Leewood Healthcare Center

A Grace HEALTHCARE Facility

Serving you from our heart

November 23, 2018

Mr. Paul Wade, LTC Supervisor

Office of Licensure and Certification

Division of Long Term Care Services

9960 Mayland Drive, Suite 401

Richmond, VA 23233

Re: Leewood Healthcare Center (Provider Number 495337)

Dear Mr. Wade,

Enclosed for your review, please find our plan of correction for survey ending November 8th, 2018. We submit this plan of correction as Leewood's allegation of compliance. Please contact me directly if you have any questions or require additional information.

Sincerely,

Terrence Kee

Administrator

7120 Braddock Road • Annandale, Virginia 22003 • Phone: (703) 256-9770 • Fax (703) 256-5105

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495337	A. BUILDING _____ B. WING _____	11/08/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEEWOOD HEALTHCARE CENTER	7120 BRADDOCK ROAD ANNANDALE, VA 22003

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E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 11/6/18 through 11/8/18. The facility was in substantial compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities.	E 000	**Plan of Correction** **Leewood Healthcare, 11/2018** This Plan of Correction is submitted as required under State and Federal law. The facility's submission of the Plan of Correction does not constitute an admission on the part of the facility that the findings cited are accurate, that the findings constitute a deficiency, or that the scope and severity determination is correct. Because the facility makes no such admissions, the statements made in the Plan of Correction cannot be used against the facility in any subsequent administrative or civil proceeding.	
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 11/6/18 through 11/8/18. Corrections are required for compliance with the following 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. The census in this 132 certified bed facility was 117 at the time of the survey. The survey sample consisted of 34 resident reviews.	F 000		
F 607 SS=D	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(3) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, This REQUIREMENT is not met as evidenced by: Based on observations, family interviews, staff interviews, facility documentation review, and clinical record review, the facility staff failed to	F 607	**F 607 Development/Implement Abuse/Neglect Policies** Compliance Date: 11/30/2018	11/30/18

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

TJK | Administrator | 11/27/18

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

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F 607	Continued From page 1 implement policies and procedures regarding a choking incident and a bruise of unknown origin for 2 residents (Resident #82, #78) in a sample of 34 residents. 1. For Resident #82, the facility staff failed to investigate a choking incident. 2. For Resident #78, the facility staff failed to investigate a bruise of unknown origin. The findings include: 1. For Resident #82, the facility staff failed to investigate a choking incident. Resident #82, an 88 year old female was admitted to the facility on 11/16/17. Diagnoses include dysphagia and dementia. Resident #82's most recent quarterly Minimum Data Set (MDS) had an Assessment Reference Date (ARD) of 08/09/2018. Resident #82 was not coded with a Brief Interview of Mental Status (BIMS) score but cognitive skills for daily decision making were coded as severely impaired. Functional status for eating was coded as requiring extensive assistance. On 11/06/18 at 1:25 PM, the Resident was observed in her bed with family at bedside. The Resident was awake and the head of the head was elevated approximately 60 degrees. She had oxygen on at 2 liters/minute via nasal cannula. On 11/06/18 at approximately 3:00 PM, the nurse's notes were reviewed. An entry dated 10/16/18 at 2:02 PM documented,	F 607	**Immediate action taken for the resident found to have been affected include:** Resident # 82 was evaluated on 10/16/2018 by a Licensed Practical Nurse, Vital signs were within normal limits. Afebrile. RP in the room when incident occurred. MD and Speech therapist made aware. On 10/17, resident's diet was downgraded to pureed texture with nectar thickened liquids. No further action required. Resident # 78 was evaluated by a licensed practical nurse on 11/8/18, a head to toe skin inspection completed. No new skin alteration noted. Resident remains stable. **Identification of other residents having the potential to be affected.** All residents have the potential to be affected. All nurses notes were reviewed by the DON and the Nurse Mangers on 11/8/2018, no new incidences of choking or injury of unknown origin identified. No other residents were identified to be affected by this practice.	

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F 607	Continued From page 2 "Family was feeding resident lunch, when she started choking. Upon suctioning resident, small pieces of watermelon were brought up. Patient is in stable condition. Vitals monitored and within normal limits. MD and speech therapy made aware." A nurse's note dated 10/24/18 documented, "Resident observed with coughing nad (sic) congestion" "O2SAT 89-90%", "MD made aware order received (sic) for chest xray order placed and done, result received (sic) Impression Right Basilar infiltrate and Pleural effusion, MD made aware order received (sic) for Levaquin 250mg by mouth daily for pneumonia" "PRN Robitussin administered for cough with effective result" The physician's orders were reviewed. An ordered dated 01/09/18 documented, "Mechanical soft diet with thin liquids." An order dated 10/09/18 documented, "Mechanical soft diet with nectar thick liquids." An order dated 10/17/18 documented, "ST to downgrade Pt to puree solid with nectar thick liquids." An order dated 10/24/18 documented, "ST clarification order: 5X/WK (five times a week) for 5 weeks to continue to monitor pts (patient's) diet tolerance with moderate oropharyngeal dysphagia." An order dated 10/29/18 documented, "Encouraged po (by mouth) nectar thickened liquids." Speech therapy notes were reviewed.	F 607	A head to toe skin inspection was conducted on all residents on 11/8/2018 by the Wound Nurse, and Unit Mangers to ensure no injury of unknown origin is observed or required an investigation. No other residents were identified to be affected by this practice. **Actions taken/systems put into place to reduce the risk of future occurrence.** Education, in-service program was conducted for all licensed nurses was initiated on 11/7/18 by the Director of Nursing/Designee on maintaining compliance with the facility policy on incident report completion protocol including choking and investigation of injury of unknown origin to be completed by 11/30/18. Any staff member unavailable for education will receive in-services prior to their return to work **How the corrective action(s) will be monitored to ensure the practice will not recur:** The Director of Nursing/Designee will review the Nurses Notes of all	

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F 607	Continued From page 3 An entry dated 10/09/18 documented, "Pt. referred to ST (speech therapy) by nursing for coughing on thin liquids." Assessment summary included "mild residue in oral cavity, pocketing of solids" with a diet recommendation of mechanical soft textures and nectar thick liquids. An entry dated 10/10/18 documented, "Pt's son reported he was concerned that pt would refuse nectar thick liquids, pt with no resistance to intake of nectar thick liquids." "ST finding thin liquids at side of bed, reporting to nursing and removing liquids from the room." An entry dated 10/15/18 documented, "ST educated staff of diet restrictions after finding thin liquids in the room and nurse attempting to get (sic) pt meds with thin liquids." An entry dated 10/17/17 documented, "Pt reportedly choked last night, ST downgrading pt to puree. Pt with prolonged and disorganized mastication, needing cues to initiate swallowing and prolonged AP transit. Pt additionally more appropriate for pureed diet to level of alertness and edentulous status." An entry dated 10/18/18 documented, "ST finding thin liquids at bedside, AGAIN, clearing from room and informing nursing of problem." An entry dated 10/19/18 documented, "ST finding thin liquids at bedside AGAIN left by family in the evening. ST removing liquids and notifying nursing of issue." An entry dated 10/23/18 documented, "ST finding thin liquids in pt's room AGAIN. ST in process of	F 607	residents daily for two weeks, weekly for four weeks and monthly for two months to ensure all incidents of choking, injury of unknown origin and protocol on investigation is implemented and completed. The Director of Nursing/Designee will present the results of reviews to the Quality Assurance Performance Improvement Committee for review and further recommendations. Quality Assurance Performance Improvement Team Members include: Administrator, Director of Nursing, Staff Development Coordinator, Director of Social Services, Director of Dietary, Director of Housekeeping, Director of Maintenance, Nurse Managers, Minimum Data Set Coordinator, Medical Director, Director of Rehab Services, and Pharmacy Consultant. If issues are identified, then additional education will be provided and modification of the Plan of Correction will be made to address the deficient practice.	

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pursuing AMA (against medical advice) form due to families (sic) noncompliance with diet restrictions after education about purpose."

On 11/07/18 at 8:40 AM, the Resident was observed awake in bed with the head of bed elevated approximately 60 degrees. She had oxygen on at 2 liters/minute via nasal cannula.

On 11/7/18 at 9:00 AM, Employee A, dietary staff, was interviewed. Employee A explained that the facility used a dietary program called TrayCard System. He provided tray cards for Resident #82. He also provided the menus for Tuesday 10/16/18 (the day of the choking incident). The menu for 10/16/18 did not list watermelon. Employee A provided a snack schedule that included fruit as the snack for Tuesdays. Employee A stated that he does the food ordering for the facility. When asked to provide the invoice for the last time the facility ordered watermelon, Employee A stated that he ordered watermelon every week. When asked if the watermelon was delivered whole or precut, Employee A stated the watermelon was whole and the facility cut up the watermelon.

When asked if there was documentation of the type of fruit served on Tuesday 10/16/18 for the 2:00 p.m. snack Employee A sated that he did not keep record. He stated that it could have been watermelon or cantaloupe. When asked how the fruit was delivered on the units for Tuesday snack day, Employee A stated that he sent large pans of cut up fruit and the staff portioned the fruit into cups.

On 11/7/18 at 9:30 a.m., the Unit Manager, Licensed Practical Nurse A (LPN A), was

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interviewed. LPN A was asked if she knew anything about Resident #82's choking incident. She did not remember the details of the incident. She did not complete an incident report.

On 11/7/18 at 9:45 AM, LPN B was interviewed. LPN B stated that the son had been feeding the Resident. LPN B stated that Certified Nursing Assistant A (CNA A) notified her that Resident #82 was choking. LPN B stated that she and LPN D responded. LPN B stated that LPN D suctioned the resident. LPN B stated that 2-3 pieces of watermelon were removed. She stated the watermelon pieces were long and skinny, about an inch long. LPN B could not remember if the watermelon was served by the facility that day or if the family brought in the fruit.

On 11/07/18 at 1:00 PM, the Resident's son and daughter-in-law were at the Resident's bedside. When asked about the choking incident, the daughter-in-law stated they were not there when it happened but her brother-in-law (Resident's other son) was there when the choking incident occurred. When asked if her brother-in-law may have brought in food from home, she stated he "never brings in food."

On 11/7/18 at 1:45 p.m., Employee A was asked again to describe how the Tuesday fruit snack was prepared to send to the unit. Employee A provided an example of the container he used. It was a tall, cylindrical container. He stated that he filled the container half full. He stated that the fruit was cut in cubes less than an inch in size. He provided an example of the cut up watermelon for the survey team. The cubes were approximately 1- 1 ½ inch cubes. Employee A stated he sent 4 oz. plastic cups and a serving

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spoon for which the nursing staff would use to serve the fruit. Employee A stated he would send applesauce for residents on puree diet.

On 11/07/18 at 3:50 PM, the Resident's younger son was interviewed. When asked about the choking incident, the son stated he arrived when CNA was finishing feeding his mom in the dining room. He stated the CNA was crushing large chunks of watermelon with a fork before feeding it to his mom. The son was shown the example of cut up watermelon provided by Employee A and he stated it looked like what the CNA was crushing and feeding to his mom that day. He also stated that the CNA left the dining room and he transported his mom back to her room and transferred her into her bed. While his mom was in the bed, he noticed she appeared to be choking so he called for the nurse.

On 11/08/18 at 8:45 AM, CNA A was interviewed. CNA A stated on the day the Resident choked, the call bell was on and she entered the room, saw the Resident choking, and notified the nurse. CNA A stated that afterwards, she went into the dining room and saw the Resident's tray on the dining room table. She stated she was not in the dining room feeding the Resident that day and does not know who was. CNA A also stated the Resident was taken back to her room by the Resident's son.

On 11/08/18 at 9:00 AM, the DON was interviewed. When asked what she knew about the choking incident, she stated "I don't know much about it." When asked if she knew who fed the Resident watermelon that day, she said the daughter-in-law gave her watermelon. She stated the family usually brings in food from home.

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When asked about an incident report, she stated she didn't have an incident report. She stated sometimes residents with dysphagia will cough while they are being fed. She then stated if the Resident couldn't breathe, that would be a "life and death situation." She also stated she didn't know the Resident needed to be suctioned.

On 11/08/18 at 9:15 AM, CNA B was interviewed. When asked about the choking incident, CNA B stated she was feeding the Resident in the dining room that day but doesn't remember what the food was. She also stated she remembers the Resident's son came into the dining room.

On 11/08/18 at 9:30 AM, LPN D was interviewed. When asked about the choking incident, LPN D states he was called to room by LPN B. He states the Resident was in the bed sweating, pale, clammy, and gasping for breath. He states suction was in the room on the crash cart. LPN D stated the son was in the room ('the one that is usually not here') and said his mom was choking. LPN D stated he looked in Resident's mouth and couldn't see anything. He suctioned her without results and then suctioned deeper. He stated a big piece of watermelon came out, then suctioned again and a smaller piece came out. He drew a picture to depict what the pieces looked like. He said the first piece was large, "about a 3-inch slice." LPN D stated he did not see any food in the room. He also stated that LPN B told him the son gave his mom 'thickened liquids.'

