in AM and remove in PM. Inspect skin two times a day." Review of Resident #25's care plan dated 8-21-18 revealed the following: "Receives Warfarin (blood thinner) due to history of lower extremity DVT (deep vein thrombosis-blood clot) , at risk for additional thrombus (clot) formation." Interventions included: TED hose as ordered, place on in AM, remove at hs (hour of sleep) daily." On 10/12/18 at 10:17 AM, Resident #25 was observed in activities asleep. Lap buddy was off, had on regular socks, no TEDS. On 10/12/18 at 10:21 A, RN (registered nurse) B was questioned about the use of TED stockings. She stated: "Yes, she is supposed to have TEDS, I just measured her for them." On 10/12/18 at 4:46 PM, the Administrator and DON (director of nursing) were notified of above findings.	F 684	was completed 11/8/18 for licensed staff on the need to ensure transcription and follow through for each new MD order. 4. Risk manager to bring results to the monthly QAPI meeting for review. The results will be discussed by the committee monthly until set thresholds are met.	
F 686 SS=G	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that-	F 686		11/19/18

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F 686	Continued From page 22 (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 (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. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and clinical record review the facility staff failed to prevent and treat pressure wounds for 2 residents (Resident #1 and #35) of 26 residents in the survey sample resulting in harm for Resident #1. 1. For Resident #1, the facility did not provide an air mattress for four months, did not administer a physician order for Flagyl (antibiotic) for nine days and did not obtain a wound consult until ten days after it was ordered by the physician. This resulted in harm. 2. For Resident #35, the facility failed to provide interventions to prevent pressure injuries. Resident #35 had three deep fingernail indentations in the right palm of the Resident's hand that had contractures. The findings included: 1. For Resident #1, the facility did not provide an air mattress for four months, did not administer a physician order for Flagyl (antibiotic) for nine days and did not obtain a wound consult until ten days after it was ordered by the physician. This resulted in harm.	F 686	This plan of correction constitutes the facilities written allegation of compliance for the deficiencies cited. However, submission of this plan of correction is not an admission that deficiencies exist or that one was cited correctly. The plan of correction is submitted to meet requirements established by federal and state law. 1. Resident #1 received the air mattress, and completed the Flagyl. The current wound orders were reviewed and revised as needed to ensure all components of the order were accurate. Licensed staff, involved in the orders for resident #1, air mattress, Flagyl and wound consults were counseled regarding order transcription and follow through. A rehab referral was completed for resident #35 to ensure accurate contracture treatment is provided and meets resident needs. 2. All other residents with wounds and contractures have the potential to be affected by the practice and a physician order audit was completed by the	

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F 686	Continued From page 23 Resident #1 was admitted to the facility on 4/5/18. Diagnoses included dementia, dysphagia, depression, protein calorie malnutrition and Alzheimer's disease. The most recent Minimum Data Set assessment was a quarterly assessment with an assessment reference date of 7/9/18. The resident had a Brief Interview of Mental Status score of 3 indicating severe cognitive impairment. She required extensive assistance with activities of daily living. On 10/10/18, Resident #1 was observed lying in bed. When asked if she had a wound, Resident #1 stated no. When asked if she had any pain, Resident #1 stated no. On 10/12/18 at 10:05 a.m. Resident #1's right hip wound was observed by Surveyor #1. The wound was clean and red around the edges, no drainage and measured approximately 2 cm x 5 cm. The right hip wound was originally identified on 4/6/18 as a stage 2 wound to the right hip that was present when she was re-admitted from the hospital to the facility. The wound was documented in the clinical record as follows: 4/6/18: "Wound Assessment Record" read, Stage 2 right hip wound, 100% excoriation, small amount of serous drainage measuring 14.0 x 7.0 x 0.1 centimeters (cm). The assessment included treatment orders that read, "Orders per hospice Nurse to Clean with normal saline, pat dry and apply foam dressing." This order was included on the April 2018	F 686	DON/ADON for any additional pressure sore orders that may have been overlooked or delayed. 3. An in-service was held 11/8/18 for licensed staff and nurse managers regarding the importance of timely order transcription and follow up. Weekly wound rounds to be completed by the nurse management team including DON/designee. The DON/ADON will ensure all new orders are reviewed in the morning meeting and audit for follow up as needed. Rehab to audit for contracture management and screen/treat residents as needed for contracture management. New admission charts will be reviewed within 24hr by nurse manager/supervisors to ensure completion, transcription and timely implementation is in place. High risk residents or residents with wounds will be reviewed for any necessary preventative measure. The DON/designee will complete audits of wound orders weekly for compliance. 4. The DON/designee will report audit findings and summary to the QAPI committee until thresholds for compliance are met.	

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Medication Administration Record (MAR) as "Right hip, ankle apply foam drsg daily, excoriation to buttock apply zinc barrier cream PRN (as needed) diaper change." This entry on the MAR does not include the part of the order that read, "clean with normal saline." While this entry on the MAR was signed off on daily, it is unclear which of the treatments were performed as it includes multiple treatments for multiple areas on the body.

4/9/18: Hospice nursing note read, "Drsgs dated 4/8/18. Reapply RT (right) ankle dressings as it not secure. Discuss care with staff nurse (name)."

4/11/18: Facility nursing note read, "resident wounds evaluated and treated per hospice nurse week of 4-11-> 4-18-18 prior to staff nurse for evaluation. Hospice nurse (name) discussed POC (plan of care) + reports overall improved, right trochanter (hip) unstageable."

4/12/18: Hospice nursing note read, "Wound care performed. The largest wound on the right hip appears to be improving. Appears dry and smaller in size. Other wounds appear to be improving as well. "

4/15/18: Physician progress note read, "called to see pt (patient) for R trochanter area wound. large eschar- boggy- malodorous. DX (diagnosis) Large decubitus R hip. P (plan)- wound care consult- Flagyl topical."

According to the April 2018 MAR, the Flagyl was not started until 4/24/18, nine days after it was ordered by the physician. The wound consult was not completed until 4/25/18, 10 days after it

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was ordered.

4/15/18: Facility nursing note read, "1420- (doctor name) in N.O. (new order). The new orders address changes to current medications. The note did not include the orders for the Flagyl or the wound consult.

4/16/18: Hospice nursing note read, "Wound care performed, 3 sites closed. RT (right) hip has 75% eschar."

4/23/18: Hospice nursing note read, "Right hip wound has drainage and odor order obtained for Flagyl 250 mg (milligram) crush to win (sic) site daily."

4/24/18: Hospice nursing note read, "Rt hip wound has eschar and drainage with odor, began Flagyl crushed to wound. Other wounds have closed."

4/25/18: Wound Care Physician progress note read, "Patient has a wound on their hip." "She presents with an unstageable (due to necrosis) of the right hip of at least 1 days duration. There is heavy serous exudate. There is no indication of pain associated with this condition." The wound measured 9 x 5 x not measurable. The wound was described with heavy serous exudate and 100% eschar. Flagyl powder once daily for 30 days was ordered for the treatment.

4/25/18: "Wound Assessment Record" read, Unstageable due to slough/eschar. Wound bed= 100% eschar. Measurements 9 cm x 5 cm. Drainage= Sanguineous, large. Infection= yes. Symptoms of infection= increased drainage, malodorous or purulent drainage. Pain with

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wound/ treatment= Yes. Pain Intensity= grimacing. Pain management= effective.

According to the April 2018 MAR, Resident #1 had an order for Tylenol liquid 650 milliliters via peg tube every 4 hours as needed for pain. She was administered this medication on two occasions, 4/14/18 and 4/17/18. She did not receive any pain medication on 4/25/18.

On 10/12/18 at 10:40 a.m., the Assistant Director of Nursing (ADON) was asked which days of the week the wound care doctor came to the facility. She stated he came every Wednesday. The ADON was asked to verify the dates that the wound care doctor came to the facility in April 2018. She showed the survey team progress notes documenting that the wound care doctor had been at the facility every Wednesday in April, to include Wednesday, 4/18/18.

The wound care doctor did not assess Resident #1 on 4/18/18.

On 10/12/18 at 12:25 p.m. Resident #1's hip wound was reviewed with the Director of Nursing (DON). It was reviewed that the physician ordered Flagyl and a wound care consult on 4/15/18 and neither intervention was implemented timely. The DON was asked how an order in a physician progress note was implemented. The DON stated that the doctor did not write his own orders, rather the doctor would flag his order in the chart. It was the responsibility of the unit nurse to transcribe the order from the physician's progress note. She stated that there was a delay in treatment for the Flagyl and she would find out why. It was also reviewed with the DON that the wound care

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doctor had been in the facility on 4/18/18 and did not assess Resident #1. The DON was asked to provide all information related to Resident #1's hip wound to include treatments, assessments and interventions in place to manage skin care.

The DON stated that the previous ADON was the facility's wound care nurse. The previous ADON left her position on 4/7/18. The current DON started working at the facility on 4/9/18 in the ADON position. On 5/7/18, the previous DON left her position and the current DON (who had been hired for the ADON position) moved into the DON role. A new ADON was hired on 8/1/18. This change in nurse staffing and loss of the wound care nurse occurred around the same time that Resident #1 was identified with the right hip wound.

Resident #1's care plan was reviewed. The skin care plan was dated 3/13/18 and was in place before Resident #1 had gone out to the hospital. It read, "(resident) is @ risk for skin breakdown r/t (related to) incontinence & pressure ulcer r/t (related to) decreased mobility. Handwritten on the document was an entry for 4/5/18 that read, "(resident) has 5 PU (pressure ulcers) upon admission from hospital- see assessment." The approaches/ interventions read, use moisture for dry skin, report new areas, weekly skin assessment, assist resident to turn, treatment as ordered- see MAR and perineal care. A new approach dated 4/6 was handwritten on the document. This approach read, "Follow skin care orders from ____ Hospice- see orders air loss mattress to bed- check function + placement every shift."

4/6/18 physician order read, "Hospice to order air

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mattress." The order was discontinued on 8/23/18.

8/23/18 physician order read, "Hospice provided AIR MATTRESS overlay settings at 120 for pressure relief at all times. Check placement and setting each shift."

The "Hospice Certification and Plan of Care" document was reviewed. The hospice nurse signed that verbal plan of care instructions were provided on 4/6/18 and the provider (facility) received the document on 4/10/18. Section 14 "DME (durable medical equipment) and Supplies" read, "Supplies: dietary supplies, feeding bags, feeding machine, gloves." The air mattress is not listed as an item supplied by the hospice company. The air mattress is not discussed in the hospice plan of care.