On 11/08/18 at 11:15 AM, the Administrator wanted to share what he learned about the choking incident. He apologized for not having an investigation. He stated he spoke with CNA B and she told him she was in the dining room that day

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but was not feeding the Resident. The Administrator stated CNA B told him the son was feeding the Resident and then brought the Resident back to her room. The Administrator stated he also spoke with CNA A. CNA A told the Administrator at the time of the incident, she went to alert LPN B and saw LPN D in the hall and asked for his assistance also. The Administrator stated the son told LPN B the son gave his mom thickened liquids but LPN D suctioned watermelon out. The Administrator stated when the son was asked if he brought in food, the son stated 'we don't bring in fruit' and another time stated 'we don't bring her food.'

The facility policy (revised 10/01/2017) for investigating and reporting accidents/incidents was reviewed. The facility policy states that "All accidents or incidents involving residents, employees, visitors, vendors, etc., occurring at our facilities must be investigated and reported to the Administrator." In Section 2.1 under General Guidelines part 1B, the policy states an incident report must be completed for all reported accidents or incidents." The purpose of investigating and reporting incidents is to "ensure the safety of all residents..." and investigations "into the cause of any incident will be tracked in order to improve care and to prevent future occurrences."

On 11/08/18 at 12:00 PM, Resident's physician verified his handwritten progress note dated 10/23/18 documented, "Pneumonia - possible aspiration"

In summary, this Resident was on a mechanical soft nectar thick liquids diet when the choking incident occurred on 10/16/18. The day before

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the choking incident occurred (10/15/18), a speech therapist witnessed a nurse attempting to give the Resident her medications with a thin liquid. There are conflicting reports about the choking incident such as where the watermelon came from (facility versus family), what size and consistency the watermelon was when the Resident ate it, and who fed the watermelon to the Resident. Seven days after the choking incident, the physician documented in the progress notes that Resident had possible aspiration pneumonia, ordered labs, chest x-ray, cough medicine, and antibiotics. There was not an investigation conducted by the facility staff and an incident report was not completed. Investigations and reporting assist facilities to identify risks, correct broken processes, and improve the health and safety of their residents.

On 11/08/18 at approximately 3:00, the Administrator and the DON were notified of concerns and they offered no further information.

2. For Resident #78, the facility staff failed to investigate a bruise of unknown origin.

Resident #78, an 83 year old female, was admitted to the facility on 10/05/2012. Diagnoses include anemia, hypertension, diabetes, depression, Parkinson's, and Alzheimer's disease.

Resident #78's most recent quarterly Minimum Data Set (MDS) had an Assessment Reference Date (ARD) of 10/01/2018. Resident #78 was not coded with a Brief Interview of Mental Status (BIMS) score but cognitive skills for daily decision-making was coded as severely impaired.

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Functional status for bed mobility, transfers, dressing, and personal hygiene was coded as requiring extensive assistance.

On 11/06/18 at 01:52 PM, the Resident was observed sitting in the day room, fully clothed. The Resident had a bruise on her right arm above and anterior to her elbow with approximately a 3-inch diameter.

On 11/07/18 at approximately 12:45 PM, the Resident was observed sitting in the day area, eating lunch with staff assistance. She had a bruise on her right arm above and anterior to her elbow with approximately a 3- inch diameter.

On the afternoon of 11/07/18, fall records for last 4 months for this Resident were requested from the DON.

On 11/08/18, the DON stated there were no fall records for past four months for Resident #78.

The care plan was reviewed. An entry dated 09/28/18 for a cut on Resident's finger included the following interventions: "I need a weekly evaluation of wound healing. I need a daily observation of skin with routine care. I need a full skin evaluation weekly with bath/shower."

Nurse's notes for September - November 2018 were reviewed. The bruise on the right arm was not addressed.

On 11/08/18 at 8:40 AM, certified nursing assistant (CNA) C was asked about the origin of the bruise on this Resident's arm. The CNA was not aware the Resident had bruise on her right elbow. The CNA observed the bruise as the

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Resident was seated in the day room and the CNA stated 'it's an old bruise'. The bruise was yellowish in the center and purplish on the edges. Licensed practical nurse (LPN) E was standing nearby and stated that it was an old bruise but did not remember how the Resident acquired bruise but stated she 'wrote it up'.

On 11/08/2018 at 10:15 AM, an incident report about Resident #78's bruise on her right arm was requested from the DON and she stated "that's a new bruise" so the incident report has not been written yet.

On 11/08/18 at 10:30 AM, an interview with LPN E was conducted. LPN E stated she did a skin check on Resident #78 on Tuesday and that bruise (on the right arm) was not there. She went on to say that the Resident's daughter was walking her mom outside yesterday and then returned and showed the staff a bump on the back of the Resident's head. LPN E stated the bruise on the Resident's arm was a "new bruise from yesterday."

On 11/08/18 at approximately 2:45 PM, the DON presented an incident report about the bruise on the right arm. It was dated 11/08/18 at 9:30 AM and documented, "Pt is noted with intact bruise to R (right) Upper arm close to the elbow. RP (responsible party) acknowledged holding pt on both arm (sic) by the elbow during ambulation out side (sic) the building yesterday. Intact bruise with dark-red puplish (sic) edges and slight greenish in color that measures 6x5x0."

In summary, a bruise was observed on Resident #78's right arm above her elbow on 11/06/18 by this surveyor and there was no evidence the staff

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F 607	Continued From page 12 was aware of the bruise, conducted an assessment, started an investigation, reported findings, or initiated a treatment plan. On 11/08/18 at approximately 2:45 PM, the Administrator and DON were notified of concerns and they offered no further information.	F 607		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.	F 609	**F 609 Reporting of Alleged Violations** Compliance Date: 11/30/18 **Immediate action taken for the resident found to have been affected include:** Resident # 82 was evaluated on 10/16/2018 by a Licensed Practical Nurse, Vital signs were within normal limits. Afebrile. RP in the room when incident occurred. MD and Speech therapist made aware. On 10/17, resident's diet was downgraded to pureed texture with nectar thickened liquids. Resident # 78 was evaluated by a licensed practical nurse on 11/8/18, a head to toe skin inspection completed. No new skin alteration noted. Resident remains stable	11/30/18

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F 609	Continued From page 13 This REQUIREMENT is not met as evidenced by: Based on observations, family interviews, staff interviews, facility documentation review, and clinical record review, the facility staff failed to investigate a choking incident and a bruise of unknown origin for 2 residents (Resident #82, #78) in a sample of 34 residents. 1. For Resident #82, the facility staff failed to investigate a choking incident. 2. For Resident #78, the facility staff failed to investigate a bruise of unknown origin. The findings include: 1. For Resident #82, the facility staff failed to investigate a choking incident. Resident #82, an 88 year old female was admitted to the facility on 11/16/17. Diagnoses include dysphagia and dementia. Resident #82's most recent quarterly Minimum Data Set (MDS) had an Assessment Reference Date (ARD) of 08/09/2018. Resident #82 was not coded with a Brief Interview of Mental Status (BIMS) score but cognitive skills for daily decision making were coded as severely impaired. Functional status for eating was coded as requiring extensive assistance. On 11/06/18 at 1:25 PM, the Resident was observed in her bed with family at bedside. The Resident was awake and the head of the head was elevated approximately 60 degrees. She had oxygen on at 2 liters/minute via nasal cannula.	F 609	**Identification of other residents having the potential to be affected.** All residents have the potential to be affected. All nurses notes were reviewed by the DON and the Nurse Mangers on 11/8/2018, no new incidences of choking or injury of unknown origin identified. No other residents were identified to be affected by this practice. A head to toe skin inspection was conducted on all residents on 11/8/2018 by the Wound Nurse, and Unit Mangers to ensure no injury of unknown origin is observed or required an investigation. No other residents were identified to be affected by this practice.	

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F 609	Continued From page 14 On 11/06/18 at approximately 3:00 PM, the nurse's notes were reviewed. An entry dated 10/16/18 at 2:02 PM documented, "Family was feeding resident lunch, when she started choking. Upon suctioning resident, small pieces of watermelon were brought up. Patient is in stable condition. Vitals monitored and within normal limits. MD and speech therapy made aware." A nurse's note dated 10/24/18 documented, "Resident observed with coughing nad (sic) congestion" "O2SAT 89-90%", "MD made aware order received (sic) for chest xray order placed and done, result received (sic) Impression Right Basilar infiltrate and Pleural effusion, MD made aware order received (sic) for Levaquin 250mg by mouth daily for pneumonia" "PRN Robitussin administered for cough with effective result" The physician's orders were reviewed. An ordered dated 01/09/18 documented, "Mechanical soft diet with thin liquids." An order dated 10/09/18 documented, "Mechanical soft diet with nectar thick liquids." An order dated 10/17/18 documented, "ST to downgrade Pt to puree solid with nectar thick liquids." An order dated 10/24/18 documented, "ST clarification order: 5X/WK (five times a week) for 5 weeks to continue to monitor pts (patient's) diet tolerance with moderate oropharyngeal dysphagia." An order dated 10/29/18 documented,	F 609	**Actions taken/systems put into place to reduce the risk of future occurrence.** Education, in-service program was conducted for all licensed nurses was initiated on 11/7/18 by the Director of Nursing/Designee on the facility policy on incident report procedures, reporting requirements and investigation of incidences of choking and injury of unknown origin to be completed by 11/30/18. Any staff member unavailable for education will receive in-services prior to their return to work. **How the corrective action(s) will be monitored to ensure the practice will not recur:** The administrator and or Director of nursing will review all incident reports on choking and injuries of unknown origin to assure the policy for investigation and reporting is followed as required for choking or injuries of unknown origin daily for two weeks, three times a week for two weeks, weekly for 4 weeks then monthly for 2 months.	

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F 609	Continued From page 15 "Encouraged po (by mouth) nectar thickened liquids." Speech therapy notes were reviewed. An entry dated 10/09/18 documented, "Pt. referred to ST (speech therapy) by nursing for coughing on thin liquids." Assessment summary included "mild residue in oral cavity, pocketing of solids" with a diet recommendation of mechanical soft textures and nectar thick liquids. An entry dated 10/10/18 documented, "Pt's son reported he was concerned that pt would refuse nectar thick liquids, pt with no resistance to intake of nectar thick liquids." "ST finding thin liquids at side of bed, reporting to nursing and removing liquids from the room." An entry dated 10/15/18 documented, "ST educated staff of diet restrictions after finding thin liquids in the room and nurse attempting to get (sic) pt meds with thin liquids." An entry dated 10/17/17 documented, "Pt reportedly choked last night, ST downgrading pt to puree. Pt with prolonged and disorganized mastication, needing cues to initiate swallowing and prolonged AP transit. Pt additionally more appropriate for pureed diet to level of alertness and edentulous status." An entry dated 10/18/18 documented, "ST finding thin liquids at bedside, AGAIN, clearing from room and informing nursing of problem." An entry dated 10/19/18 documented, "ST finding thin liquids at bedside AGAIN left by family in the evening. ST removing liquids and notifying	F 609	The Administrator/Designee will present the results of reviews to the Quality Assurance Performance Improvement Committee for review and further recommendations. Quality Assurance Performance Improvement Team Members include: Administrator, Director of Nursing, Staff Development Coordinator, Director of Social Services, Director of Dietary, Director of Housekeeping, Director of Maintenance, Nurse Managers, Minimum Data Set Coordinator, Medical Director, Director of Rehab Services, and Pharmacy Consultant. If issues are identified, then additional education will be provided and modification of the Plan of Correction will be made to address the deficient practice	

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nursing of issue."

An entry dated 10/23/18 documented, "ST finding thin liquids in pt's room AGAIN. ST in process of pursuing AMA (against medical advice) form due to families (sic) noncompliance with diet restrictions after education about purpose."

On 11/07/18 at 8:40 AM, the Resident was observed awake in bed with the head of bed elevated approximately 60 degrees. She had oxygen on at 2 liters/minute via nasal cannula.

On 11/7/18 at 9:00 AM, Employee A, dietary staff, was interviewed. Employee A explained that the facility used a dietary program called TrayCard System. He provided tray cards for Resident #82. He also provided the menus for Tuesday 10/16/18 (the day of the choking incident). The menu for 10/16/18 did not list watermelon. Employee A provided a snack schedule that included fruit as the snack for Tuesdays. Employee A stated that he does the food ordering for the facility. When asked to provide the invoice for the last time the facility ordered watermelon, Employee A stated that he ordered watermelon every week. When asked if the watermelon was delivered whole or precut, Employee A stated the watermelon was whole and the facility cut up the watermelon.

When asked if there was documentation of the type of fruit served on Tuesday 10/16/18 for the 2:00 p.m. snack Employee A sated that he did not keep record. He stated that it could have been watermelon or cantaloupe. When asked how the fruit was delivered on the units for Tuesday snack day, Employee A stated that he sent large pans of cut up fruit and the staff portioned the fruit into

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cups.