The air mattress was not included on the April 2018 MAR or TAR. As the air mattress was re-ordered on 8/23/18, it appears that this is the first date the air mattress was implemented for Resident #1. The air mattress was included on the October 2018 MAR. The entry read, "Hospice provided air mattress overlay settings at 120 for pressure relief at all times Check placement and settings each shift."

In summary, Resident #1 was re-admitted to the facility from the hospital with a stage 2 wound to the right hip. The facility did not implement the air mattress ordered on 4/6/18. On 4/11/18, the wound was documented as unstageable. On 4/15/18, the wound was documented by the physician to have an odor indicating that an infection was present. The physician ordered the antibiotic Flagyl and it was not implemented for

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nine days. The doctor also ordered a wound consult. On 4/16/18, the hospice nurse documented that the wound had 75% eschar. On 4/23/18, the hospice nurse documented that the wound had drainage and odor (indicating infection was present). The antibiotic Flagyl was started on 4/24/18. The wound doctor was at the facility on 4/18/18 and did not assess Resident #1. The wound doctor assessed the resident the following week on 4/25/18, ten days after the consult was ordered. The wound care doctor described the wound as 100% eschar with heavy serous exudate. On 4/25/18, the facility staff described the wound as having an infection with symptoms described as increased drainage and malodorous or purulent drainage. As facility staff did not implement physician ordered interventions, Resident #1's wound progressed from a stage 2 wound to an infected, unstageable wound with 100% eschar.

2. For Resident #35, the facility failed to provide interventions to prevent pressure injuries. Resident #35 had three deep fingernail indentations in the right palm of the Resident's hand that had contractures.

Resident #35, a 94 year old male, was admitted to the facility on 11/01/2016. Diagnoses include hypertension, dementia, gastroesophageal reflux, dysphagia, contractures, and hypothyroidism. Resident #35 has bilateral above-the-knee amputations and receives tube feedings via gastrostomy tube.

Resident # 35's most recent quarterly Minimum Data Set (MDS) had an Assessment Reference

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Date (ARD) of 09/10/2018. Resident #35 did not have a Brief Interview of Mental Status (BIMS) score recorded but cognitive skills for daily decision-making were coded as severely impaired. Functional status for mobility was coded as total dependence on staff for performance and support.

On 10/10/2018 at 1:40 PM, Resident #35 was observed awake in bed in supine position and the head of the bed was elevated approximately 45 degrees. It was noted Resident had closed fists and arms were flexed consistent with contractures. Hand padding was not visualized.

On 10/10/2018 at 4:00 PM, Resident #35 was observed in bed.

On 10/11/2018 at 8:35 AM, Resident #35 was observed awake in bed in the supine position and the head of the bed was elevated approximately 45 degrees. No hand padding was visualized.

On 10/11/2018 at 11:15 AM, Resident #35 was observed in bed.

On 10/12/2018 at 8:30 AM, Resident #35 was observed awake in bed in supine position and the head of the bed elevated approximately 45 degrees.

On 10/12/2018 10:00 AM, Registered Nurse (RN) B and two surveyors entered the Resident's room. RN B performed a skin assessment. No open areas or rashes were visualized. Both of Resident's arm and hands had contractures with flexed elbows and closed fists. RN stated it was difficult to extend Resident's fingers. Two surveyors observed three deep fingernail imprints

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F 686	Continued From page 31 on Resident's right palm when RN extended right fingers. No breaks in skin were observed but noted an odor when Resident's fists were opened. On 10/12/2018 at approximately 10:25 AM, an interview with certified nursing assistant (CNA) A was conducted. When asked about hand padding, the CNA stated they tried washcloths but 'they don't stay' stated the washcloths 'come out and get all over the bed.' On 10/12/2018, physician's orders were reviewed. There were no current orders pertaining to assessment or interventions associated with contractures. The care plan was reviewed. Risk for skin breakdown is on the care plan, but measures to prevent pressure injury from contractures was not addressed in the care plan. The nursing weekly summaries were reviewed. Copies of nurse's notes for the months of August, September, and October 2018 were requested of facility staff. The facility provided nine nursing weekly summary documents dated from 08/02/2018 to 09/29/2018. All of the summaries document skin as dry and intact but none of the summaries document skin assessment associated with contractures of arms and hands. On 10/12/2018, the findings were shared with Administrator and the DON. No further documentation was offered.	F 686		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2)	F 689		11/19/18

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F 689	Continued From page 32 §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and clinical record review the facility staff failed to provide toileting supervision and implement fall interventions for 2 residents (Resident #56, #6) of 26 residents in the survey sample. 1. Resident #56 required total dependence of one staff while toileting. She was observed alone on the toilet in her room. 2. For Resident #6, the facility failed to implement a bed alarm as a fall intervention. The findings included: 1. Resident #56 required total dependence of one staff while toileting. She was observed alone on the toilet in her room. Resident #56, a 91 year old, was re-admitted to the facility on 9/25/18. Diagnoses included hip and rib fracture, osteoarthritis, depression, diabetes, and hypertension. The most recent Minimum Data Set assessment was a quarterly assessment with an assessment reference date of 10/2/18. The resident was coded with a Brief Interview of Mental Status score of 13 indicating no cognitive impairment.	F 689	This plan of correction constitutes the facilities written allegation of compliance for the deficiencies cited. However, submission of this plan of correction is not an admission that deficiencies exist or that one was cited correctly. The plan of correction is submitted to meet requirements established by federal and state law. 1. Resident #56 had a new bowel and bladder assessment completed. Resident #6 was reassessed by the interdisciplinary team and appropriate fall interventions were applied. 2. Any residents with fall interventions and bladder training programs are at risk for the same practice and all current orders for interventions and bladder programs were reviewed. 3. The interdisciplinary team consisting of rehab, DON/nursing, MDS and risk manager will review each MD order for interventions and bladder programs and ensure compliance. The team will review each new MD order in the daily morning meeting for transcription and application	

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F 689	Continued From page 33 She was coded to require total dependence of one staff person while toileting. It was coded that a urinary and bowel toileting program were being used. On 9/21/18, Resident #56 fell and broke her hip and ribs. She returned to the facility after a four day hospital stay. Some of the falls Resident #56 sustained at the facility involved the resident trying to toilet herself and falling on the way to the bathroom. According to the fall care plan, a new intervention dated 9/30/18 was added to the care plan to address Resident #56's toileting needs. The intervention read, Restorative for bowel and bladder every 2 hours. Therapy to look at wheelchair for comfort/ appropriate use. Continue all fall interventions. A signed telephone order dated 10/1/18 was located in the record. The order read, "Schedule Bowel + Bladder Q (every) 2 hours while awake. Restorative to do 7-3. Document on B + B sheet." On 10/11/18 at 9:29 a.m., Resident #56 was observed on the toilet in her room alone. No staff were present in the room. While this surveyor was standing in the hall outside of Resident #56's room, CNA A was observed to exit the room next to Resident #56's room. CNA A assisted the resident who lived in the room to walk down the hall and off the unit. After she was done helping the other resident, CNA A returned to help Resident #56 in the bathroom. On 10/12/18 at 10:12 a.m., Certified Nursing Assistant A (CNA A) was interviewed. She was	F 689	on the MAR. Risk manager will audit equipment/treatment needs three times per week for 30 days to ensure compliance with new orders. An in-service was completed on 11/8/18 for licensed staff on the need to ensure transcription and follow through for each new MD order. 4. Risk Manager to bring audit results to the monthly QAPI meeting for review. The results will be discussed by the committee monthly until set thresholds are met.	

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assigned to care for Resident #56. When asked if Resident #56 was on a toileting program , CNA A stated yes. When asked how often she provided care for Resident #56, CNA A stated every four hours. When asked what type of care was provided, CNA A stated she helped the resident go to the bathroom. When asked where the resident usually went to the bathroom, CNA A stated that the resident went in her room. CNA A stated that there used to be a bedside commode in the resident's room, but Resident #56 preferred to use the regular toilet. CNA A stated that during the time of the interview, Resident #56 was in therapy but the staff tried to keep her in activities or at the nursing station.

CNA A was asked how much assistance Resident #56 needed to use the toilet. CNA A stated she used the gait belt to help Resident #56 transfer to the toilet. CNA A stated that she would leave the resident on the toilet and wait in the room. It was reviewed with CNA A that Resident #56 was observed alone in her room on the toilet on 10/11/18 while CNA A was helping the resident in the next room. CNA A stated that she never went further than room 184, a room over from Resident #56.

At the end of day meeting on 10/12/18, the Administrator and Director of Nursing (DON) were notified of the concern that Resident #56 was left alone on the toilet in her room. It was reviewed that Resident #56 was coded to need total dependence of one staff for toileting needs. When asked if Resident #56 should be left alone on the toilet, the DON stated that it is best practice to stay with the resident while they are on the toilet.

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2. For Resident #6, the facility failed to implement a bed alarm as a fall intervention.

Resident #6, an 88 year old male was admitted to the facility on 03/27/2018. Diagnoses include coronary artery disease, heart failure, hypertension, peripheral vascular disease, diabetes, dementia, and depression.

Resident # 6's most recent quarterly Minimum Data Set (MDS) had an Assessment Reference Date (ARD) of 07/12/2018. Resident #6 did not have a Brief Interview of Mental Status (BIMS) score recorded but cognitive skills for daily decision-making were coded as severely impaired. Functional status for mobility and transfers was coded as total dependence on staff for performance and support. Surface-to-surface transfers were coded as unsteady and only able to stabilize with human assistance.

The following observations were made:

10/10/2018 4:00 PM The Resident was observed in bed in supine position and the head of the bed was elevated approximately 15 degrees. There were no mats on the floor by the Resident's bed and a bed alarm was not visualized.

10/11/2018 8:40 AM The Resident was observed in bed and there were no mats on the floor by the Resident's bed and a bed alarm was not visualized.

10/11/2018 9:30 AM The Resident was observed in bed sleeping in the supine position and the

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head of the bed was elevated to approximately 45 degrees. There were no mats on the floor by the Resident's bed and a bed alarm was not visualized.