On 11/7/18 at 9:30 a.m., the Unit Manager, Licensed Practical Nurse A (LPN A), was interviewed. LPN A was asked if she knew anything about Resident #82's choking incident. She did not remember the details of the incident. She did not complete an incident report.

On 11/7/18 at 9:45 AM, LPN B was interviewed. LPN B stated that the son had been feeding the Resident. LPN B stated that Certified Nursing Assistant A (CNA A) notified her that Resident #82 was choking. LPN B stated that she and LPN D responded. LPN B stated that LPN D suctioned the resident. LPN B stated that 2-3 pieces of watermelon were removed. She stated the watermelon pieces were long and skinny, about an inch long. LPN B could not remember if the watermelon was served by the facility that day or if the family brought in the fruit.

On 11/07/18 at 1:00 PM, the Resident's son and daughter-in-law were at the Resident's bedside. When asked about the choking incident, the daughter-in-law stated they were not there when it happened but her brother-in-law (Resident's other son) was there when the choking incident occurred. When asked if her brother-in-law may have brought in food from home, she stated he "never brings in food."

On 11/7/18 at 1:45 p.m., Employee A was asked again to describe how the Tuesday fruit snack was prepared to send to the unit. Employee A provided an example of the container he used. It was a tall, cylindrical container. He stated that he filled the container half full. He stated that the fruit was cut in cubes less than an inch in size.

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He provided an example of the cut up watermelon for the survey team. The cubes were approximately 1- 1 ½ inch cubes. Employee A stated he sent 4 oz. plastic cups and a serving spoon for which the nursing staff would use to serve the fruit. Employee A stated he would send applesauce for residents on puree diet.

On 11/07/18 at 3:50 PM, the Resident's younger son was interviewed. When asked about the choking incident, the son stated he arrived when CNA was finishing feeding his mom in the dining room. He stated the CNA was crushing large chunks of watermelon with a fork before feeding it to his mom. The son was shown the example of cut up watermelon provided by Employee A and he stated it looked like what the CNA was crushing and feeding to his mom that day. He also stated that the CNA left the dining room and he transported his mom back to her room and transferred her into her bed. While his mom was in the bed, he noticed she appeared to be choking so he called for the nurse.

On 11/08/18 at 8:45 AM, CNA A was interviewed. CNA A stated on the day the Resident choked, the call bell was on and she entered the room, saw the Resident choking, and notified the nurse. CNA A stated that afterwards, she went into the dining room and saw the Resident's tray on the dining room table. She stated she was not in the dining room feeding the Resident that day and does not know who was. CNA A also stated the Resident was taken back to her room by the Resident's son.

On 11/08/18 at 9:00 AM, the DON was interviewed. When asked what she knew about the choking incident, she stated "I don't know

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much about it." When asked if she knew who fed the Resident watermelon that day, she said the daughter-in-law gave her watermelon. She stated the family usually brings in food from home. When asked about an incident report, she stated she didn't have an incident report. She stated sometimes residents with dysphagia will cough while they are being fed. She then stated if the Resident couldn't breathe, that would be a "life and death situation." She also stated she didn't know the Resident needed to be suctioned.

On 11/08/18 at 9:15 AM, CNA B was interviewed. When asked about the choking incident, CNA B stated she was feeding the Resident in the dining room that day but doesn't remember what the food was. She also stated she remembers the Resident's son came into the dining room.

On 11/08/18 at 9:30 AM, LPN D was interviewed. When asked about the choking incident, LPN D states he was called to room by LPN B. He states the Resident was in the bed sweating, pale, clammy, and gasping for breath. He states suction was in the room on the crash cart. LPN D stated the son was in the room ('the one that is usually not here') and said his mom was choking. LPN D stated he looked in Resident's mouth and couldn't see anything. He suctioned her without results and then suctioned deeper. He stated a big piece of watermelon came out, then suctioned again and a smaller piece came out. He drew a picture to depict what the pieces looked like. He said the first piece was large, "about a 3-inch slice." LPN D stated he did not see any food in the room. He also stated that LPN B told him the son gave his mom 'thickened liquids.'

On 11/08/18 at 11:15 AM, the Administrator

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wanted to share what he learned about the choking incident. He apologized for not having an investigation. He stated he spoke with CNA B and she told him she was in the dining room that day but was not feeding the Resident. The Administrator stated CNA B told him the son was feeding the Resident and then brought the Resident back to her room. The Administrator stated he also spoke with CNA A. CNA A told the Administrator at the time of the incident, she went to alert LPN B and saw LPN D in the hall and asked for his assistance also. The Administrator stated the son told LPN B the son gave his mom thickened liquids but LPN D suctioned watermelon out. The Administrator stated when the son was asked if he brought in food, the son stated 'we don't bring in fruit' and another time stated 'we don't bring her food.'

The facility policy (revised 10/01/2017) for investigating and reporting accidents/incidents was reviewed. The facility policy states that "All accidents or incidents involving residents, employees, visitors, vendors, etc., occurring at our facilities must be investigated and reported to the Administrator." In Section 2.1 under General Guidelines part 1B, the policy states an incident report must be completed for all reported accidents or incidents." The purpose of investigating and reporting incidents is to "ensure the safety of all residents..." and investigations "into the cause of any incident will be tracked in order to improve care and to prevent future occurrences."

On 11/08/18 at 12:00 PM, Resident's physician verified his handwritten progress note dated 10/23/18 documented, "Pneumonia - possible aspiration"

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In summary, this Resident was on a mechanical soft nectar thick liquids diet when the choking incident occurred on 10/16/18. The day before the choking incident occurred (10/15/18), a speech therapist witnessed a nurse attempting to give the Resident her medications with a thin liquid. There are conflicting reports about the choking incident such as where the watermelon came from (facility versus family), what size and consistency the watermelon was when the Resident ate it, and who fed the watermelon to the Resident. Seven days after the choking incident, the physician documented in the progress notes that Resident had possible aspiration pneumonia, ordered labs, chest x-ray, cough medicine, and antibiotics. There was not an investigation conducted by the facility staff and an incident report was not completed. Investigations and reporting assist facilities to identify risks, correct broken processes, and improve the health and safety of their residents.

On 11/08/18 at approximately 3:00, the Administrator and the DON were notified of concerns and they offered no further information.

2. For Resident #78, the facility staff failed to investigate a bruise of unknown origin.

Resident #78, an 83 year old female, was admitted to the facility on 10/05/2012. Diagnoses include anemia, hypertension, diabetes, depression, Parkinson's, and Alzheimer's disease.

Resident #78's most recent quarterly Minimum Data Set (MDS) had an Assessment Reference

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Date (ARD) of 10/01/2018. Resident #78 was not coded with a Brief Interview of Mental Status (BIMS) score but cognitive skills for daily decision-making was coded as severely impaired. Functional status for bed mobility, transfers, dressing, and personal hygiene was coded as requiring extensive assistance.

On 11/06/18 at 01:52 PM, the Resident was observed sitting in the day room, fully clothed. The Resident had a bruise on her right arm above and anterior to her elbow with approximately a 3-inch diameter.

On 11/07/18 at approximately 12:45 PM, the Resident was observed sitting in the day area, eating lunch with staff assistance. She had a bruise on her right arm above and anterior to her elbow with approximately a 3- inch diameter.

On the afternoon of 11/07/18, fall records for last 4 months for this Resident were requested from the DON.

On 11/08/18, the DON stated there were no fall records for past four months for Resident #78.

The care plan was reviewed. An entry dated 09/28/18 for a cut on Resident's finger included the following interventions: "I need a weekly evaluation of wound healing. I need a daily observation of skin with routine care. I need a full skin evaluation weekly with bath/shower."

Nurse's notes for September - November 2018 were reviewed. The bruise on the right arm was not addressed.

On 11/08/18 at 8:40 AM, certified nursing

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assistant (CNA) C was asked about the origin of the bruise on this Resident's arm. The CNA was not aware the Resident had bruise on her right elbow. The CNA observed the bruise as the Resident was seated in the day room and the CNA stated 'it's an old bruise'. The bruise was yellowish in the center and purplish on the edges. Licensed practical nurse (LPN) E was standing nearby and stated that it was an old bruise but did not remember how the Resident acquired bruise but stated she 'wrote it up'.

On 11/08/2018 at 10:15 AM, an incident report about Resident #78's bruise on her right arm was requested from the DON and she stated "that's a new bruise" so the incident report has not been written yet.

On 11/08/18 at 10:30 AM, an interview with LPN E was conducted. LPN E stated she did a skin check on Resident #78 on Tuesday and that bruise (on the right arm) was not there. She went on to say that the Resident's daughter was walking her mom outside yesterday and then returned and showed the staff a bump on the back of the Resident's head. LPN E stated the bruise on the Resident's arm was a "new bruise from yesterday."

On 11/08/18 at approximately 2:45 PM, the DON presented an incident report about the bruise on the right arm. It was dated 11/08/18 at 9:30 AM and documented, "Pt is noted with intact bruise to R (right) Upper arm close to the elbow. RP (responsible party) acknowledged holding pt on both arm (sic) by the elbow during ambulation out side (sic) the building yesterday. Intact bruise with dark-red puplish (sic) edges and slight greenish in color that measures 6x5x0."

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F 609	Continued From page 24 The facility policy (revised 10/01/2017) for investigating and reporting accidents/incidents was reviewed. The facility policy states that "All accidents or incidents involving residents, employees, visitors, vendors, etc., occurring at our facilities must be investigated and reported to the Administrator." In Section 2.1 under General Guidelines part 1B, the policy states an incident report must be completed for all reported accidents or incidents." The purpose of investigating and reporting incidents is to "ensure the safety of all residents..." and investigations "into the cause of any incident will be tracked in order to improve care and to prevent future occurrences." In summary, a bruise was observed on Resident #78's right arm above her elbow on 11/06/18 by this surveyor and there was no evidence the staff was aware of the bruise, conducted an assessment, started an investigation, reported findings, or initiated a treatment plan. On 11/08/18 at approximately 2:45 PM, the Administrator and DON were notified of concerns and they offered no further information.	F 609		
F 656 SS=E	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	F 656	**F 656 Develop/Implement Comprehensive Care Plan** Compliance Date: 11/12/2018 **Immediate action taken for the resident found to have been affected include:**	11/12/18

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F 656	Continued From page 25 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 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, facility documentation review, and clinical record review, the facility staff failed to develop and implement a comprehensive person centered care plan for three Residents (Residents #43, #20, and #59) of	F 656	1. A comprehensive care plan for dementia care that describes and addresses behaviors was developed and implemented for Resident # 43 by the MDS Coordinator, Unit Manager and Interdisciplinary Team including the resident's sister on 11/9/2018. 2. A comprehensive care plan for dementia care that describes and addresses behaviors was developed and implemented for Resident #20 by the MDS Coordinator, Unit Manger and Interdisciplinary Team including resident's son on 11/9/2018. 3. Resident # 59's care plan was reviewed and updated on 11/9/18 by the MDS coordinator, Unit Manger and Interdisciplinary team to address his dementia needs and behaviors requiring use of psychotropic medications.	

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F 656	Continued From page 26 the 34 residents in the survey sample. 1. Resident #43 did not have a comprehensive care plan for dementia care. 2. Resident #20 did not have a comprehensive care plan for dementia care. 3. Resident #59's care plan did not describe, nor address, his dementia needs, or behaviors. The findings included: 1. Resident #43 did not have a comprehensive care plan for dementia care. Resident #43 was admitted to the facility on 10/31/17. Diagnoses included, but not limited to, Dementia, muscular dystrophy and high blood pressure. Resident #43's Minimum Data Set (MDS, an assessment protocol) with an Assessment Reference Date of 9-7-18 coded Resident #43 with severe cognitive impairment. The MDS was completed as a significant change in status assessment as the resident had completed Hospice. The resident required extensive care with all ADL's (activities of daily living such as bed mobility and toileting) of two staff members. The resident was incontinent of bowel and bladder. The resident was coded with no behaviors during the seven day lookback. Review of the Hospice notes dated 8-22-18 revealed: "Patient is in bed awake and confuse (sic). She appear (sic) lethargic, pale and thin.	F 656	**Identification of other residents having the potential to be affected.** The facility has determined that all residents with a dementia diagnosis have the potential to be affected. A review of the care plan for all residents with a dementia diagnosis was conducted on 11/12/18 by the Director of Nursing and MDS coordinators. Two residents' dementia care plans were reviewed and updated to describe and address behaviors on 11/12/18 by the MDS Coordinator, Unit Manger and Interdisciplinary Team.	