On 10/11/2018 at approximately 10:30 AM, Admin B, RN B, and two surveyors entered the Resident's room to perform a skin assessment. When Admin B was asked if a bed alarm was on the bed, she inspected the bed, looked under the Resident, felt the sheets under Resident, and stated that there was not a bed alarm on the bed.

On 10/11/2019, physician's orders were reviewed. An order written on 09/13/2018 at 4:30 PM states, "Bed alarm (pressure) Pad floor on Resident's left side when pad available". An order dated 10/02/2018 stated "Bed alarm at all times. Check function every shift. "

The care plan was reviewed. Resident was identified as at risk for falls and injury secondary to dependence on others for mobility. The care plan was not revised to include bed alarm at all times.

Nurse's notes were reviewed. All entries on the nurse's notes from 10/02/2018 through 10/10/2018 did not document that Resident had a bed alarm in place.

A nursing note entry timed and dated 09/13/2018 at 2:00 AM states Resident "observed on fall per CNA (certified nursing assistant). Laceration noted to right ear. Cleaned with normal saline and gauze applied." Facility staff monitored Resident post-fall and nurse's notes dated 09/13/2018 through 09/15/2018 documented the bed alarm was in place.

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F 689	Continued From page 37 The Resident Incident Report dated 09/13/2018 was reviewed. The narrative of the incident states, "Resident observed on the floor on the Resident's left side of bed. Rolled out of bed." Immediate post-incident action documented, "Bed alarm applied to bed, left side of patients (sic) floor will be padded when pad available." On 10/12/2018, the Administrator and the DON were notified and they offered no further information.	F 689		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder	F 690		11/19/18

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F 690	Continued From page 38 receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and clinical record review the facility staff failed to implement a toileting program for 1 resident (Resident #56) of 26 residents in the survey sample. Resident #56 was not toileted every 2 hours as ordered. The findings included: Resident #56, a 91 year old, was re-admitted to the facility on 9/25/18. Diagnoses included hip and rib fracture, osteoarthritis, depression, diabetes, and hypertension. The most recent Minimum Data Set assessment was a quarterly assessment with an assessment reference date of 10/2/18. The resident was coded with a Brief Interview of Mental Status score of 13 indicating no cognitive impairment. She was coded to require total dependence of one staff person while toileting. It was coded that a urinary and bowel toileting program were being used. On 9/21/18, Resident #56 fell and broke her hip	F 690	This plan of correction constitutes the facilities written allegation of compliance for the deficiencies cited. However, submission of this plan of correction is not an admission that deficiencies exist or that one was cited correctly. The plan of correction is submitted to meet requirements established by federal and state law. 1. Resident #56 had a new bowel and bladder assessment completed on 11/1/18. 2. Any other incontinent residents have the potential for the same practice and a review was completed for any other current assessments in place indicating a bladder training and toileting program. 3. Each incontinent resident will have a bowl and bladder assessment completed. For those residents who meet the criteria for retraining, a toileting program will be established and followed. Resident status sheets and care plans will be updated to	

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F 690	Continued From page 39 and ribs. She returned to the facility after a four day hospital stay. Some of the falls Resident #56 sustained at the facility involved the resident trying to toilet herself and falling on the way to the bathroom. According to the fall care plan, a new intervention dated 9/30/18 was added to the care plan to address Resident #56's toileting needs. The intervention read, Restorative for bowel and bladder every 2 hours. Therapy to look at wheelchair for comfort/ appropriate use. Continue all fall interventions. A signed telephone order dated 10/1/18 was located in the record. The order read, "Schedule Bowel + Bladder Q (every) 2 hours while awake. Restorative to do 7-3. Document on B + B sheet." On 10/11/18 at 9:29 a.m., Resident #56 was observed on the toilet in her room alone. No staff were present in the room. While this surveyor was standing in the hall outside of Resident #56's room, CNA A was observed to exit the room next to Resident #56's room. CNA A assisted the resident who lived in the room to walk down the hall and off the unit. After she was done helping the other resident, CNA A returned to help Resident #56 in the bathroom. On 10/12/18 at 10:12 a.m., Certified Nursing Assistant A (CNA A) was interviewed. She was assigned to care for Resident #56. When asked if Resident #56 was on a toileting program , CNA A stated yes. When asked how often she provided care for Resident #56, CNA A stated every four hours. When asked what type of care was provided, CNA A stated she helped the	F 690	reflect the toileting program and assistance necessary. Toileting times will be listed on the bowel and bladder flowsheet. The DON/ADON or designee will audit programs for compliance weekly. Licensed nurses and certified nursing assistants were in-serviced on the process. 4. The ADON/RN Supervisor will report audit findings to the monthly QAPI meeting for review. The results will be discussed by the committee monthly until established thresholds are met.	

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resident go to the bathroom. When asked where the resident usually went to the bathroom, CNA A stated that the resident went in her room. CNA A stated that there used to be a bedside commode in the resident's room, but Resident #56 preferred to use the regular toilet. CNA A stated that during the time of the interview, Resident #56 was in therapy but the staff tried to keep her in activities or at the nursing station.

On 10/12/18 at 10:30 a.m., a Restorative Aide was asked if Resident #56 was on a toileting program. The Restorative Aide stated yes. When asked if she toileted Resident #56, the Restorative Aide stated that CNA A toileted the resident during the day. It is noted that the unit CNA (CNA A) was tasked to toilet Resident #56 during the 7-3 shift rather than the restorative staff as indicated in the physician order.

The Restorative Aide was asked to provide documentation of the toileting program. She provided a book that included a chart titled "Bathroom Times" labeled with Resident #56's name. The chart included the days of the month. Each day was broken down into two hour time slots where staff were to initial that toileting occurred.

According to the Bathroom Times form, there was no documentation that toileting occurred on the following dates and times:
10/2/18: 8:00 a.m.
10/3/18: 12:00 p.m. thru 10:00 p.m.
10/4/18: 12:00 p.m. and 2:00 p.m.
10/5/18: 6:00 a.m. thru 2:00 p.m.
10/6/18: 6:00 a.m. thru 2:00 p.m.
10/7/18: this date was not included on the form
10/8/18: 6:00 a.m. thru 2:00 p.m.

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F 690	Continued From page 41 10/9/18: no toileting documented 10/10/18: 10:00 a.m. thru 2:00 p.m. 10/11/18: 8:00 a.m. thru 2:00 p.m. 10/12/18: no documentation as of 10:30 a.m. when the form was copied. On 10/12/18 after the toileting program documents were copied, CNA A approached this surveyor and stated that she misspoke during her earlier interview. CNA A stated that she toilets Resident #56 every two hours. CNA A stated she did not know why she said she toileted the resident every four hours. She stated that she takes the resident to the bathroom four times per shift not every four hours. At the end of day meeting on 10/12/18, the Administrator and Director of Nursing were notified of the concerns regarding Resident #56's toileting program.	F 690		
F 697 SS=D	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and clinical record review the facility staff failed to provide pain management for 1 resident (Resident #56) of 26 residents in the survey sample. Resident #56 expressed having pain but did not have pain management in place.	F 697	This plan of correction constitutes the facilities written allegation of compliance for the deficiencies cited. However, submission of this plan of correction is not an admission that deficiencies exist or that one was cited correctly. The plan of correction is submitted to meet	11/19/18

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F 697	Continued From page 42 The findings included: Resident #56, a 91 year old, was re-admitted to the facility on 9/25/18. Diagnoses included hip and rib fracture, osteoarthritis, depression, diabetes, and hypertension. The most recent Minimum Data Set assessment was a quarterly assessment with an assessment reference date of 10/2/18. The resident was coded with a Brief Interview of Mental Status score of 13 indicating no cognitive impairment. She was coded to require total dependence of one staff person while toileting. She was coded to have frequent pain making it hard to sleep and limiting daily activities. On 9/21/18, Resident #56 fell and broke her hip and ribs. She returned to the facility after a four day hospital stay. On 10/10/18 at 1:15 p.m., an interview was conducted with Resident #56. She stated that she fell trying to transfer herself from the recliner to her bed. She stated that she broke her hip. She expressed that she had some pain and that she can not turn herself while in bed. When asked if the staff given her any medication for pills, Resident #56 stated "they give me lots of pills." Resident #56's medication orders were reviewed. The following pain medications were included: 1. (9/25/18) Lidocaine 5% patch apply to rib daily for 14 days. Discontinue 10/10/18. 2. (9/26/18) Oxycodone 5 milligram, take 2.5 milligram by mouth as needed every 6 hours for 5 days for pain. Discontinue 10/1/18.	F 697	requirements established by federal and state law. 1. Resident #56 pain management program was reviewed and corrected as needed with notification to resident, MD and responsible party. 2. Any resident coded on the MDS as having pain was reviewed by the interdisciplinary team and pain management programs were corrected as needed. 3. The licensed staff were educated by the staff educator on 11/8/18 the facility policy and procedure for pain management program which consist of the appropriate routine pain medication with a PRN for any breakthrough pain according to pain level. The pain flow sheet questions will be used for documentation each shift. The risk manager and social service will interview residents with pain tree times per week for 30 days for pain management and documentation of improved pain relief. 4. Risk manager to bring audit results to the monthly QAPI meeting for review. The results will be discussed by the committee monthly until set thresholds are met.	

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3. (9/25/18) Tylenol 325 milligram tablet, take 650 milligram by mouth three times a day for 7 days for pelvic pain. Stop 10/2/18.

On 10/4/18, the physician assessed Resident #56. The progress note read, "Pt (patient) reports still with pain in pelvis but is better." The assessment/ plan section read, "Pelvis fx (fracture)- pt (patient) is slowly improving. Cont (continue) present meds for pain control."

As of the physician assessment on 10/4/18, the pain medications to treat the pelvic fracture had been discontinued two days prior. The only pain medication Resident #56 was receiving was a lidocaine patch to her broken rib. A lidocaine patch is used to treat the specific area to which it is applied. The lidocaine patch applied to the rib area would not provide pain relief to the pelvic area.

The October 2018 Medication Administration Record (MAR) was reviewed. Pain assessment was documented on the MAR. On 10/1/18, 8:00 a.m., pain was documented as 6. The as needed pain medication was not administered. On 10/4/18, 12:00 a.m., a pain rating of 8 was documented. No pain medication was administered as the as needed pain medication had been discontinued. It does not appear that Resident #56's pain was addressed by facility staff on 10/4/18. While a defined pain scale was not documented on the MAR or in the physician orders, pain is usually measured on a scale from 1-10, with 10 indicating the worst pain ever experienced. No further pain was documented on the MAR.

On 10/12/18 at 10:12 a.m., Certified Nursing

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F 697	Continued From page 44 Assistant A (CNA A) was interviewed. She was assigned to care for Resident #56. When asked if Resident #56 ever complained for pain, CNA A stated that Resident #56 would express being sore after therapy. CNA A stated Resident #56 went to therapy daily. Resident #56's physician orders included a therapy order dated 9/26/18: PT (physical therapy) to evaluate and treat as indicated/ PT (physical therapy) services 5 times a week for 14 weeks for therapy exercise/ therapy functional mobility/ gait training with pt (patient) and caregiver education. OT (occupational therapy) to evaluate and seen 5 times a week x 12 weeks for therapy education; therapy activities/ wheelchair management." Resident #56's care plan was reviewed. The care plan did not address pain management. On 10/12/18 at the end of day meeting, the Administrator and Director of Nursing were notified of the concerns regarding Resident #56's pain management.	F 697		
F 744 SS=E	Treatment/Service for Dementia CFR(s): 483.40(b)(3) §483.40(b)(3) A resident who displays or is diagnosed with dementia, receives the appropriate treatment and services to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, clinical record review and facility documentation review, the facility staff failed to provide dementia care to	F 744	This plan of correction constitutes the facilities written allegation of compliance for the deficiencies cited. However,	11/19/18

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F 744	Continued From page 45 4 Residents (#28, #43, #23, #13) 1. Resident #28 was placed on Seroquel (antipsychotic) 25 mg (milligrams) twice daily for "dementia with behavioral disturbance." There is no appropriate diagnosis for use and the medication is associated with increased risk of death in elderly people with dementia. There are no care plan interventions to address behaviors or for the continued use of an antipsychotic. 2. Resident #43 was placed on Seroquel (antipsychotic) 50 mg (milligrams) twice daily for "dementia without behavioral disturbance." There is no appropriate diagnosis for use and the medication is associated with increased risk of death in the elderly with dementia. There are no care plan interventions to address behaviors or for the continued use of an antipsychotic. 3. For Resident #23, the facility staff failed to assess for behavior triggers (of agitation) and evaluate the effectiveness of non-pharmacologic interventions to minimize unwanted behaviors. 4. For Resident #13, the facility staff failed to assess for triggers for the yelling behavior, develop interventions, and evaluate effectiveness of non-pharmacologic measures related to the behavior of yelling. The Findings included: 1. Resident #28 was placed on Seroquel (antipsychotic) 25 mg (milligrams) twice daily for "dementia with behavioral disturbance." There is no appropriate diagnosis for use and the medication is associated with increased risk of	F 744	submission of this plan of correction is not an admission that deficiencies exist or that one was cited correctly. The plan of correction is submitted to meet requirements established by federal and state law. 1. Residents #28, 43, 23, and 13 had new assessments completed by nursing, activities, and social services to review for targeted behaviors, non-pharmacological interventions and alternatives to antipsychotic drugs. 2. All residents on antipsychotic medications with a dx of dementia are at risk for the same practice. 3. A new monthly meeting was initiated by the interdisciplinary team to discus residents with diagnoses of dementia for targeted behaviors, non-pharmacological interventions based on resident/responsible party interviews, and prior interests, preferences and past behaviors and resolutions. The nursing staff were educated by the facility educator on the care of dementia residents. Licensed staff were educated on 11/8/18 for the policy and procedure for the use of psychotropic medications including appropriate dx, targeted behaviors and non-pharmacological interventions. The interdisciplinary team will review each new physician order for psychotropic medications for appropriate dx in the morning meeting and notify the physician for any discrepancies or alternatives. The DON/ADON will audit	

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F 744	Continued From page 46 death in elderly people with dementia. There are no care plan interventions to address behaviors or for the continued use of an antipsychotic. Resident #28 was a 72 year old who was admitted to the facility on 6/12/17. Resident #28's diagnosis included Dementia with Behavioral Disturbance, Lobar pneumonia, Chronic Kidney Disease, Heart Disease, Type 2 Diabetes Mellitus with hyperglycemia, and Dependence on Renal Dialysis. The Minimum Data Set, an Annual Assessment with an Assessment Reference Date of 6/4/18, coded Resident #28 as not having any behavioral issues. On 10/12/18 a review of Resident #28's clinical record was conducted, revealing a care plan. It read, "Problem onset: 6/4/18, receives psychotropic medication due to diagnosis of psychosis." Psychosis is not an official diagnosis. Resident #28's care plan did not address dementia care and services. On 1/25/18, Resident #28 was seen by a Nurse Practitioner. The report read, "Behavior agitated, oriented to self and place. Speech clear, Denies psychotic symptoms, hallucinations, etc. Disoriented to time and situation, Memory impairment. Denies suicidal and homicidal ideation. Recommendations: Seroquel 25 MG twice daily." On 10/11/18 a review was conducted of facility documentation, revealing a Psychoactive Medication Informed Consent, signed by Resident #28's Responsible Party (Daughter). It read, "1/25/18. A physician has prescribed	F 744	residents currently on antipsychotic medications for appropriateness and discus possible alternatives with physicians for those not meeting the criteria for the medication. 4. The DON to bring audit results to the monthly QAPI meeting for review. The results will be discussed by the committee monthly until established thresholds are met.	

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Seroquel 25 MG 2 times daily. Possible side effects: abnormal movement of facial muscles & tongue, liver failure, muscle pain, depression." The facility failed to inform the Responsible Party of the boxed warning regarding Seroquel. The 2018 Nursing Drug Handbook listed a boxed warning regarding Seroquel. It read, "Drug isn't indicated for use in elderly patients with dementia-related psychosis because of increased risk of death from Cardiovascular Disease of infection."

On 10/11/18 an interview was conducted with the Director of Nursing (Administration B). When asked about possible alternate medications or interventions for dementia care, she stated that she was not aware of any. The facility Administrator (Administration A) was present. No further information was received.

2. Resident #43 was placed on Seroquel (antipsychotic) 50 mg (milligrams) twice daily for "dementia without behavioral disturbance." There is no appropriate diagnosis for use and the medication is associated with increased risk of death in the elderly with dementia. Additionally, there were no care plan interventions to address behaviors or for the continued use of an antipsychotic.

Resident # 43 was admitted to the facility 3-4-17. Her diagnoses included but were not limited to: Stroke, dementia and hemiplegia.

Resident #43's most recent MDS (minimum data set) with an ARD (assessment reference date) of 9-24-18 was coded as a quarterly assessment.

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Resident #43 was coded as having a BIMS (Brief Interview for Memory Status) Score of 9 out of 15 indicating moderate cognitive impairment. She was coded as needing extensive to total assistance of one staff member to perform her activities of daily living. Resident #43 was coded as requiring extensive assistance for eating. There were no behaviors documented for the 7 day look back period.

On 10-12-18, Resident #43 was observed up in her wheelchair at the dining room table. A CNA was in close proximity. There was only soft food on the tray, there were no large chunks of any food served.

On 10/10/18 at 01:39 PM: Review of the clinical record revealed the resident is currently on Seroquel 50 mg twice daily for dementia with behavior disturbance.

On 6/21/18, IDT (interdisciplinary team) notes read (in relating to an incident where the resident hit at another resident the day before): "No observations of any contact behavior with other residents. No injuries. Up in wheelchair attending activities and in dining room with pleasant attidue (sic). No aggressive behaviors observed."

Review of the clinical record revealed on 7-25-18 at 8:30 AM, the resident was "fighting at staff and throwing things, keeps saying don't want it, leave me alone.. behaviors she did quiet down some and medication was given . No more aggressive behaviors noted."

Review of the 7-25-18 IDT notes revealed the following: "Sitting in dining room and began to throw food and drink at others at table...

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Psychoactive medication review was done on 7-24-18 and IDT concluded no changes be made in her medication due to continued hitting swatting at people. No contact made with others." There was no documented attempt to discover triggers/factors to the behavior described above (did not want to take medication) except to continue antipsychotic use of medications.

Review of the care plan dated 7-19-18 documented the resident has diagnosis of depression, psychosis and has "hallucinations of cats in her room- she tries to feed them." No other targeted behaviors were listed. Interventions included:

* Evaluate effectiveness and side effects of medication for possible decrease/elimination of psychotropic drugs
* Monitor pharmacist drug regime review of identification of potential drug interactions
* Monitor interaction of resident with others for appropriateness
* Monitor residents mood state
* Monitor residents behavior in public/private
* Notify MD of changes in mood or behaviors- such as hallucinations. Resident states she feeds cats in her room, she takes food from her trays and places on the floor.
* AIMS (test to check for adverse effects of antipsychotic medications) every 6 months
* Monitor resident's mental status functioning on ongoing basis

The above care plan does not address causative factors and triggers to the behaviors or non pharmacological interventions. There is no plan for dementia care.

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Review of the pharmacy recommendations revealed a GDR (gradual dose reduction) was requested on 4-17-18 and 10-12-17, which were declined by physician.

Review of Nursing Drug Handbook, 2011, pages 984- 986 revealed the following information for Seroquel: "Indications for use: treatment for schizophrenia, acute manic episodes with bipolar disorder." There is a boxed warning for elderly patients with dementia related psychosis, "drug isn't indicated for use because of increased risk of death."

In summary, Resident #43 was prescribed an antipsychotic medication without appropriate diagnosis for use and with an increased risk of death in elderly patients with dementia. There was no GDR of the medication, however, it was continued without adequate documentation of triggered behaviors (except feeding cats) and interventions to address behaviors of residents with dementia.

On 10-12-18 at 4:46 PM, the Administrator and DON (director of nursing) were notified of above findings.

3. For Resident #23, the facility staff failed to assess for behavior triggers (of agitation) and evaluate the effectiveness of non-pharmacologic interventions to minimize unwanted behaviors.

Resident #23, an 86 year old male was admitted to the facility on 11/13/2017. Diagnoses included hypertension, gastroesophageal reflux disease,

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cerebrovascular accident, dementia, depression, and psychotic disorder (other than schizophrenia).