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F 656	Continued From page 27 On 11/08/18 at 10:02 AM, A phone interview with Other A (Hospice nurse) regarding Resident #43's use of Haldol was conducted. The Hospice nurse stated, "She has been discharged from Hospice a month ago." She also stated the Haldol was started because of increased screaming and yelling that would not subside and that it worked for her. She said Ativan did not work well, and the family did not want it used. 11/08/18 at 11:23 AM, a review of the clinical record including MAR's (medication administration record) revealed the resident started on 8-27-18 with Haldol 0.5 mg (milligrams) every day at bedtime for restlessness and agitation for 14 days. On 8-28-18, the order for Haldol was changed to give 0.5 mg every 4 hours as needed for restlessness and agitation for 14 days. None was given in September and it was discontinued after 14 days. On 9-14-18 the Haldol was increased to 0.5 mg twice daily. Review of Resident #43's care plan dated 9-14-18 contained the following: "I am at risk for side effects from antipsychotic drug use for restlessness and agitation." The interventions included: * Administer my medication as ordered by physician * Observe me for adverse side effects * Monitor my behavior * Pharmacy consultant review of my medication monthly * Keep call light within arm's length of me and teach me how to use call light to request assistance There were no targeted behaviors, non	F 656	**Actions taken/systems put into place to reduce the risk of future occurrence.** Education was done with the MDS Coordinators, Unit Managers, Social Services Director, and Activities Director by the Director of Nursing on 11/8/18 regarding the development and implementation of comprehensive care plan. Education was done for all licensed nurses starting on 11/8/18 by the Director of Nursing/Designee on policy and procedure of behavior management and documentation on residents with dementia. **How the corrective action(s) will be monitored to ensure the practice will not recur:** The Director of Nursing or designee will review care plans for residents with a diagnosis of dementia to ensure a comprehensive care is implemented that describes and addresses behaviors, weekly for 4 weeks then monthly for 2 months. The Administrator/Designee will present the results of reviews to the Quality Assurance Performance Improvement Committee for review	

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F 656	Continued From page 28 pharmacological interventions to address behaviors or to address dementia care. The facility presented a form named "Behavior Management". For yelling behaviors it included: "Give the person something to eat or suck on (hard candy). Distract the resident by talking or getting the resident involved in a favorite activity. Provide comfort such as touch (holding hands), music, or comfort objects (dolls or stuffed animals). If cause is overstimulation, move the person to a quieter environment. If cause is too little stimulation, give more chances for human contact. On 11/08/18 at 12:41 PM, an interview was conducted with LPN (licensed practical nurse) H. LPN (H) stated, "For dementia care, I will usually put that part in and will care plan with the behaviors." LPN (H) stated, It is not on the care plan" (interventions to address behaviors due to dementia). 2. Resident #20 did not have a comprehensive care plan for dementia care. Resident #20 was admitted to the facility on 2-10-18. Diagnoses included, but not limited to, Dementia, hypertension and prostate cancer. Resident #20's Minimum Data Set (MDS, an assessment protocol) with an Assessment Reference Date of 8-9-18 coded Resident #20 with severe cognitive impairment. The MDS was completed as a quarterly assessment. The resident required extensive care with all ADL's (activities of daily living such as bed mobility and toileting) of two staff members. The resident was	F 656	and further recommendations. Quality Assurance Performance Improvement Team Members include: Administrator, Director of Nursing, Staff Development Coordinator, Director of Social Services, Director of Dietary, Director of Housekeeping, Director of Maintenance, Nurse Managers, Minimum Data Set Coordinator, Medical Director, Director of Rehab Services, and Pharmacy Consultant. If issues are identified, then additional education will be provided and modification of the Plan of Correction will be made to address the deficient practice	

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incontinent of bowel and bladder. The resident was coded with behaviors not affecting others such as hitting 1-3 days during the 7 day lookback and wandering behaviors 4-6 days during the lookback period.

Review of the care plan dated 8-13-18 revealed the following regarding behaviors:

1. "Resident sleep (sic) on the floor difficult to redirect at time (sic). Interventions included not to argue with resident, Talk in a calm voice, redirect to sleep on the bed."

2. Attempt to get out of facility to go home wheeling the suitcase. Interventions included redirect resident in a calm manner, psych consult as needed, medications as needed and assist to secure unit when resident is actively exit seeking.

On 11/08/18 at 12:41 PM, an interview with LPN (Licensed practical nurse) H- care planner was conducted regarding behaviors of Resident #20 . She stated he disrobes, is resistant to care and is physically abusive. She was not sure if he has wanderguard, but all the doors are secured by code (will alarm if resident goes out). LPN (H) stated you never can tell what causes his behaviors. LPN (H) was unsure what kind of kind of job the resident had done in the past. The LPN did state that the behaviors were not addressed on the care plan.

Review of the Behavior Management form that was given to the surveyor by the DON (director of nursing) included behaviors such as wandering. The form included such interventions as minimizing day time napping, and that "exercise is good, let them pace." For a resident exposing

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himself, "look for the reason behind the behavior. He may simply need to go to the bathroom." Catastrophic reactions are "emotional outbursts such as crying or yelling, hitting or screaming. When residents have a catastrophic reaction it is usually in response to failure or feeling overwhelmed." Interventions include: "Approach calmly and slowly from the front, using a gentle but firm tone of voice. Do not argue, validate their feelings. Guide to a quiet place if necessary. If you are unable to calm the person and you need to protect yourself, get out of range or leave the room if the person is safe."

On 11-8-18 at approximately 2:30 PM, the Administrator and DON were notified of the above findings.

3. Resident #59's care plan did not describe, nor address, his dementia needs, nor behaviors, for which the Resident received 5 psychotropic medications.

Resident #59 was admitted to the facility on 4-25-18. Diagnoses included but were not limited to; unspecified dementia, without behavioral disturbance, Alzheimer dementia, femur fracture, dysphagia, history of falling, cardiac disease, and cognitive communication deficit.

Resident #59's most recent Minimum Data Set (an assessment protocol) was a quarterly assessment with an Assessment Reference Date of 10-17-18 coded Resident #59 with a BIMS (brief interview of mental status) score of "99", or

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unable to complete, due to cognitive impairment. Resident #59 required extensive assistance for his ADL's (activities of daily living such as bed mobility and toileting) of one to two staff members. The resident was incontinent of bowel & bladder.

On 11-7-18 at 10:30 a.m., Resident #59 was observed in the back of the main dining/living room area of the locked Alzheimer's unit. The Resident was sitting in a high back wheel chair at a dining table alone. The Resident was against the wall to his left, and had a short "knee" wall behind him. The Resident was staring down at the table, and nothing was on the table. The surveyor approached the Resident and said "hello", and asked the Resident his name, and other questions, the Resident did not look up or speak.

On 11-8-18 at 11:00 a.m., during a second observation of Resident #59, the Resident was observed in the back of the main dining/living room area of the locked Alzheimer's unit. The Resident was sitting in a high back wheel chair at a dining table alone. The Resident was against the wall to his left, and had a short "knee" wall behind him. The Resident was staring down at the table, and a newspaper was on the table folded, the Resident was not looking at it, but was staring down at the table. The surveyor approached the Resident and said "hello", and asked the Resident his name, and other questions, the Resident did not look up or speak.

Review of the physician's orders in the clinical record revealed the resident was currently receiving the following 5 psychotropic medications, and melatonin for sleep at night;

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1. Wellbutrin for depression
2. Depakote for unknown/no medical need given
3. Razadyne for dementia
4. Namenda for dementia
5. Seroquel for dementia with agitation

Review of the current care plan dated 5-3-18, revealed only 4 care planned problem areas that could be related to dementia. three were developed on 5-3-18, and the last was added on 6-20-18. Those follow with their goals and interventions to be used:

1. "PROBLEM". "The resident is easily upset, he refuses care, attempts to hit staff, and very difficult to redirect." The "GOAL". "safety of residents and staff with no incident reports of injury to others thru nrst (sic) review."
The "INTERVENTIONS/approaches". "approach resident with cayusion (sic), try to redirect resident, attend to needs as quickly as possible, continue full assist in care, ADL care".

2. "PROBLEM". "I am at risk for side effects from antidepressant medication use."
The "GOAL". "I will have no injury related to medication usage/side effects thru next review."
The "INTERVENTIONS/approaches". "administer my medication as ordered by physician, observe me for adverse side effects, document and report to physician, pharmacy consultant review of my medication monthly."

3. "PROBLEM". "I am at risk for side effects from antipsychotic drug use."
The "GOAL". "I will have no serious injury related to medication usage/side effects thru next review."

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The "INTERVENTIONS/approaches". "administer my medication as ordered by physician, observe me for adverse side effects, document and report to physician, monitor my behavior."

4. dated 6-20-18 "PROBLEM". "Impaired decision making skills related to diagnosis of Alzheimer's disease as evidenced by staff assessments for cognition."
The "GOAL". "Resident will accept judgement of staff/significant other regarding plan of care as appropriate thru next review date."
The "INTERVENTIONS/approaches". "explain each activity/care procedure prior to beginning it, observe for changes in cognitive status, establish daily routine with resident, praise resident for each decision made, give resident two choices when presenting decisions, offer simple choices to resident, give resident no choice that will be overwhelming".

Review of physician progress notes, to include geriatric psychiatric evaluations revealed that the only "behavior" documented in the clinical record was refusal of care, and agitation when staff pursued or insisted on giving care when the resident refused. Two gradual dose reductions were completed, (Razadyne in June 2018, and Seroquel in August 2018), with success, as no worsening of the Resident's refusal of care occurred afterward.

The Medication, and Treatment Administration Records (MAR's/TAR's) were reviewed and revealed an area for "Behavior charting". No "behaviors" were charted as ever occurring in the months of September, October, nor November 2018. For August 2018, only one time was

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behavior documented in a 4 month period, which was 8-30-18 at 3:00 p.m., and no nursing note describes what that episode consisted of.

Review of nursing progress notes revealed no aggressive behaviors toward peers. The only "behavior" documented in the clinical record was refusal of care, and agitation when staff pursued or insisted on giving care when the resident refused.

There were no targeted behaviors addressed on the plan of care, nor were there any non pharmacological interventions included for the Resident's refusal of care or agitation during refused care. There is no indication that the staff ever identified the possible reason for the refusal of care, nor were there any plans to mitigate the agitation and upset expressed by the Resident. The Resident had a flat and blunted, lethargic affect on both surveyor observations, and did not respond to direct questioning, nor did he interact with his surroundings. The Resident appeared as in a stupor, staring at the table, with no reaction to verbal stimuli.

On 11-8-18, an interview was conducted with LPN E. LPN E was the Resident's care giver, and stated when asked, "yes, I take care of him every day." LPN E stated that the Resident never bothered other Residents, he was just upset sometimes with staff when they tried to change him, or give him a bath. She further stated that the Resident liked the little area by the wall, and that he had a book he liked, and if staff gave it to him, he would sit quietly and was no problem at all. LPN A, the unit manager approached and stated, "we don't have any problem with him except for incontinent care, then he can get

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agitated, but the medicine helps with this." LPN A was asked why he was not allowed to refuse, and she stated "because he doesn't know what is best for himself because of his dementia."

On 11-8-18 at 12:20 p.m., an interview was conducted with the care plan coordinator LPN H. LPN H was asked to tell surveyors how care planning was completed for dementia residents, she stated "It can be done with behaviors included or not, but if the resident has behaviors we care plan it." She stated that the purpose of the care plan was to instruct staff on the care needed for this particular resident. She was asked to review Resident #59's care plan and tell me what his behaviors were, and what they were doing for them. LPN H stated "he refuses care, and will hit staff, and is difficult to redirect." She was asked what do staff do when this happens? She reviewed the care plan, and stated "I don't know." She was asked if she knew what triggered the refusals, and she stated "I don't know." She was asked if he received the psychotropic medications for these behaviors, and she stated "yes."

The Facility policy entitled "Behavior Management" was reviewed and revealed training was given to staff in regard to resisting care, catastrophic reactions, agitation, redirection, and interventions that would be appropriate in treating these circumstances. Most were not used in Resident # 59's care plan.

On 11-8-19 at 1:00 p.m., the Administrator and Director of Nursing (DON) were made aware of the findings. At the time of exit the DON stated there was no further information available to submit to surveyors.