Resident #23 most recent quarterly Minimum Data Set (MDS) had an Assessment Reference Date (ARD) of 08/20/2018. Resident #23 was coded with a Brief Interview of Mental Status (BIMS) score of 3 out of 15 indicative of severely impaired cognitive skills. Behaviors such as hallucinations and delusions were coded as not occurring. Physical behaviors such as hitting, pushing, or grabbing was coded as occurring 1 to 3 days in the quarter. Functional status for mobility and transfers was coded as limited assistance and guidance from staff as Resident is highly involved in self-performance.

The physician's orders from February 2018 to October 2018 were reviewed. An order initiated on 02/12/2018 and current documented "Seroquel 50 mg by mouth daily at bedtime" and coded "F02.80 Dementia in oth diseases classd elsewhr w/o behavrl disturb" (sic).

An order initiated on 02/13/2018 and current documented "Seroquel 25 mg by mouth daily at 1 PM" and coded "F02.80 Dementia in oth diseases classd elsewhr w/o behavrl disturb" (sic). An order initiated on 02/13/2018 documented "Seroquel 25 mg Give one tablet by mouth every morning" and coded "F02.80 Dementia in oth diseases classd elsewhr w/o behavrl disturb" (sic).

The Resident was receiving a total of 100 mg of Seroquel daily.

The physician's progress notes from February

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2018 to October 2018 were reviewed.

An entry dated 02/04/2018 documented "Pt. resting today. Still anxious at times." "A/P (assessment/plan) Dementia - pt overall doing well. Still agitated at times. Is progressing well."

An entry dated 03/03/2018 documented "Pt alert and happy. Not agitated." "A/P Psychosis/Dementia - overall doing well. Still requires meds for agitation."

Subsequent progress notes through October 2018 documented Resident behavior ranging from cooperative to very agitated with plans to continue current med regimen.

Nurse's noted for the month of February 2018 (when the antipsychotic medications were initiated) were requested from facility staff and they presented copies of nurse's notes ranging from 02/11/2018 through 02/28/2018.

An entry dated 02/11/2018 at 5:00 PM documented "No reported aggressive behavior or noted at this time."

Two entries dated 02/12/2018 (Not timed) documented "No aggressive behavior."

An entry dated 02/12/2018 (11-7) documented "Agitated, cursing at times."

An entry dated 02/13/2018 at 4:20 PM documented "No aggressive behavior."

An entry dated 02/13/2018 (11/7) documented "Agitation noted at times."

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Subsequent daily nurse's notes for the month of February 2018 document Resident exhibits no aggressive behaviors.

Nurse's noted for September and October 2018 were requested from facility staff and they presented one page of nurse's notes with entries ranging from 08/04/2018 through 09/03/2018.

An entry dated 08/04/2018 (7-3) documented Resident "very abusive hitting on staff Will cont to monitor for aggressive behavior." A second entry (7-3) by same provider documented Resident "very abusive and hitting at staff refused to stay in chair while trying to clean up bed."

The next entry was dated 09/03/2018 at 6:00 AM and documented "No abusive behavior noted."

An entry dated 09/03/2018 at 1:30 PM documented "Notifying MD of Resident trying to go in another pt room on 09/02/18 and became extremely aggitated (sic) and aggressive putting hands around nurses neck." A second entry by same provider at 2:00 PM documented "Resident has been very quiet and no aggitation (sic) noted today."

Interdisciplinary progress notes ranging from 06/07/2018 through 09/03/2018 were reviewed. The only entry mentioning behaviors was dated 09/03/2018 when Resident was found wandering into another room and documented Resident "became aggitated (sic) when nurse attempted to redirect and hit the nurse. (Resident) was assisted back to his room and remained in his room at that time. No further behaviors noted throughout night by 11-7A nurse."

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The care plan was reviewed. A non-pharmacological intervention for unwanted behaviors lists "attempt to redirect (Resident) during times of unwanted behaviors." A revision dated 01/22/2018 lists "staff will approach calm and if combative, allow time to calm down and re-approach with 2 CNA's."

Assessment of triggers for unwanted behaviors, Resident care preferences (routines, interests, choices) associated with untoward behaviors, and effectiveness of interventions to minimize untoward behaviors are not documented in the care plan or nurse's notes.

On 10/12/2018 at 11:50 AM in an interview with the DON, she stated that facility staff wants to meet quarterly to review information on all residents receiving psychoactive medications.

On 10/12/2018, the Administrator and DON were notified of concerns and they offered no further documentation or information.

4. For Resident #13, the facility staff failed to assess for triggers for the yelling behavior, develop interventions, and evaluate effectiveness of non-pharmacologic measures related to the behavior of yelling.

Resident #13, an 80 year old female, was admitted to the facility on 04/28/2018. Diagnoses include hypertension, dementia, depression, mixed anxiety disorders, and psychotic disorder (other than schizophrenia).

Resident #13's most recent quarterly Minimum Data Set (MDS) had an Assessment Reference

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Date (ARD) of 08/02/2018. Resident #13 was coded with a Brief Interview of Mental Status (BIMS) score of 3 out of 15 indicative of severely impaired cognitive skills. Behaviors such as hallucinations and delusions were coded as not occurring. Physical and verbal behaviors toward others were coded as not being exhibited. Functional status for mobility and transfers was coded as total dependence on staff.

The physician's orders were reviewed. The Resident has an order for Risperdal 1 mg twice a day for "psychosis, anxiety, and delusion paranoid". The order was initiated 09/10/2018.

The care plan dated 08/09/2018 was reviewed. There were no targeted behaviors noted on the care plan. The care plan did not have any non-pharmacological interventions for behaviors of yelling. An entry dated 06/07/2018 states "Severe aggitation (sic) + anxiety" was crossed out. An entry dated 06/08/2018 stated "Dr. Anderson D/C medication and ordered antipsychotic to help with agitation (sic) and anxiety." An entry dated 06/24/2018 states, "Resident continues to holler + agitate other residents" was crossed out and stated "Resolved" and dated 08/09/2018.

The nurse's notes from July 2018 to October 2018 were reviewed. An entry dated 07/01/2018 (11-7) documents "no hollering observed - quiet." An entry dated 07/01/2018 (3-11) documents "resident up in geri-chair - behaving fairly well - ". There were no other entries addressing targeted behaviors.

The nursing weekly summary documents ranging from 08/02/2018 to 10/04/2018 were reviewed.

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F 744	Continued From page 56 Entries dated 08/02/2018, 08/23/2018, 09/06/2018, 09/13/2018, and 10/11/2018 documented "no agitation noted." There were no other entries addressing targeted behaviors. The Medication Administration Record was reviewed for the month of September 2018. Risperdal was administered twice a day but there was no behavior monitoring documentation. A review of a consultation report dated 06/12/2018 was performed. There were no behaviors documented on the consultation and the diagnosis for the use of an antipsychotic medication is "dementia with behavioral disturbance." On 10/12/2018 at 11:50 AM in an interview with the DON, she stated that facility staff wants to meet quarterly to review information on all residents receiving psychoactive medications. On 10/12/2018, the Administrator and DON were notified of concerns and they offered no further documentation or information.	F 744		
F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the	F 756		11/19/18

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F 756	Continued From page 57 facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview facility documentation review, the facility pharmacy failed, for 1 resident (#28) to report irregularities in monthly reviews. 1. For Resident #28 the facility pharmacy failed to identify a contraindication with Seroquel and Dementia. The Findings included:	F 756	This plan of correction constitutes the facilities written allegation of compliance for the deficiencies cited. However, submission of this plan of correction is not an admission that deficiencies exist or that one was cited correctly. The plan of correction is submitted to meet requirements established by federal and state law.	

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F 756	Continued From page 58 Resident #28 was a 72 year old who was admitted to the facility on 6/12/17. Resident #28's diagnosis included Dementia with Behavioral Disturbance, Lobar pneumonia, Chronic Kidney Disease, Heart Disease, Type 2 Diabetes Mellitus with hyperglycemia, and Dependence on Renal Dialysis. The Minimum Data Set, an Annual Assessment with an Assessment Reference Date of 6/4/18, coded Resident #28 as not having any behavioral issues. On 10/12/18 a review of Resident #28's clinical record was conducted, revealing a care plan. It read, "Problem onset: 6/4/18, receives psychotropic medication due to diagnosis of psychosis." Psychosis is not an official diagnosis. Resident #28's care plan did not address dementia care and services. On 1/25/18, Resident #28 was seen by a Nurse Practitioner. The report read, "Behavior agitated, oriented to self and place. Speech clear, Denies psychotic symptoms, hallucinations, etc. Disoriented to time and situation, Memory impairment. Denies suicidal and homicidal ideation. Recommendations: Seroquel 25 MG twice daily." Resident #28's clinical record contained monthly pharmacy reviews for the past 12 months. None of the pharmacy reviews cited the boxed Warning for Seroquel. The 2018 Nursing Drug Handbook listed a boxed warning regarding Seroquel. It read, "Drug isn't indicated for use in elderly patients with	F 756	1. Pharmacist reviewed resident #28 for drug irregularity with the use of Seroquel. 2. All residents with drug irregularities have the potential to be affected by the practice and the pharmacist completed a full house audit for any missed irregularities since last visit. 3. In-service completed 11/8/18 for licensed nurses regarding the consent and education for psychotropic medications with black box warning by the facility pharmacist. The education is to be completed and documented prior to the consent being signed. The medical director will send a letter to all physicians and nurse practitioners regarding the regulation and addressing pharmacy consultant recommendations for antipsychotics with black box warnings, and the appropriate diagnoses and use of those medications that have black box warnings. An audit of all antipsychotic medications was completed 10/31/18 by the DON/ADON, pharmacist and medical director for appropriate diagnoses and corrections made as needed including new consent and responsible party education. 4. The DON will review audit results in the monthly QAPI meeting and the committee with results summarized with further monitoring to be decided by the QAPI committee if thresholds are not met.	