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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 not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and clinical record review, the facility staff failed for 1 resident (Resident #82) of 34 residents in the survey sample to review and revise the comprehensive care plan. 1. For Resident #82, the facility did not discontinue the use of adaptive utensils on the	F 657	**F 657 Care Plan Timing and Revision** Compliance Date: 11/7/18 **Immediate action taken for the resident found to have been affected include:** Resident # 23's orders were reviewed. A clarification order was written on 11/7/18 by licensed nurse to discontinue the order for angled utensils. The care plan was updated on 11/7/18 by the MDS Coordinator to reflect the change. **Identification of other residents having the potential to be affected.** The facility has determined that residents with adaptive utensil use have the potential to be affected. All residents with orders for adaptive utensil were reviewed by the MDS Coordinator, Dietitian and Rehab Director on 11/7/18 to ensure residents orders were current and are accurately reflected on the care plan. No other residents identified to be affected by this practice.	11/7/18

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F 657	Continued From page 37 comprehensive care plan. The findings included: Resident #23, a 75 year old, was admitted to the facility on 4/17/17. Diagnoses included multiple sclerosis, dysphagia, paralytic syndrome, hypertension, diabetes and chronic kidney disease. The most recent Minimum Data Set assessment was significant change assessment with an assessment reference date of 8/14/18. The resident was coded with a Brief Interview of Mental Status score of 9 indicating moderate cognitive impairment and required extensive assistance with activities of daily living. On 11/7/18, Resident #23 was observed eating breakfast and lunch in her room. She was observed to use regular utensils during both meals. Resident #23's comprehensive care plan was reviewed. The care plan dated 3/24/18 read, "Resident requires angled utensils at every meal to enable her to help feed herself due to MS (multiple sclerosis)". The comments section dated 9/17/18 read continue with plan of care. At the end of day meeting on 11/7/18, the Administrator and Director of Nursing were notified that Resident #23 was observed eating without her adaptive utensils. On 11/8/18 at 8:30 a.m., the Administrator provide the following Occupational Therapy note dated 4/25/17, "pt (patient) does not want to use build up handles on utensils." The Administrator stated that the intervention should have been taken off the care plan.	F 657	**Actions taken/systems put into place to reduce the risk of future occurrence.** An in-service education program was conducted on 11/7/18 by the Rehab Director to the therapists regarding writing discontinue orders on adaptive utensils timely to reflect discontinuance of orders. An in-service education program was conducted by the Director of Nursing/Designee to the licensed nurses on the monitoring and use of adaptive utensils initiated on 11/8/18. **How the corrective action(s) will be monitored to ensure the practice will not recur:** The Director of Nursing and/or unit managers will review physician's orders daily during the morning clinical meeting to identify new or discontinued adaptive utensil orders to determine if care plans are updated with interventions in place and orders are carried out.	

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F 744 SS=E	Treatment/Service for Dementia CFR(s): 483.40(b)(3)	F 744		

§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, facility record review, and clinical record review, the facility staff failed to provide adequate treatment and services for four Residents with dementia (Resident #59, #43, #20, and #82) in a survey sample of 34 Residents.

1. Resident #59 received 5 psychotropic medications without non-pharmacological interventions, and was medicated for "behaviors", with none described or care planned for, other than refusing care, and attempting to hit staff when they did not afford him his right to refuse.

2. Resident #43 did not receive care and services for treatment of her dementia and was placed on an antipsychotic.

3. Resident #20 did not receive care and services to treat his dementia. Instead the resident was on two types of antipsychotics simultaneously.

4. For Resident #82, the facility staff failed to assess for triggers, identify behaviors, and develop non-pharmacological interventions to provide Resident-specific dementia care and services.

The findings included:

The Director of Nursing or designee will audit the residents with orders for adaptive utensil use daily for 2 weeks, 3 times a week for two weeks then weekly for 4 weeks to assure adaptive utensil use is in place and is accurately care planned.

The Director of Nursing/Designee will present the results of audits to the Quality Assurance Performance Improvement Committee for review and further recommendations. Quality Assurance Performance Improvement Team Members include: Administrator, Director of Nursing, Staff Development Coordinator, Director of Social Services, Director of Dietary, Director of Housekeeping, Director of Maintenance, Nurse Managers, Minimum Data Set Coordinator, Medical Director, Director of Rehab Services, and Pharmacy Consultant. If issues are identified, then additional education will be provided and modification of the Plan of Correction will be made to address the deficient practice

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F 744	Continued From page 39	F 744	**F 744 Treatment/ Service for Dementia**	11/12/18

1. Resident #59 received 5 psychotropic medications without non-pharmacological interventions, and was medicated for "behaviors", with none described or care planned for, other than refusing care, and attempting to hit staff when they do not afford him his right to refuse.

Resident #59 was admitted to the facility on 4-25-18. Diagnoses included but were not limited to; unspecified dementia, without behavioral disturbance, Alzheimer dementia, femur fracture, dysphagia, history of falling, cardiac disease, and cognitive communication deficit.

Resident #59's most recent Minimum Data Set (an assessment protocol) was a quarterly assessment with an Assessment Reference Date of 10-17-18 coded Resident #59 with a BIMS (brief interview of mental status) score of "99", or unable to complete, due to cognitive impairment. Resident #59 required extensive assistance for his ADL's (activities of daily living such as bed mobility and toileting) of one to two staff members. The resident was incontinent of bowel & bladder.

On 11-7-18 at 10:30 a.m., Resident #59 was observed in the back of the main dining/living room area of the locked Alzheimer's unit. The Resident was sitting in a high back wheel chair at a dining table alone. The Resident was against the wall to his left, and had a short "knee" wall behind him. The Resident was staring down at the table, and nothing was on the table. The surveyor approached the Resident and said "hello", and asked the Resident his name, and other questions, the Resident did not look up or speak.

Compliance Date: 11/12/2018

Immediate action taken for the resident found to have been affected include:

1. Resident # 59's care plan was reviewed and updated on 11/9/18 by the MDS coordinator, Unit Manger and Interdisciplinary team to address his dementia needs and behaviors with non-pharmacological interventions and approaches in addition to the use of psychotropic medications.

2. A comprehensive care plan for dementia care that describes and addresses behaviors with non-pharmacological interventions and approaches was developed and implemented for Resident # 43 by the MDS Coordinator, Unit Manager and Interdisciplinary Team including the resident's sister on 11/9/2018.

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F 744	Continued From page 40 On 11-8-18 at 11:00 a.m., during a second observation of Resident #59, the Resident was observed in the back of the main dining/living room area of the locked Alzheimer's unit. The Resident was sitting in a high back wheel chair at a dining table alone. The Resident was against the wall to his left, and had a short "knee" wall behind him. The Resident was staring down at the table, and a newspaper was on the table folded, the Resident was not looking at it, but was staring down at the table. The surveyor approached the Resident and said "hello", and asked the Resident his name, and other questions, the Resident did not look up or speak. Review of the physician's orders in the clinical record revealed the resident was currently receiving the following 5 psychotropic medications, and melatonin for sleep at night; 1. Wellbutrin for depression 2. Depakote for unknown/no medical need given 3. Razadyne for dementia 4. Namenda for dementia 5. Seroquel for dementia with agitation Review of the current care plan dated 5-3-18, revealed only 4 care planned problem areas that could be related to dementia. three were developed on 5-3-18, and the last was added on 6-20-18. Those follow with their goals and interventions to be used: 1. "PROBLEM". "The resident is easily upset, he refuses care, attempts to hit staff, and very difficult to redirect." The "GOAL". "safety of residents and staff with no incident reports of injury to others thru nrst (sic) review."	F 744	3. A comprehensive care plan for dementia care that describes and addresses behaviors with non-pharmacological interventions and approaches was developed and implemented for Resident #20 by the MDS Coordinator, Unit Manger and Interdisciplinary Team including resident's son on 11/9/2018. 4. Resident # 82's medication list and care plan reviewed on 11/9/2018 by licensed nurse, Seroquel was discontinued by the physician on 11/9/2018. Care plan for psychotropic drug use was resolved on 11/9/2018 by the Unit Manager. No further action required, resident is not receiving any psychotropic medication.	

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F 744	Continued From page 41 The "INTERVENTIONS/approaches". "approach resident with cayusion (sic), try to redirect resident, attend to needs as quickly as possible, continue full assist in care, ADL care". 2. "PROBLEM". "I am at risk for side effects from antidepressant medication use." The "GOAL". "I will have no injury related to medication usage/side effects thru next review." The "INTERVENTIONS/approaches". "administer my medication as ordered by physician, observe me for adverse side effects, document and report to physician, pharmacy consultant review of my medication monthly." 3. "PROBLEM". "I am at risk for side effects from antipsychotic drug use." The "GOAL". "I will have no serious injury related to medication usage/side effects thru next review." The "INTERVENTIONS/approaches". "administer my medication as ordered by physician, observe me for adverse side effects, document and report to physician, monitor my behavior." 4. dated 6-20-18 "PROBLEM". "Impaired decision making skills related to diagnosis of Alzheimer's disease as evidenced by staff assessments for cognition." The "GOAL". "Resident will accept judgement of staff/significant other regarding plan of care as appropriate thru next review date." The "INTERVENTIONS/approaches". "explain each activity/care procedure prior to beginning it, observe for changes in cognitive status, establish daily routine with resident, praise resident for each decision made, give resident two choices when presenting decisions, offer simple choices	F 744	**Identification of other residents having the potential to be affected.** The facility has determined that all residents receiving psychotropic medications have the potential to be affected. A review of the care plan and behavior management log for all residents with a dementia diagnosis was conducted on 11/12/18 by the Director of Nursing and MDS coordinators. Two residents' dementia care plans were reviewed and updated to describe and address behaviors with non-pharmacological approaches and interventions on 11/12/18 by the MDS Coordinator, Unit Manger and Interdisciplinary Team.	

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F 744	Continued From page 42 to resident, give resident no choice that will be overwhelming". Review of physician progress notes, to include geriatric psychiatric evaluations revealed that the only "behavior" documented in the clinical record was refusal of care, and agitation when staff pursued or insisted on giving care when the resident refused. Two gradual dose reductions were completed, (Razadyne in June 2018, and Seroquel in August 2018), with success, as no worsening of the Resident's refusal of care occurred afterward. Physician orders were reviewed and documented that Occupational Therapy was ordered to be continued 3 times per week for 1 week on 11-1-18, and Physical therapy was ordered to be continued 3 times per week for 6 weeks beginning 10-25-18. This indicated that the Resident did follow directions and was able to be directed and redirected or therapy would not have been appropriate to order. The Medication, and Treatment Administration Records (MAR's/TAR's) were reviewed and revealed an area for "Behavior charting". No "behaviors" were charted as ever occurring in the months of September, October, nor November 2018. For August 2018, only one time was behavior documented in a 4 month period, which was 8-30-18 at 3:00 p.m., and no nursing note describes what that episode consisted of. Review of nursing progress notes revealed no aggressive behaviors toward peers. The only "behavior" documented in the clinical record was refusal of care, and agitation when staff pursued or insisted on giving care when the resident	F 744	**Actions taken/systems put into place to reduce the risk of future occurrence.** An in-service education program was conducted by the Director of Nursing/Designee on policy and procedure of behavior management and documentation of non-pharmacological interventions utilizing the behavior monitoring tool to ensure dementia residents receive care and services to treat dementia was given to the licensed nursing staff starting on 11/9/2018. Education was done with the MDS Coordinators, Unit Managers, Social Services Director, and Activities Director by the Director of Nursing on 11/8/18 regarding the development and implementation of comprehensive care plan to include documentation of non-pharmacological approaches to reflect care and services given to treat dementia.	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 744	Continued From page 43	F 744	**How the corrective action(s) will be monitored to ensure the practice will not recur:**	

refused.

The only behaviors documented or described by staff is refusal of care, and agitation during care that is refused. There were no targeted behaviors addressed on the plan of care, nor were there any non pharmacological interventions included for the Resident's refusal of care or agitation during refused care. There is no indication that the staff ever identified the possible reason for the refusal of care, nor were there any plans to mitigate the agitation and upset expressed by the Resident. The Resident had a flat and blunted, lethargic affect on both surveyor observations, and did not respond to direct questioning, nor did he interact with his surroundings. The Resident appeared as in a stupor, staring at the table, with no reaction to verbal stimuli.

On 11-8-18, an interview was conducted with LPN E. LPN E was the Resident's care giver, and stated when asked, "yes, I take care of him every day." LPN E stated that the Resident never bothered other Residents, he was just upset sometimes with staff when they tried to change him, or give him a bath. She further stated that the Resident liked the little area by the wall, and that he had a book he liked, and if staff gave it to him, he would sit quietly and was no problem at all. LPN A, the unit manager approached and stated, "we don't have any problem with him except for incontinent care, then he can get agitated, but the medicine helps with this." LPN A was asked why he was not allowed to refuse, and she stated "because he doesn't know what is best for himself because of his dementia."

On 11-8-18 at 12:20 p.m., an interview was

The Director of Nursing and/or unit managers will review behavior monitoring tool for all residents utilizing psychotropic medication during the morning clinical meeting to ensure that non pharmacological interventions are utilized for residents manifesting inappropriate behaviors or mood and is accurately documented on the care plan including approaches, five times per week for 2 weeks, then 3 times a week for two weeks then weekly for 4 weeks.