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F 756	Continued From page 59 dementia-related psychosis because of increased risk of death from Cardiovascular Disease of infection." On 10/11/18 an interview was conducted with the Director of Nursing (Administration B). When asked about possible alternate medications or interventions for dementia care, she stated that she was not aware of any. The facility Administrator (Administration A) was present. They were informed of the findings regarding the pharmacy reviews. No further information was received.	F 756		
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	F 758		11/19/18

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F 758	Continued From page 60 behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on observation, facility staff interview, clinical record review, and facility documentation review, the facility staff failed for 5 Residents (Resident #23, #13, #28, #53, #43) in a sample of 26 residents to ensure they were free from unnecessary psychotropic medications. 1. For Resident #23, the facility staff failed to ensure he was free from the psychotropic medication Seroquel which is not indicated for residents with the diagnosis of dementia with or without behavioral disturbances.	F 758	This plan of correction constitutes the facilities written allegation of compliance for the deficiencies cited. However, submission of this plan of correction is not an admission that deficiencies exist or that one was cited correctly. The plan of correction is submitted to meet requirements established by federal and state law. 1. Residents #28, 43, 23, 53, and 13 had new assessments completed by nursing, activities and social service to review for	

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F 758	Continued From page 61 2. For Resident #13, the facility staff failed to ensure she was free from the psychotropic medication Risperdal which is not indicated for residents with a diagnosis of dementia with behavioral disturbance. 3. For Resident #28, the facility staff failed to ensure that he was free of Seroquel, which according to the Black Box Warning, is not indicated for use in residents with Dementia-related psychosis. 4. Resident #53 was administered Seroquel (antipsychotic medication) without an appropriate supporting diagnosis. 5. Resident #43 did not have an appropriate diagnosis for the use of Seroquel (antipsychotic) and did not address or target behaviors requiring the use. The findings included: 1. For Resident #23, the facility staff failed to ensure he was free from the psychotropic medication Seroquel which is not indicated for residents with the diagnosis of dementia with or without behavioral disturbances. Resident #23, an 86 year old male was admitted to the facility on 11/13/2017. Diagnoses included hypertension, gastroesophageal reflux disease, cerebrovascular accident, dementia, depression, and psychotic disorder (other than schizophrenia). Resident #23 most recent quarterly Minimum Data Set (MDS) had an Assessment Reference Date (ARD) of 08/20/2018. Resident #23 was	F 758	targeted behaviors, non-pharmacological interventions and alternatives to antipsychotic drugs. Behavior monitoring is in place for all psychotropic medications per regulatory guidelines. 2. All residents on psychotropic medications with a dx of dementia are at risk for the same practice and monthly psychotropic meeting to be held starting 10/31/18. 3. In-service completed 11/8/18 by the facility pharmacist for licensed nurses, and the interdisciplinary team regarding education for psychotropic medications which includes: black box warnings, targeted behaviors, PRN usage, correct dx, appropriate monitoring of behaviors and side effects, resident/responsible party education and consent. The medical director will send a letter to all physicians and nurse practitioners regarding the regulation, addressing pharmacy consultant recommendations for psychotropics, black box warnings, appropriate diagnoses, and PRN usage. An audit of all antipsychotic medications was completed 10/31/18 by the DON/ADON, pharmacist and medical director for appropriate diagnoses. Any PRN psychotropic medications were discontinued or used for no longer than 14 days with appropriated physician documentation. MDS to update care plans. 4. The DON will review audit results in the monthly QAPI meeting and the committee	

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F 758	Continued From page 62 coded with a Brief Interview of Mental Status (BIMS) score of 3 out of 15 indicative of severely impaired cognitive skills. Behaviors such as hallucinations and delusions were coded as not occurring. Physical behaviors such as hitting, pushing, or grabbing was coded as occurring 1 to 3 days in the quarter. Functional status for mobility and transfers was coded as limited assistance and guidance from staff as Resident is highly involved in self-performance. The PASARR dated 10/23/17 was reviewed which indicated that the Resident did not have a serious mental illness such as schizophrenia or other psychotic disorder. The physician's orders from February 2018 to October 2018 were reviewed. An order initiated on 02/12/2018 and current documented "Seroquel 50 mg by mouth daily at bedtime" and coded "F02.80 Dementia in oth diseases classd elsewhr w/o behavrl disturb" (sic). An order initiated on 02/13/2018 and current documented "Seroquel 25 mg by mouth daily at 1 PM" and coded "F02.80 Dementia in oth diseases classd elsewhr w/o behavrl disturb" (sic). An order initiated on 02/13/2018 documented "Seroquel 25 mg Give one tablet by mouth every morning" and coded "F02.80 Dementia in oth diseases classd elsewhr w/o behavrl disturb" (sic). The Resident was receiving a total of 100 mg of Seroquel daily. The physician's progress notes from February 2018 to October 2018 were reviewed. An entry dated 02/04/2018 documented "Pt.	F 758	with results summarized with further monitoring to be decided by the QAPI committee if thresholds are not met.	

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resting today. Still anxious at times." "A/P (assessment/plan) Dementia - pt overall doing well. Still agitated at times. Is progressing well." An entry dated 03/03/2018 documented "Pt alert and happy. Not agitated." "A/P Psychosis/Dementia - overall doing well. Still requires meds for agitation."

Subsequent progress notes through October 2018 documented Resident behavior ranging from cooperative to very agitated with plans to continue current med regimen.

Nurse's noted for the month of February 2018 (when the antipsychotic medications were initiated) were requested from facility staff and they presented copies of nurse's notes ranging from 02/11/2018 through 02/28/2018. An entry dated 02/11/2018 at 5:00 PM documented "No reported aggressive behavior or noted at this time." Two entries dated 02/12/2018 (Not timed) documented "No aggressive behavior." An entry dated 02/12/2018 (11-7) documented "Agitated, cursing at times." An entry dated 02/13/2018 at 4:20 PM documented "No aggressive behavior." An entry dated 02/13/2018 (11/7) documented "Agitation noted at times." Subsequent daily nurse's notes for the month of February 2018 document Resident exhibits no aggressive behaviors.

Nurse's noted for September and October 2018 were requested from facility staff and they presented one page of nurse's notes with entries ranging from 08/04/2018 through 09/03/2018. An entry dated 08/04/2018 (7-3) documented Resident "very abusive hitting on staff Will cont to monitor for aggressive behavior." A second entry (7-3) by same provider documented Resident

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"very abusive and hitting at staff refused to stay in chair while trying to clean up bed."

The next entry was dated 09/03/2018 at 6:00 AM and documented "No abusive behavior noted." An entry dated 09/03/2018 at 1:30 PM documented "Notifying MD of Resident trying to go in another pt room on 09/02/18 and became extremely aggitated (sic) and aggressive putting hands around nurses neck." A second entry by same provider at 2:00 PM documented "Resident has been very quiet and no aggitation (sic) noted today."

Interdisciplinary progress notes ranging from 06/07/2018 through 09/03/2018 were reviewed. The only entry mentioning behaviors was dated 09/03/2018 when Resident was found wandering into another room and documented Resident "became aggitated (sic) when nurse attempted to redirect and hit the nurse. (Resident) was assisted back to his room and remained in his room at that time. No further behaviors noted throughout night by 11-7A nurse."

The care plan was reviewed. A non-pharmacological intervention for unwanted behaviors lists "attempt to redirect (Resident) during times of unwanted behaviors." A revision dated 01/22/2018 lists "staff will approach calm and if combative, allow time to calm down and re-approach with 2 CNA's."

Triggers for unwanted behaviors, Resident care preferences (routines, interests, choices) associated with behaviors, and effectiveness of interventions to minimize untoward behaviors were not documented in the care plan or nurse's notes.

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F 758	Continued From page 65 The facility staff was asked to provide psychiatric documentation but none was presented. There was no evidence in the documentation that when the behaviors were exhibited the staff evaluated the Resident for unmet needs or other potential underlying causes. An antipsychotic such as Seroquel is contraindicated in "elderly patients with dementia-related psychosis because of increased risk of death from CV disease or infection." (Nursing 2018 Drug Handbook, 2018, p. 1274) On 10/12/2018 at 11:50 AM in an interview with the DON, she stated that facility staff wants to meet quarterly to review information on all residents receiving psychoactive medications. On 10/12/2018, the Administrator and DON were notified of concerns and they offered no further documentation or information. 2. For Resident #13, the facility staff failed to ensure she was free from the psychotropic medication Risperdal which is not indicated for residents with a diagnosis of dementia with behavioral disturbance. Resident #13, an 80 year old female, was admitted to the facility on 04/28/2018. Diagnoses include hypertension, dementia, depression, mixed anxiety disorders, and psychotic disorder (other than schizophrenia). Resident #13's most recent quarterly Minimum Data Set (MDS) had an Assessment Reference	F 758		

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Date (ARD) of 08/02/2018. Resident #13 was coded with a Brief Interview of Mental Status (BIMS) score of 3 out of 15 indicative of severely impaired cognitive skills. Behaviors such as hallucinations and delusions were coded as not occurring. Physical and verbal behaviors toward others were coded as not being exhibited. Functional status for mobility and transfers was coded as total dependence on staff.

On 10-10-18 at 1:45 PM, the Resident was observed laying in her bed on her right side. The Resident was dressed, groomed, awake, quiet and in no apparent distress.

The care plan dated 08/09/2018 was reviewed. There were no targeted behaviors noted on the care plan. The care plan did not have any non-pharmacological interventions for behaviors of yelling. An entry dated 06/07/2018 states "Severe aggitation (sic) + anxiety" was crossed out. An entry dated 06/08/2018 stated "Dr. Anderson D/C medication and ordered antipsychotic to help with agitation (sic) and anxiety." An entry dated 06/24/2018 states, "Resident continues to holler + agitate other residents" was crossed out and stated "Resolved" and dated 08/09/2018.

The nurse's notes from July 2018 to October 2018 were reviewed. An entry dated 07/01/2018 (11-7) documents "no hollering observed - quiet." An entry dated 07/01/2018 (3-11) documents "resident up in geri-chair - behaving fairly well - ". There were no other entries addressing targeted behaviors.

The nursing weekly summary documents ranging from 08/02/2018 to 10/04/2018 were reviewed.

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Entries dated 08/02/2018, 08/23/2018, 09/06/2018, 09/13/2018, and 10/11/2018 documented "no agitation noted." There were no other entries addressing targeted behaviors.

The physician's orders were reviewed. The Resident has an order for Risperdal 1 mg twice a day for "psychosis, anxiety, and delusion paranoid". The order was initiated 09/10/2018.

The Medication Administration Record was reviewed for the month of September 2018. Risperdal was administered twice a day but there was no behavior monitoring documentation.

A review of a consultation report dated 06/12/2018 was performed. There were no behaviors documented on the consultation and the diagnosis for the use of an antipsychotic medication is "dementia with behavioral disturbance."

An antipsychotic such as Seroquel is contraindicated in "elderly patients with dementia-related psychosis because of increased risk of death from CV disease or infection." (Nursing 2018 Drug Handbook, 2018, p. 1274)

On 10/12/2018 at 11:50 AM in an interview with the DON, she stated that facility staff wants to meet quarterly to review information on all residents receiving psychoactive medications.