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F 744	Continued From page 44 conducted with the care plan coordinator LPN H. LPN H was asked to tell surveyors how care planning was completed for dementia residents, she stated "It can be done with behaviors included or not, but if the resident has behaviors we care plan it." She stated that the purpose of the care plan was to instruct staff on the care needed for this particular resident. She was asked to review Resident #59's care plan and tell me what his behaviors were, and what they were doing for them. LPN H stated "he refuses care, and will hit staff, and is difficult to redirect." She was asked what do staff do when this happens? She reviewed the care plan, and stated "I don't know." She was asked if she knew what triggered the refusals, and she stated "I don't know." She was asked if he received the psychotropic medications for these behaviors, and she stated "yes." The Facility policy entitled "Behavior Management" was reviewed and revealed training was given to staff in regard to resisting care, catastrophic reactions, agitation, redirection, and interventions that would be appropriate in treating these circumstances. Most were not used in Resident # 59's care plan. On 11-8-19 at 1:00 p.m., the Administrator and Director of Nursing (DON) were made aware of the findings. At the time of exit the DON stated there was no further information available to submit to surveyors. 2. Resident #43 did not receive care and services for treatment of her dementia and was placed on an antipsychotic.	F 744	The Director of Nursing/Designee will present the results of reviews to the Quality Assurance Performance Improvement Committee for review and further recommendations. Quality Assurance Performance Improvement Team Members include: Administrator, Director of Nursing, Staff Development Coordinator, Director of Social Services, Director of Dietary, Director of Housekeeping, Director of Maintenance, Nurse Managers, Minimum Data Set Coordinator, Medical Director, Director of Rehab Services, and Pharmacy Consultant. If issues are identified, then additional education will be provided and modification of the Plan of Correction will be made to address the deficient practice	

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F 744	Continued From page 45	F 744		

Resident #43 was admitted to the facility on 10/31/17. Diagnoses included, but not limited to, Dementia, muscular dystrophy and high blood pressure.

Resident #43's Minimum Data Set (MDS, an assessment protocol) with an Assessment Reference Date of 9-7-18 coded Resident #43 with severe cognitive impairment. The MDS was completed as a significant change in status assessment as the resident had completed Hospice. The resident required extensive care with all ADL's (activities of daily living such as bed mobility and toileting) of two staff members. The resident was incontinent of bowel and bladder. The resident was coded with no behaviors during the seven day lookback.

11/07/18 01:35 PM, a clinical record review revealed Hospice was initiated 6-5-18 for senile degeneration and muscular dystrophy.

On 11/08/18 at 10:00 AM, a review of the meal intakes for September, October and November, 2018 revealed the resident had eaten 0% for meals 3 times in September, and 8 times in October, and had eaten only 25 % 17 times in September, 43 times in October and 14 times in November.

11/08/18 at 10:02 AM, a phone interview with other A (Hospice nurse) regarding Resident #20's use of Haldol was conducted. The Hospice nurse stated, "She has been discharged from Hospice a month ago." She also stated the Haldol was started because of increased screaming and yelling that would not subside and that it worked for her. She said Ativan did not work well, and

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F 744	Continued From page 46	F 744		

the family did not want it used.

11/08/18 at 11:23 AM Review of the clinical record including MAR's revealed 8-27-18, the resident was taking Haldol 0.5 mg (milligrams) every day at bedtime for restlessness and agitation for 14 days. On 8-28-18, the order was given for Haldol give 0.5 mg every 4 hours as needed for restlessness and agitation for 14 days. None was given in September and it was discontinued after 14 days.

On 7-11-18, a pharmacy recommendation addressed prn (as needed) haldol has been in place for more than 14 days. The physician declined the recommendation, "Passed (sic) attempt to schedule results in worsening Sx (symptoms). Patient is Hospice.".

On 9-14-18 the Haldol was increased to 0.5 mg twice daily and had been given during the days of survey.

Saunders Nursing Drug Handbook 2011, pages 558 to 560, classified Haldol as an antipsychotic, used to treat schizophrenia and Tourette's. There is a black box warning for this drug which states, "Increased risk of mortality in elderly patients with dementia related psychosis."

Review of Resident #43's care plan dated 9-14-18 contained the following: "I am at risk for side effects from antipsychotic drug use for restlessness and agitation." The interventions included:

* Administer my medication as ordered by physician
* Observe me for adverse side effects

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* Monitor my behavior
* Pharmacy consultant review of my medication monthly
* Keep call light within arm's length of me and teach me how to use call light to request assistance

There were no yelling behaviors or non pharmacological interventions in the care plan.

3. Resident #20 did not receive care and services to treat his dementia. Instead the resident was on two types of antipsychotics simultaneously.

Resident #20 was admitted to the facility on 2-10-18. Diagnoses included, but not limited to, Dementia, hypertension and prostate cancer.

Resident #20's Minimum Data Set (MDS, an assessment protocol) with an Assessment Reference Date of 8-9-18 coded Resident #20 with severe cognitive impairment. The MDS was completed as a quarterly assessment. The resident required extensive care with all ADL's (activities of daily living such as bed mobility and toileting) of two staff members. The resident was incontinent of bowel and bladder. The resident was coded with behaviors not affecting others such as hitting 1-3 days during the 7 day lookback and wandering behaviors 4-6 days during the lookback period.

On 11/07/18 at 10:19 AM, an interview was conducted the Resident's son on the phone. The son stated he has heard from the nurses that he is sleeping a lot, but that he had "violent behaviors" and the medication had to be

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increased recently.

On 11/07/18 at 12:59 PM LPN (licensed practical nurse) G, stated the resident had come out of his room wearing only brief and T shirt, tried to redirect him and he hit aide in the face. He was out of it completely "had to lock myself in room because he was trying to get at me." Appetite good, does not eat at usual times, give snacks. Will not wake him up as he gets very agitated.

On 11/07/18 at 1:03 PM the resident was observed sitting on side of bed, eating lunch. Would visibly flinch when construction worker drilling into wall next door. Cursed when noise would get louder next door.

On 11/07/18 at 3:25 PM an interview was conducted with the DON (director of nursing) regarding behaviors. The DON stated he wanders outside the room, not exit seeking, can come out naked, and that it had been awhile since he has been loud and angry.

On 11/08/18 at 8:45 AM, the resident was observed in room, in bed asleep. No tray was in the room.

On 11/08/18 at 10:02 AM, A phone interview with other A (Hospice nurse) regarding Resident #20's use of Haldol was conducted. The Hospice nurse stated, "He has been difficult to manage and had to have increased doses of Seroquel. She also stated the Haldol was used for agitation, he becomes restless, combative, refuses to follow commands and aggressive,. She stated that Haldol is "normally used for restlessness but the behavior itself was the reason the Haldol was being used."

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On 11/08/18 at 10:49 AM, a review of the clinical record including MAR's (medication administration record), behavior records revealed the resident was started on 8-1-18 on Haldol 2 mg (milligrams) every 6 hours for psychosis.

The resident also had an order dated 9-24-18 for Ativan (antianxiety) 0.5 mg every 4 hours as needed for agitation, which was discontinued on 10-17-18 (greater than 14 days). No Ativan was given during September. In October, the resident received Ativan on 10-4-18, 10-15-18, 10-16-18.

On 10-16-18, the as needed order for Ativan was renewed for 14 more days without a physician making a visit to the resident. The resident received Ativan twice on 10-25-18 and once on 10-30-18. The resident was also taking Seroquel (antipsychotic) started on 7-16-18 at once daily for delusions. On 9-24-18, the Seroquel was increased to 50 mg twice daily. On 11-6-18, the Seroquel dose was increased to 100 mg twice daily. The resident continued on Haldol 2 mg every 6 hours.

On 10-30-18, the Ativan was again renewed (without a physician assessment) and with no stop date and given on 10-3-18.

On 11/08/18 at 11:33 AM, a review of the physician's notes documented the resident had vascular dementia. The psychiatric nurse practitioner documented in the 8-20-18 notes, "Patient is very lethargic and on Haldol. Staff report he wakes up and become agitated at times. If he is in need of the Ativan (antianxiety) I will re add it to prn for later in the day, but his lethargy needs to be monitored and documented

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properly." Review of the psychiatric note dated 10-31-18 revealed the following: "Patient noted to be very lethargic today and hard to wake up for visit again." The psychiatric NP (nurse practitioner) also noted; "Watch lethargy and contact psych if it persists or worsens."

Review of the care plan dated 8-13-18 revealed the following regarding behaviors:

1. "Resident sleep (sic) on the floor difficult to redirect at time (sic). Interventions included not to argue with resident, Talk in a calm voice, redirect to sleep on the bed."

2. Attempt to get out of facility to go home wheeling the suitcase. Interventions included redirect resident in a calm manner, psych consult as needed, medications as needed and assist to secure unit when resident is actively exit seeking.

On 11/08/18 at 12:41 PM, an interview with LPN (Licensed practical nurse) H- care planner was conducted regarding behaviors of Resident #20 . She stated he disrobes, is resistant to care and is physically abusive. She was not sure if he has wanderguard, but all the doors are secured by code (will alarm if resident goes out). LPN (H) stated you never can tell what causes his behaviors. LPN (H) was unsure what kind of kind of job the resident had done in the past. The LPN did state that the behaviors were not addressed on the care plan.

11/08/18 at 1:02 PM An interview with the DON was again conducted. She stated he fights with staff, gets agitated. She then described agitation as "he tries to punch and kick." She stated Haldol is used for bipolar, schizophrenia,

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Touretts, Huntington's, to control behaviors for dementia. When asked about overuse of antipsychotic medications, the DON stated, "You don't want to chemically restrain or decrease the quality of life."

Saunders Nursing Drug Handbook 2011, pages 558 to 560, classified Haldol as an antipsychotic, used to treat schizophrenia and Tourette's. There is a black box warning for this drug which states, "Increased risk of mortality in elderly patients with dementia related psychosis."

Saunders Nursing Drug Handbook, 2011, pages 984-986 classified Seroquel as an antipsychotic, used to treat schizophrenia, acute manic episodes of bipolar disorder. It also has a black box warning in the elderly with dementia related psychosis are at increased risk of death.

Review of the Behavior Management form that was given to the surveyor by the DON (director of nursing) included behaviors such as wandering. The form included such interventions as minimizing day time napping, and that "exercise is good, let them pace." For a resident exposing himself, "look for the reason behind the behavior. He may simply need to go to the bathroom." Catastrophic reactions are "emotional outbursts such as crying or yelling, hitting or screaming. When residents have a catastrophic reaction it is usually in response to failure or feeling overwhelmed." Interventions include: "Approach calmly and slowly from the front, using a gentle but firm tone of voice. Do not argue, validate their feelings. Guide to a quiet place if necessary. If you are unable to calm the person and you need to protect yourself, get out of range or leave the room if the person is safe."

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On 11-8-18 at approximately 2:30 PM, the Administrator and DON were notified of above findings.

4. For Resident #82, the facility staff failed to assess for triggers, identify behaviors, and develop non-pharmacological interventions to provide Resident-specific dementia care and services.

Resident #82, an 88 year old female was admitted to the facility on 11/16/17. Diagnoses include dysphagia and dementia.

Resident #82's most recent quarterly Minimum Data Set (MDS) had an Assessment Reference Date (ARD) of 08/09/2018. Resident #82 was not coded with a Brief Interview of Mental Status (BIMS) score but cognitive skills for daily decision making were coded as severely impaired. Functional status for bed mobility, dressing, eating, and personal hygiene was coded as requiring extensive assistance.

On 11/06/18 at 1:25 PM, the Resident was observed in her bed with family at bedside. The Resident was awake, calm, and the head of the head was elevated approximately 60 degrees. She had oxygen on at 2 liters/minute via nasal cannula.

On 11/07/18 at 8:40 AM, the Resident was observed awake in bed, quiet, with the head of bed elevated approximately 60 degrees. She had oxygen on at 2 liters/minute via nasal cannula.

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The physician's orders were reviewed. An order dated 11/16/17 documented, "Dental, Psych, Podiatric, Opthamological and Audiological services may be obtained for the resident as indicated."

An order dated 11/16/17 documented, "Quetiapine fumarate 25 mg tab. Give one tablet by mouth at bedtime for mood."

An order dated 11/16/17 documented, "Monitor and document mood and behavior every shift."

The Medication Regime Review document with dates ranging from 12/6/17 to 10/9/18 was reviewed. The page contained monthly pharmacist signatures and dated. For monthly entries on 12/6/17, 1/8/18, 2/7/18, 3/8/18, 4/9/18, and 6/8/18, the box labeled "see report for any noted irregularities and/or recommendations" was selected. For monthly entries dated 5/4/18, 7/11/18, 8/13/18, 9/12/18, and 10/9/18, the box labeled "NI (no irregularities)" was selected. There was no other documentation on the form.

The MAR (medication administration record) for October and November 2018 was reviewed. Quetiapine was signed off as being administered daily as scheduled. Under behavior charting, "monitor and document mood and behavior every shift", there were staff initials daily and "0" behaviors documented daily.

Resident notes were reviewed ranging August - November 2018. Asocial service entry dated 8/10/18 at 2:23 PM documented, "She is pleasant and cooperative with care and no moods or behaviors have been documented. Resident is on Seroquel for mood and is being followed by psych

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group for medication management."

A nurse's note dated 8/24/18 at 10:20 PM documented, "no abnormal behavior/distress observed."