On 10/12/2018, the Administrator and DON were notified of concerns and they offered no further documentation or information.

3. For Resident #28, the facility staff failed to

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ensure that he was free of Seroquel, which according to the Black Box Warning, is not indicated for use in residents with Dementia-related psychosis.

Resident #28 was a 72 year old who was admitted to the facility on 6/12/17. Resident #28's diagnosis included Dementia with Behavioral Disturbance, Lobar pneumonia, Chronic Kidney Disease, Heart Disease, Type 2 Diabetes Mellitus with hyperglycemia, and Dependence on Renal Dialysis.

The Minimum Data Set, an Annual Assessment with an Assessment Reference Date of 6/4/18, coded Resident #28 as not having any behavioral issues.

On 10/12/18 a review of Resident #28's clinical record was conducted, revealing a care plan. It read, "Problem onset: 6/4/18, receives psychotropic medication due to diagnosis of psychosis." Psychosis is not an official diagnosis.

On 1/25/18, Resident #28 was seen by a Nurse Practitioner. The report read, "Behavior agitated, oriented to self and place. Speech clear, Denies psychotic symptoms, hallucinations, etc. Disoriented to time and situation, Memory impairment. Denies suicidal and homicidal ideation. Recommendations: Seroquel 25 MG twice daily."

On 10/11/18 a review was conducted of facility documentation, revealing a Psychoactive Medication Informed Consent, signed by Resident #28's Responsible Party (Daughter). It read, "1/25/18. A physician has prescribed Seroquel 25 MG 2 times daily. Possible side

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effects: abnormal movement of facial muscles & tongue, liver failure, muscle pain, depression." The facility failed to inform the Responsible Party of the boxed warning regarding Seroquel. The 2018 Nursing Drug Handbook listed a boxed warning regarding Seroquel. It read, "Drug isn't indicated for use in elderly patients with dementia-related psychosis because of increased risk of death from Cardiovascular Disease of infection."

On 10/11/18 an interview was conducted with the Director of Nursing (Administration B). When asked about possible alternate medications or interventions, she stated that she was not aware of any. The facility Administrator (Administration A) was present. No further information was received.

4. Resident #53 was administered Seroquel (antipsychotic medication) without an appropriate supporting diagnosis.

Resident #53, a 72 year old, was admitted to the facility on 9/24/18. Diagnoses included vascular dementia with behaviors, delirium, hypertension and hyperlipidemia.

The most recent Minimum Data Set assessment was an Admission assessment with an assessment reference date of 10/1/18. The resident has a Brief Interview of Mental Status score of 1 indicating severe cognitive impairment.

Resident #53 was observed throughout the survey seated at the nursing station sleeping in his wheel chair. No behaviors were observed.

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Resident #53 had a physician order dated 9/24/18 for Seroquel 25 milligrams at bedtime for vascular dementia with behavioral disturbance. According to the October 2018 Medication Administration Record (MAR), this medication was administered as ordered.

Resident #53's baseline care plan completed 9/24/18 was reviewed. The baseline care plan included pre-printed "Problem, Need, Strength, Potential Concern" issues. The problem "Behavior Problem" was marked "N/A" with no behaviors checked. The problem "Resident is using psychotropic drugs" was checked. This section included the statement "antipsychotic to manage the symptoms for DX (diagnosis) of " and "BPSD-Behavioral or Psychosocial Symptoms of Dementia" was checked. The "Approach" section included "Identify target behavior" and "Identify trigger/ likes".

The targeted behaviors, triggers and likes were not included in the clinical record.

On 10/4/18, the physician assessed Resident #53. The progress note read, "Pt (patient) is moving better. Is tearful at times. Denies pain. Is eating better." "A/P (assessment/plan) Dementia/ CVA (cerebrovascular accident)- pt (patient) still tearful at times, will try antidepressant."

10/5/18 Interdisciplinary Note read, "(name), son of (Resident #53) concerned about him crying + anxious in the evenings. He wants his father to receive some medication for this- reported to (doctor) by (name)."

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On 10/5/18, the physician ordered Lexapro (for depression) 10 milligrams 1 tab daily.

At the end of day meeting on 10/11/18, it was reviewed with the Director of Nursing (DON) and Administrator that dementia with behaviors was not an approved diagnosis to justify the use of Seroquel in a patient with dementia. It was reviewed that there were no targeted behaviors documented in the clinical record. The facility staff were asked to provide documentation of Resident #53's behaviors and non-pharmacological interventions to be used for Resident #53.

On 10/12/18 at the end of day meeting, it was reviewed with the DON and Administrator that no documentation had been provided regarding Resident #53's behaviors or non-pharmacological interventions. The DON stated that Resident #53 has been on the Seroquel before he was admitted to the facility. She stated that the resident was tearful. It was reviewed with the DON that it was concerning that Seroquel was being used to treat the behavior of tearfulness and the physician started an additional antipsychotropic medication to also address the tearfulness. It was reviewed that in addition to Seroquel being contraindicated for use in the elderly with dementia, the Seroquel was also not effective in treating Resident #53's tearful behavior.

The below information about Seroquel was accessed on 10/15/18 at 4:52 p.m. at the website https://reference.medscape.com/drug/seroquel-xr-quetiapine-342984
"Black Box Warnings: Not approved for dementia-related psychosis; elderly patients with

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dementia-related psychosis who are treated with antipsychotic drugs are at increased risk of death, as shown in short-term controlled trials; deaths in these trials appeared to be either cardiovascular (eg, heart failure, sudden death) or infectious (eg, pneumonia) in nature."

5. Resident #43 did not have an appropriate diagnosis for the use of Seroquel (antipsychotic) and did not address or target behaviors requiring the use.

Resident # 43 was admitted to the facility 3-4-17. Her diagnoses included but were not limited to: Stroke, dementia and hemiplegia.

Resident #43's most recent MDS (minimum data set) with an ARD (assessment reference date) of 9-24-18 was coded as a quarterly assessment. Resident #43 was coded as having a BIMS (Brief Interview for Memory Status) Score of 9 out of 15 indicating moderate cognitive impairment. She was coded as needing extensive to total assistance of one staff member to perform her activities of daily living. Resident #43 was coded as requiring extensive assistance for eating. There were no behaviors documented for the 7 day look back period.

On 10-12-18, Resident #43 was observed up in her wheelchair at the dining room table. A CNA was in close proximity. There was only soft food on the tray, there were no large chunks of any food served.

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On 10/10/18 at 01:39 PM: Review of the clinical record revealed the resident is currently on Seroquel 50 mg twice daily for dementia with behavior disturbance.

On 6/21/18, IDT (interdisciplinary team) notes read (in relating to an incident where the resident hit at another resident the day before): "No observations of any contact behavior with other residents. No injuries. Up in wheelchair attending activities and in dining room with pleasant attidue (sic). No aggressive behaviors observed."

Review of the clinical record revealed on 7-25-18 at 8:30 AM, the resident was "fighting at staff and throwing things, keeps saying don't want it, leave me alone.. behaviors she did quiet down some and medication was given . No more aggressive behaviors noted."

Review of the 7-25-18 IDT notes revealed the following: ""Sitting in dining room and began to throw food and drink at others at table... Psychoactive medication review was done on 7-24-18 and IDT concluded no changes be made in her medication due to continued hitting swatting at people. No contact made with others." There was no documented attempt to discover triggers/factors to the behavior described above (did not want to take medication) except to continue antipsychotic use of medications.

Review of the care plan dated 7-19-18 documented the resident has diagnosis of depression, psychosis and has "hallucinations of cats in her room- she tries to feed them." No other targeted behaviors were listed. Interventions included:

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* Evaluate effectiveness and side effects of medication for possible decrease/elimination of psychotropic drugs
* Monitor pharmacist drug regime review of identification of potential drug interactions
* Monitor interaction of resident with others for appropriateness
* Monitor residents mood state
* Monitor residents behavior in public/private
* Notify MD of changes in mood or behaviors- such as hallucinations. Resident states she feeds cats in her room, she takes food from her trays and places on the floor.
* AIMS (test to check for adverse effects of antipsychotic medications) every 6 months
* Monitor resident's mental status functioning on ongoing basis

The above care plan does not address causative factors and triggers to the behaviors or non pharmacogical interventions. There is no plan for dementia care.

Review of the pharmacy recommendations revealed a GDR (gradual dose reduction) was requested on 4-17-18 and 10-12-17, which were declined by physician.

Review of Nursing Drug Handbook, 2011, pages 984- 986 revealed the following information for Seroquel: "Indications for use: treatment for schizophrenia, acute manic episodes with bipolar disorder." There is a black box warning for elderly patients with dementia related psychosis, "drug isn't indicated for use because of increased risk of death."