A social services note dated 10/11/18 at 8:00 PM documented, "No mood alteration has been documented. Resident continues on Seroquel for mood and Melatonin for sleep. Resident is generally pleasant but has a habit of grabbing or pinching at times."

An interdisciplinary team meeting/MDS note dated 10/16/18 at 2:43 PM documented, "Receives psychotropic medications for insomnia and mood disorder no adverse side effects noted at this time."

A nurse's note dated 10/20/18 documented, "Resident alert and verbally responsive. Pleasant and cooperative."

A nurse's note dated 11/8/18 at 3:33 AM documented, "Resident unable to comprehend commands when spoken to but would smile at staff speaking to her."

The care plan was reviewed. A problem onset dated 11/29/17 documented, "I am at risk for side effects from antipsychotic drug use due to mood." Interventions included, "Administer my medication as ordered by physician. Observe me for adverse side effects, document and report to my physician. Monitor my behavior." There were no targeted behaviors listed on the care plan or non-pharmacological interventions associated with behaviors of grabbing or pinching as documented in the social services note.

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F 744	Continued From page 55 There was no evidence in the nurse's notes or care plan the Resident has been assessed to develop and implement Resident-specific behavior management associated with diagnosis of dementia and Resident's personal preference and expressions. On 11/08/18 at 11:45 AM, when LPN B was asked about behaviors exhibited by Resident #82, she stated she hasn't seen any behaviors in Resident #82. She went on to say Resident #82 is "always sweet." On 11/08/18, at 1:00 PM, the MDS/care plan nurse was asked what would be on the care plan for residents with dementia and she stated "you can have dementia with behaviors or without behaviors." When asked what would be on the care plan for a resident with dementia that had no behaviors and she stated "dementia care" but was unable to elaborate. On 11/08/18 at approximately 2:45 PM, the Administrator and DON were notified of concerns and they offered no further information.	F 744	**F 755 Pharmacy Services** Compliance Date: 11/8/2018 **Immediate action taken for the resident found to have been affected include:** Resident #29 was evaluated on 11/9/18 by Unit Manager, no complaints of pain or signs and symptoms of GI discomfort or reflux noted. MD and RP made aware. No further action required. **Identification of other residents having the potential to be affected.** The facility has determined that all residents have the potential to be affected.	11/8/18
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.	F 755	100% audit of resident charts for non-covered medication notifications were conducted on 11/9/2018 by the unit managers to assure all notifications have been addressed by the physician and all medications have been provided to the residents. No other residents were identified to be affected by this practice.	

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F 755	Continued From page 56 §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility documentation and clinical record review the facility failed for 1 resident (Resident #29) in a survey sample of 34 Residents to provide medications as ordered by physician. For Resident #29 the facility failed to obtain medication ordered by physician or obtain substitute until the medication was available. The findings include: Resident #29, a 69 year old man, was admitted to the facility on 10/10/2016 with diagnoses	F 755	**Actions taken/systems put into place to reduce the risk of future occurrence.** An in-service education program was conducted by the Director of Nursing/Designee to all licensed nurses initiated on 11/9/2018 on ensuring pharmacy recommendations are reviewed, completed and addressed timely by the physician and that all medications are administered as ordered. Emphasis made on ensuring availability of medication or obtaining alternative pharmaceutical therapy if not available. **How the corrective action(s) will be monitored to ensure the practice will not recur:** The Director of Nursing and/or unit managers will review pharmacy recommendations during the morning clinical meeting to assure recommendations are carried out timely and medications are administered as ordered; five times per week for 2 weeks, then 3 times a week for two weeks then weekly for 4 weeks.	

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F 755	Continued From page 57 including but not limited to Dysphagia, Muscular weakness, Aphasia (inability to talk), Parkinson's disease, and Hemiplegia. The most recent (Minimum Data Set) MDS with an (Assessment Reference Date) ARD of 02/19/2018 coded the Resident as having a (Brief Interview of Mental Status) of 15 indicating no cognitive impairment. On 11/7/2018 during clinical record review it was noted that Resident had order for Protonix Suspension 40 (milligrams) mg (by mouth) PO every day for (Gastro Esophageal Reflux Disease). The medication had been originally ordered on 10/13/2017. On review of the (Medication Administration Record) it was noted that the Resident missed 11 doses of the medication in October. 10/05/2018 at 6:00 AM 10/10/2018 at 6:00 AM 10/11/2018 at 6:00 AM 10/13/2018 at 6:00 AM 10/14/2018 at 6:00 AM 10/15/2018 at 6:00 AM 10/16/2018 at 6:00 AM 10/17/2018 at 6:00 AM 10/18/2018 at 6:00 AM 10/19/2018 at 6:00 AM 10/20/2018 at 6:00 AM On 11/8/2018 an interview was conducted with the DON who stated "Well the insurance refused to pay for the liquid Protonix anymore and this Resident cannot swallow pills and he needs the liquid." She went on to say they used to cover it but then stopped paying for the liquid and the Pharmacy tried to get the doctor to substitute but	F 755	The Director of Nursing/Designee will present the results of audits to the Quality Assurance Performance Improvement Committee for review and further recommendations. Quality Assurance Performance Improvement Team Members include: Administrator, Director of Nursing, Staff Development Coordinator, Director of Social Services, Director of Dietary, Director of Housekeeping, Director of Maintenance, Nurse Managers, Minimum Data Set Coordinator, Medical Director, Director of Rehab Services, and Pharmacy Consultant. If issues are identified, then additional education will be provided and modification of the Plan of Correction will be made to address the deficient practice	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 755	Continued From page 58 the "Doctor would not sign, he refused the Pharmacy Recommendations." The DON supplied three pharmacy recommendations titled "Urgent - Non -Covered Medication" - one notification was dated 07/25/18 the second one was dated 08/28/2018 and the third was dated 10/1/2018 all of the documents were marked as "DENIED - Severe Dysphagia". The DON stated that the doctor finally substituted the Protonix with another medication when he saw the insurance would not cover it. The Doctor wrote an order on 10/21/2018 for "Dexilant DR 60 mg by mouth once daily. Swallowing- may open capsule and sprinkle content onto apple sauce to be swallowed whole do not chew." The Administrator was made aware on 11/6/2018 and no further information was provided.	F 755	**F 758 Free of Unnecessary Psychotropic Meds/PRN use** Compliance Date: 11/21/2018 **Immediate action taken for the resident found to have been affected include:** Resident #4 was assessed by the psychiatric Nurse Practitioner on 11/21/2018, to review Temazepam use, gradual dose reduction not done, due to patient's request to continue with therapy. Melatonin was discontinued. Resident # 82, medication list reviewed on 11/9/2018 by licensed nurse, Seroquel was discontinued by the physician on 11/9/2018. Care plan for psychotropic drug use was resolved on 11/9/2018 by the Unit Manager. No further action required.	11/21/18
F 758 SS=D	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---	F 758		

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F 758	Continued From page 59 §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive 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 staff interview, facility documentation and clinical record review the facility failed to ensure that 2 Residents (Resident #4 and #82) in a survey sample of 34 Residents were free from	F 758	**Identification of other residents having the potential to be affected.** The facility has determined that all residents receiving psychoactive medications have the potential to be affected. 100% audit on all residents taking psychoactive medications were initiated on 11/9/2018 by the Director of Nursing and Unit Managers to ensure that all psychoactive medications have an attempted gradual dose reduction in place. No other resident identified to have been affected by this practice. 100% audit on all residents taking psychoactive medications were initiated on 11/9/2018 by the Director of Nursing and Unit Managers to ensure that residents that are taking antipsychotic medications have an appropriate diagnosis which excludes dementia. No other resident identified to have been affected by this practice.	

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	495337	A. BUILDING _____ B. WING _____	11/08/2018

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F 758	Continued From page 60 unnecessary medications. 1. For Resident #4, the facility failed to attempt gradual dose reduction of Psychotropic Drug Temazepam for a year. 2. For Resident #82, the facility staff failed to ensure she was free from the psychotropic medication Seroquel which is not indicated for residents with a diagnosis of dementia. The findings included: Resident #4, a 76 year old man, was admitted to the facility on 01/01/2013 with diagnoses of but not limited to Diabetes, Hypertension, Atrial Fibrillation, and Depressive Disorder. On 11/06/2018 during clinical record review it was noted that Resident #4 had orders for Temazepam 15 (milligram) mg 1 capsule by mouth at bedtime and that order started on 5/7/2017 he also had an order for Wellbutrin ER 75 mg. (an antidepressant) twice daily. On 11/08/2018 at 11:00 AM an interview was conducted with the DON and she was asked why Resident was on Temazepam she stated "Temazepam is a Hypnotic he takes it to help him sleep." When asked about the Wellbutrin she stated "The Wellbutrin is an Antidepressant." Upon further investigation of the clinical record the Resident has had Pharmacy reviews every month however they failed to suggest a GDR for the Psychotropic medications. On 11/08/2018 during end of day meeting with	F 758	**Actions taken/systems put into place to reduce the risk of future occurrence.** An in-service education on ensuring GDR's are done timely for residents with psychoactive medication use was given by the Medical Director on 11/21/018 to the Psychiatric services team to ensure GDR's are done timely per pharmacy recommendations and state guidelines. An in-service education was given on 11/21/2018 by the Medical Director to the Psychiatric Services team on ensuring appropriate diagnosis is provided for all antipsychotic drug use. **How the corrective action(s) will be monitored to ensure the practice will not recur:** The Director of Nursing and/or unit managers will review pharmacy recommendations monthly for requests for GDR and ensure follow through by attending physician or psychiatric practitioner. Review will be done monthly.	

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F 758	Continued From page 61 DON she stated "It was my understanding that only Psychoactive Medications like Seroquel and Zyprexa needed a GDR." On 11/08/2018 during clinical record review it was noted that according to the MDS from past year there has been no GDR for the Psychotropic medications. According to the MDS: Annual - 10/31/2017 Section N- Medications- Resident #4 was coded as having received Antidepressants as well as Hypnotics 7 days a week. According to section N-0450- Has GDR (Gradual Dose Reduction) been attempted the question was left blank. Section C - Last attempted GDR- NONE. Section E- Date physician document clinically contraindicated - NONE Quarterly MDS- 01/30/18 -Section N- Medications- Resident #4 was coded as having received Antidepressants as well as Hypnotics 7 days a week. According to section N-0450- Has GDR (Gradual Dose Reduction) been attempted the question was left blank. Section C - Last attempted GDR- NONE. Section E- Date physician document clinically contraindicated - NONE Quarterly -4/30/2018 -Section N- Medications- Resident #4 was coded as having received Antidepressants as well as Hypnotics 7 days a week. According to section N-0450- Has GDR (Gradual Dose Reduction) been attempted the question was left blank. Section C - Last attempted GDR-NONE. Section E- Date physician document clinically contraindicated -	F 758	The Director of Nursing and Designee will review telephone orders daily during morning clinical meeting to ensure appropriate diagnosis is used for patients taking psychotropic medications. To be done daily for 2 weeks, three times a week for 2 weeks, monthly for 2 months. The Director of Nursing/Designee will present the results of reviews to the Quality Assurance Performance Improvement Committee for review and further recommendations. Quality Assurance Performance Improvement Team Members include: Administrator, Director of Nursing, Staff Development Coordinator, Director of Social Services, Director of Dietary, Director of Housekeeping, Director of Maintenance, Nurse Managers, Minimum Data Set Coordinator, Medical Director, Director of Rehab Services, and Pharmacy Consultant. If issues are identified, then additional education will be provided and modification of the Plan of Correction will be made to address the deficient practice	

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NONE

Quarterly - 07/30/2018- Section N- Medications- Resident #4 was coded as having received Antidepressants as well as Hypnotics 7 days a week. According to section N-0450- Has GDR (Gradual Dose Reduction) been attempted the question was left blank. Section C - Last attempted GDR- NONE. Section E- Date physician document clinically contraindicated - NONE

Administrator was notified of lack of GDR on 11/08/2018 no further information was provided.

2. For Resident #82, the facility staff failed to ensure she was free from the psychotropic medication Seroquel which is not indicated for residents with a diagnosis of dementia.

Resident #82, an 88 year old female was admitted to the facility on 11/16/17. Diagnoses include dysphagia and dementia.

Resident #82's most recent quarterly Minimum Data Set (MDS) had an Assessment Reference Date (ARD) of 08/09/2018. Resident #82 was not coded with a Brief Interview of Mental Status (BIMS) score but cognitive skills for daily decision making were coded as severely impaired. Functional status for bed mobility, dressing, eating, and personal hygiene was coded as requiring extensive assistance.

On 11/06/18 at 1:25 PM, the Resident was observed in her bed with family at bedside. The Resident was awake, calm, and the head of the

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head was elevated approximately 60 degrees. She had oxygen on at 2 liters/minute via nasal cannula.

On 11/07/18 at 8:40 AM, the Resident was observed awake in bed, quiet, with the head of bed elevated approximately 60 degrees. She had oxygen on at 2 liters/minute via nasal cannula.

The physician's orders were reviewed. An order dated 11/16/17 documented, "Dental, Psych, Podiatric, Opthamological and Audiological services may be obtained for the resident as indicated."

An order dated 11/16/17 documented, "Quetiapine fumarate 25 mg tab. Give one tablet by mouth at bedtime for mood."

An order dated 11/16/17 documented, "Monitor and document mood and behavior every shift."

The Medication Regime Review document with dates ranging from 12/6/17 to 10/9/18 was reviewed. The page contains monthly pharmacist signatures and dated. For monthly entries on 12/6/17, 1/8/18, 2/7/18, 3/8/18, 4/9/18, and 6/8/18, the box labeled "see report for any noted irregularities and/or recommendations" is selected. For monthly entries dated 5/4/18, 7/11/18, 8/13/18, 9/12/18, and 10/9/18, the box labeled "NI (no irregularities)" is selected. There was no other documentation on the form.

The MAR (medication administration record) for October and November 2018 was reviewed. Quetiapine was signed off as being administered daily as scheduled. Under behavior charting, "monitor and document mood and behavior every

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shift", there were staff initials daily and "0" behaviors documented daily.

Resident notes were reviewed ranging August - November 2018. Asocial service entry dated 8/10/18 at 2:23 PM documented, "She is pleasant and cooperative with care and no moods or behaviors have been documented. Resident is on Seroquel for mood and is being followed by psych group for medication management."

A nurse's note dated 8/24/18 at 10:20 PM documented, "no abnormal behavior/distress observed."

A social services note dated 10/11/18 at 8:00 PM documented, "No mood alteration has been documented. Resident continues on Seroquel for mood and Melatonin for sleep. Resident is generally pleasant but has a habit of grabbing or pinching at times."

An interdisciplinary team meeting/MDS note dated 10/16/18 at 2:43 PM documented, "Receives psychotropic medications for insomnia and mood disorder no adverse side effects noted at this time."

A nurse's note dated 10/20/18 documented, "Resident alert and verbally responsive. Pleasant and cooperative."

A nurse's note dated 11/8/18 at 3:33 AM documented, "Resident unable to comprehend commands when spoken to but would smile at staff speaking to her."

The care plan was reviewed. A problem onset dated 11/29/17 documented, "I am at risk for side

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effects from antipsychotic drug use due to mood." Interventions included, "Administer my medication as ordered by physician. Observe me for adverse side effects, document and report to my physician. Monitor my behavior." There were no targeted behaviors listed on the care plan or non-pharmacological interventions associated with behaviors of grabbing or pinching as documented in the social services note.

There was no evidence in the nurse's notes or care plan the Resident has been assessed to develop and implement Resident-specific behavior management associated with diagnosis of dementia and Resident's personal preference and expressions.

On 11/08/18 at 11:45 AM, when LPN B was asked about behaviors exhibited by Resident #82, she stated she hasn't seen any behaviors in Resident #82. She went on to say Resident #82 is "always sweet."

On 11/08/18 at approximately 1:10 PM, the DON was asked about antipsychotics and she stated she would expect to see antipsychotics prescribed for residents with bipolar, schizophrenia, Tourette syndrome, and Huntington's (chorea). When asked why a resident with dementia is prescribed an antipsychotic, she stated they are used a lot for residents with dementia and behavior problems. She went on to say they don't want to chemically restrain or over-sedate (residents).

On 11/08/18 at approximately 2:45 PM, the Administrator and DON were notified of concerns and they offered no further information.

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F 758	Continued From page 66 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).	F 758	**F 761 Label/Store Drugs and Biologicals** Compliance Date: 11/7/2018	11/7/18
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, staff Interview, and facility Record Review, the facility staff failed to ensure that medications were not in an unlocked area,	F 761	**Immediate action taken for the resident found to have been affected include:** The medications were removed from the wall cabinet by the Unit Manager on 11/7/18 and was disposed of according to facility policy. Unit does not have any wandering patients at the time of incident. No further action required. All unit wall cabinets and common areas searched for unlocked and unsecured medications on 11/7/2018 by the Director of Nursing and Unit Managers. No other unit was identified to be affected by this practice. **Identification of other residents having the potential to be affected.** The facility has determined that all residents have the potential to be affected. All unit wall cabinets and common areas searched for unlocked and unsecured medications on	

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F 761	Continued From page 67 and available to residents. A wall cabinet on the Azalea unit was open, unlocked, and could be easily accessed by wandering Residents. The cabinet contained 2 open gallon sized zip lock bags of various medications, on the bottom shelf, closest to the counter top. The findings include: On 11-17-18 at 9:17 a.m., The wall cabinet directly over the nursing station counter top, was opened by surveyors from the hallway. The cabinet contained 2 large gallon size zip lock bags full of open, and unopened medications. No nursing staff were in the nursing station, and Residents were wandering the halls freely. Some residents were noted to be in wheel chairs, and some were ambulatory. On 11-17-18 at 9:30 a.m., A Licensed Practical Nurse returned to the nursing station (LPN F), and surveyors pointed to the medications from the cabinet at that time, and asked her why the medications were there unlocked. LPN F stated "We put them in the cabinet waiting to destroy them." LPN F then started to leave the nursing station, and was asked if she planned to leave the medications there, and she stated "I am waiting for the DON" (Director of Nursing). She then exited the nursing station again leaving the medications unattended. Surveyors then removed the medications from the cabinet and began documenting what was found in the bags. On 11-17-18 at 9:36 a.m., the nurse and DON arrived on the unit and spoke with surveyors.	F 761	11/7/2018 by the Director of Nursing and Unit Managers. No other unit was identified to be affected by this practice. **Actions taken/systems put into place to reduce the risk of future occurrence.** An in-service education program was conducted by the Director of Nursing/Designee on 11/7/2018 to all licensed nurses regarding medication storage and disposal policy. **How the corrective action(s) will be monitored to ensure the practice will not recur:** The Director of Nursing or designee will perform inspections on all unit wall cabinets and common areas for unsecured and unlocked medications daily for two weeks, three times a week for two weeks, weekly for two weeks and monthly for two months to ensure all medications are stored according to policy and remains out of access to residents.	

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F 761	Continued From page 68 The DON was asked if medications should be left unlocked and unattended in the cabinet, and she stated "no." A third surveyor observed the locked medication storage room, and LPN F stated that room was where medications should be stored, and pointed to a large bin which she stated was "where medications were placed to return to the pharmacy". Those medications were opened, and unopened, but were not scheduled (controlled) drugs. LPN F stated "all controlled drugs had to be destroyed by 2 nurses, the pharmacy would not take them back, one of the nurses present to destroy controlled medications was always the DON." The medications found in the unlocked cabinet were reviewed by 2 surveyors, and found to be; some new medications that were unopened and not expired, some opened medications with no open date, so expiration could not be known, and some open with an open date on the bottle, and were expired. The bags contained multiple bottles of those medications listed below, some open & some unopened. The items were as follows; Tylenol suppositories 325 mg (milligrams) unopened Sodium chloride tablets 1000 mg opened, and unopened Vitamin C 500 mg opened, and unopened Multivitamins opened, and unopened Zinc 220 mg opened, and unopened Dulcolax 5 mg opened Calcium carbonate 500 mg opened, and unopened Iron plus Vitamin C opened	F 761	The Director of Nursing/Designee will present the results of audits to the Quality Assurance Performance Improvement Committee for review and further recommendations. Quality Assurance Performance Improvement Team Members include: Administrator, Director of Nursing, Staff Development Coordinator, Director of Social Services, Director of Dietary, Director of Housekeeping, Director of Maintenance, Nurse Managers, Minimum Data Set Coordinator, Medical Director, Director of Rehab Services, and Pharmacy Consultant. If issues are identified, then additional education will be provided and modification of the Plan of Correction will be made to address the deficient practice	

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F 761	Continued From page 69 Loratidine opened Pepcid 10 mg opened Vitamin B complex opened Docusate 100 mg opened Senna plus 60 mg opened Magnesium oxide 400 mg opened Iron tablets opened Review of the pharmacy policy and procedure for medication storage was discussed with the DON. She stated that "Facility staff should record the date opened on the medication container when the medication has been opened, and all medications must be stored in a locked area unavailable to residents." On 11-17-18, and 11-18-18, at the end of day debriefs the facility Administrator and DON were notified of the above findings.	F 761	**F 808 Therapeutic Diet Prescribed by Physician** Compliance Date: 11/7/2018 **Immediate action taken for the resident found to have been affected include:** Resident #25's fluid restriction order was clarified on 11/7/2018 and again on 11/8/2018 by licensed nurse to indicate correct amount of fluid restriction to be observed by the dietary department and was reflected on the dinner meal ticket for 11/8/2018. No further action required.	11/7/18
F 808 SS=D	Therapeutic Diet Prescribed by Physician CFR(s): 483.60(e)(1)(2) §483.60(e) Therapeutic Diets §483.60(e)(1) Therapeutic diets must be prescribed by the attending physician. §483.60(e)(2) The attending physician may delegate to a registered or licensed dietitian the task of prescribing a resident's diet, including a therapeutic diet, to the extent allowed by State law. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility documentation and clinical record review the facility failed to ensure that 1 Resident (Resident #55) of 34 residents was provided the therapeutic diet as ordered by physician.	F 808	**Identification of other residents having the potential to be affected.** The facility has determined that all residents who are on a fluid restriction have the potential to be affected.	

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F 808	Continued From page 70 For Resident #55 the facility failed to ensure Resident was given the correct amount of fluids on his fluid restricted Renal Diet. The findings included: Resident #55 a 79 year old man was admitted to the facility with diagnoses of but not limited to End Stage Renal Disease, Dependent on Renal Dialysis, Dysphagia, (Methicillin Resistant Staphylococcus Aurous) MRSA to (Peripherally Inserted Central line Catheter) PICC line. On 11/7/2018 it was noted during clinical record review that Resident was on a fluid restricted renal diet due to his diagnosis of End Stage Renal Disease. The order in the chart dated 10/23/2018 that read " Fluid Restrictions: Day 150 (milliliters) ml. Evening 100 ml, Night 50 ml, Total 300. The Remaining Fluid to Be Provided By Dietary." The order did not specify how much the additional fluid to be provided by Dietary was supposed to be. Further down on the list of orders was an order dated 10/19/18 that read "Fluid Restriction 1.5 ml in 24 hours." During lunch observation on 11/8/2018 it was noted that the Resident only had 8 oz. tea on his lunch tray. On 11/8/2018 Employee A was asked to pull the Dietary Tickets for Resident #55. The dietary ticket showed Fluid Restriction 1400 ml / day. Breakfast states 620 ml, he was given 8 oz. each of Water and milk and 4 oz. of orange juice. Under that statement there is DISLIKES- MILK, REGULAR SUGAR. The Resident gets milk	F 808	An audit of all residents with a fluid restriction was conducted by the Director of Nursing and Unit Mangers on 11/7/2018 to ensure fluid restriction orders and meal tickets are accurate and residents are receiving correct amounts of fluid based on their restriction. No other resident was identified to have been affected by this practice. **Actions taken/systems put into place to reduce the risk of future occurrence.** An in-service education program was initiated on 11/7/2018 by the Director of Nursing/Designee to the Registered Dietitian, dietary staff and nursing personnel on ensuring accuracy of fluid amount provided to residents with fluid restrictions. **How the corrective action(s) will be monitored to ensure the practice will not recur:** The Director of Nursing or designee will review physicians orders and telephone orders daily for two weeks, then 3 times a week for two weeks then weekly for 4 weeks to ensure adequate and accurate amounts of fluid are provided to residents with a fluid restriction.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495337	A. BUILDING _____ B. WING _____	11/08/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEEWOOD HEALTHCARE CENTER	7120 BRADDOCK ROAD ANNANDALE, VA 22003

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 808	Continued From page 71 which is mentioned under dislikes and is using up 240 ml of his allotted 1500 ml of fluids. The DON was notified of the discrepancy in orders vs. Dietary tickets. DON stated she was not sure why the Dietary orders stated 1400 ml /day fluid restriction and the chart stated 1500 ml /day. The DON came back later that day and stated that she had spoken to the doctor and clarified that it should have been 1500 ml /day and 300 ml to be given by nursing staff the remaining 1200 ml by Dietary. The DON also stated she would check with the Resident's family to find out what the preferences are as resident is non English speaking. The Administrator was notified at the end of day meeting on 11/7/2018 and no further information was provided.	F 808	The Director of Nursing/Designee will present the results of audits to the Quality Assurance Performance Improvement Committee for review and further recommendations. Quality Assurance Performance Improvement Team Members include: Administrator, Director of Nursing, Staff Development Coordinator, Director of Social Services, Director of Dietary, Director of Housekeeping, Director of Maintenance, Nurse Managers, Minimum Data Set Coordinator, Medical Director, Director of Rehab Services, and Pharmacy Consultant. If issues are identified, then additional education will be provided and modification of the Plan of Correction will be made to address the deficient practice	