In summary, Resident #43 was prescribed an

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F 758	Continued From page 75 antipsychotic medication without appropriate diagnosis for use and with an increased risk of death in elderly patients with dementia. There was no GDR of the medication, however, it was continued without adequate documentation of triggered behaviors (except feeding cats) and interventions to address behaviors of residents with dementia. On 10-12-18 at 4:46 PM, the Administrator and DON (director of nursing) were notified of above findings.	F 758		
F 803 SS=G	Menus Meet Resident Nds/Prep in Adv/Followed CFR(s): 483.60(c)(1)-(7) §483.60(c) Menus and nutritional adequacy. Menus must- §483.60(c)(1) Meet the nutritional needs of residents in accordance with established national guidelines.; §483.60(c)(2) Be prepared in advance; §483.60(c)(3) Be followed; §483.60(c)(4) Reflect, based on a facility's reasonable efforts, the religious, cultural and ethnic needs of the resident population, as well as input received from residents and resident groups; §483.60(c)(5) Be updated periodically; §483.60(c)(6) Be reviewed by the facility's dietitian or other clinically qualified nutrition professional for nutritional adequacy; and	F 803		11/19/18

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F 803	Continued From page 76 §483.60(c)(7) Nothing in this paragraph should be construed to limit the resident's right to make personal dietary choices. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility documentation and clinical record review, the facility failed to, for one resident, Resident #43, in a survey sample of 26 residents, to ensure the resident's mechanical soft diet was followed, resulting in harm. Resident #43 was served cantaloupe chunks instead of a fruit crisp that was on the Registered Dietician's approved menu. As a result of eating a cantaloupe chunk, the resident choked and required the Heimlich maneuver and suctioning. The findings included: Resident # 43 was admitted to the facility 3-4-17. Her diagnoses included but were not limited to: Stroke, dementia and hemiplegia. Resident #43's most recent MDS (minimum data set) with an ARD (assessment reference date) of 9-24-18 was coded as a quarterly assessment. Resident #43 was coded as having a BIMS (Brief Interview for Memory Status) Score of 9 out of 15 indicating moderate cognitive impairment. She was coded as needing extensive to total assistance of one staff member to perform her activities of daily living. Resident #43 was coded as requiring extensive assistance for eating. The resident was coded as having a mechanically altered diet. On 10/10/18 at 1:33 PM a review of the clinical record revealed the resident's diet was changed	F 803	This plan of correction constitutes the facilities written allegation of compliance for the deficiencies cited. However, submission of this plan of correction is not an admission that deficiencies exist or that one was cited correctly. The plan of correction is submitted to meet requirements established by federal and state law. 1. The CDM was educated by the registered dietician on resident #43's mechanically altered diet. 2. All other residents with mechanically altered diets were reviewed by the registered dietician for accuracy. 3. Education on the policy and procedure for mechanically altered diets, was provided by the registered dietician for dietary personnel on 11/1/18. The RD will audit on each visit for diet accuracy for the next 30 days. The CDM and speech therapy will audit three times per week, alternating meals for diet accuracy. 4. The CDM will bring all audit results to the monthly QAPI meeting and the committee with results summarized with further monitoring to be decided by the QAPI committee if thresholds are not met.	

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from puree to soft/chopped meats in August, 2018.

On 10/10/18 at 1:46 PM a review of the clinical record revealed the IDT (interdisciplinary team) notes dated 10-3-18 at 12:30 PM revealed "CNA (certified nursing assistant) reported resident having difficulty swallowing and talking. I asked her could she speak and she could not. Heimlich maneuver given x two. Resident removed from dining room to MDS office and PT (physical therapist) Director assisted with Heimlich - Resident moving air and taken to her room and suctioned by nurse and coughed up chunk of cantaloupe."

Review of the nurse's note dated 10-3-18 at 1:40 PM documented: "The resident rushed back from dining room- choking- lips blue- suction x 3-4 minutes with Yankauer catheter- large piece of cantaloupe was coughed up by resident- Resident speaking after episode- some coughing, VS 98-104-16 150/80, and a chest X-Ray was done."

Review of the incident report for the incident dated 10-3-18 revealed: "MDS nurse suctioned and resident spit out a piece of cantaloupe about the size of a quarter."

Review of the dietary note for 10-3-18 at 12:30 PM revealed: "Heimlich maneuver given x 2.... coughed up chunks of cantaloupe."

Review of the lunch menu for 10-3-18 revealed the following items were served for a soft diet: ground apple ginger pork, dressing with gravy, baby carrots (cooked), roll, fruit crisp.

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Review of the Speech Therapy (ST) discharge summary notes revealed: "Patient exhibits moderate oropharyngeal dysphagia (dysphagia) ... may need to avoid specific food items or require additional time."

Review of the care plan dated 7-19-18 revealed the resident "requires a mechanical soft diet with the following interventions:

* Allow ample time to ingest meal
* Encourage to finish at least one item on plate.
* Feed as she allows if she refuses to feed herself
* Routine and as needed review by RD
* Use of divided plate for easier retrieval of food
* Encourage fluid intake
* Weight monthly and as needed"

The care plan was revised on 10-3-18 to include the resident was at risk for aspiration with the goal of no further episodes of aspiration/choking. Interventions included:

* Restorative (nursing) for dining
* Continue mechanical soft diet
* Out of bed for all meals
* Sit upright 30 minutes after meals

On 10/10/18 at 2:18 PM, an interview with RN (registered nurse) A (unit manager) was conducted. She stated that she was at the nurses desk, she (the resident) was in the large dining room and was being rolled to the room and that she got the suction machine, suctioned her, and the catheter pulled out a chunk of cantaloupe about the "size of a quarter", "Just one piece."

On 10/10/18 at 2:30 PM, an interview was

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conducted with the ST (speech therapist). She stated the resident was doing fine on mechanical chopped meats, had increased her intake, no choking or coughing. She is now in restorative dining. She also stated she can clear with liquids, can spit out if she can't swallow, "As long as it is soft cooked gravy with meat." The ST was asked if cantaloupe was appropriate for the soft diet, she stated "No, it is huge pieces, should not have been given to her." She approximated the size of the chunks of cantaloupe "1 x 1 inch or so", and that she would do better with canned fruits/vegetables. The ST stated, " The cantaloupe is hard." She did state: "I have not seen any cantaloupe or hard fruits/vegetables" since the episode.

On 10/10/18 at 2:46 PM, the dietary manager was interviewed. She stated the resident's diet was regular with ground meat/mechanical which means "ground meat." She stated the 10-3-18 lunch for the soft diet was pork/gravy, dressing and gravy, carrots, supposed to be fruit crisp. She stated that the fruit crisp was not served as it was not available and gave fresh fruit as a substitute, stating, "It was cantaloupe." She stated that the dietary manger makes the decision for the alternate. She described the fruit crisp would have been baked peaches with an oatmeal crust. When asked about the size of the chunks of the cantaloupe as "Cantaloupe like a square, like chunks. She held her fingers apart to approximately one inch by one inch. When asked what measures had taken place to prevent further incidents of choking, the dietary manager stated: "We are not serving fresh fruit anymore and unless "it is small", as "instructed by the DON (director of nursing) ." She stated the RD (registered dietician) comes in twice weekly. The

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dietary manager produced from their diet manual a description of the mechanical soft diet. This included: "A mechanical soft is used for individuals who have difficulty chewing regular textured foods ... Foods that are difficult to chew are chopped, ground, shredded and/or cooked to facilitate chewing and ease of swallowing." It included for fruits: "include a variety with more fruit than juice as appropriate: Canned, cooked, tender, , chopped or shredded, or juice at appropriate thickness."

On 10/11/18 at 10:04 AM, the RD came in to talk about the choking incident. The RD was questioned as to how does the dietary manager know what substitutes to employ when food on the menu is not available. The RD stated, "Staff has been taught for appropriate substitutes." The RD stated that on the mechanically altered diet the fruit "should be fine cut." She went on to state, "I will be meeting with dietary staff today, I will review what is in place to avoid this, I don't want this to happen again." She later presented an inservice dated 8-16-18 to include:

* Right texture of diets- choking issues
* Drain steam table nightly
* Be careful wearing gloves while serving
* When pureeing items from packages, put in bowl before processor
* Residents cup on tray if sent out be responsible for getting back
* Keep kitchen open until 8:00 PM

In summary, Resident #43 did not receive the ordered diet that had been approved by the RD and instead received cantaloupe of at least the size of a quarter which caused choking- blue lips, inability to speak, requiring emergency treatment

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F 803	Continued From page 81 of several Heimlich maneuvers (4-5) and suctioning for 3-4 minutes to dislodge the obstruction. On 10-11-18 at 2:53 PM, the facility Administrator and DON were notified of a harm level deficiency. On 10-12-18, Resident #43 was observed up in her wheelchair at the dining room table. A CNA was in close proximity. There was only soft food on the tray, there were no large chunks of any food served. On 10-12-18 at 11:15 AM, the Administrator was questioning harm level deficiency as she believed it was a potential for harm and that melon is allowed on a mechanical diet. "We wish they had cut it more."	F 803		
F 881 SS=E	Antibiotic Stewardship Program CFR(s): 483.80(a)(3) §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)(3) An antibiotic stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use. This REQUIREMENT is not met as evidenced by: Based on staff interview and facility documentation review, the facility staff failed to implement an antibiotic stewardship program. The facility staff failed to monitor antibiotic usage and collect outcome data until June, 2018.	F 881	This plan of correction constitutes the facilities written allegation of compliance for the deficiencies cited. However, submission of this plan of correction is not an admission that deficiencies exist or that one was cited correctly. The plan of	11/19/18

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F 881	Continued From page 82 The Findings included: On 10/12/18 at 9:33 A.M., a review was conducted of the facility's Infection Control Program. The Assistant Director of Nursing (RN A) stated that she started an antibiotic stewardship when she began working at the facility in June, 2018. The Director Of Nursing (Administration B) agreed. The Director of Nursing stated that the facility did not have any documentation that an antibiotic stewardship program was developed and implemented prior to June 2018. On 10/12/18 a review was conducted of facility documentation, revealing an Antibiotic Stewardship Policy dated December, 2016. It read, "Antibiotic usage and outcome data will be collected and documented using a facility-approved antibiotic surveillance tracking form. The data will be used to guide decisions for improvement of individual resident antibiotic prescribing practices and facility-wide antibiotic stewardship." On 10/12/18 at 2:50 P.M., an interview was conducted with the facility Administrator (Administration A). She stated that there was an issue with staff turnover, and the antibiotic stewardship program was not fully implemented. Regarding the former Director of Nursing, the Administrator stated, "Unfortunately she didn't implement it at the time." The Administrator further stated that the facility also had a corporate consultant overseeing the process. No further information was received.	F 881	correction is submitted to meet requirements established by federal and state law. 1. The DON initiated a facility antibiotic stewardship program following the facility policy and procedures on 11/7/18. 2. All new orders for antibiotics will be reviewed upon receipt by the licensed nurses and in the morning meeting by the interdisciplinary team for review and criteria using McGreer's criteria. 3. The ADON/Antibiotic Steward will follow the policy and contact the physician as needed for those antibiotics not meeting criteria. The medical director, DON/ADON and pharmacist will meet monthly starting 11/7/18 to review the policy for stewardship, and proceed to review any antibiotics that do not meet criteria. The DON/ADON and licensed staff were educated by the facility pharmacist and staff educator on the process for completion of the infection reports review of criteria, logging of antibiotics for tracking and trending and education needed to maintain stewardship protocols. The antibiotic steward will audit all antibiotics ongoing and intervene as needed with physicians, MDS coding and care plan and family education. The pharmacist will report quarterly on antibiotic stewardship findings. 4. Antibiotic steward to report audit findings to the QAPI committee monthly ongoing to ensure thresholds for	

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F 881	Continued From page 83	F 881	compliance are met.	