STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49E131	A. BUILDING _____ B. WING _____	03/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SW VA M H INST GERI TRT CTR	340 BAGLEY CIRCLE MARION, VA 24354

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E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 03/12/19 through 03/14/19. The facility was in substantial compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities.	E 000		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 3/12/19 through 3/14/19. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. The census in this 25 certified bed facility was 20 at the time of the survey. The survey sample consisted of 13 current Resident reviews and 2 closed record reviews.	F 000	RECEIVED APR 0 2 2019 VDH/OLC	
F 558 SS=C	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview and staff interview, the facility staff failed to post the diet menu at a level that was visual by residents seated in wheelchairs and non-ambulatory residents. The findings included:	F 558	**F 558** Menu displayed at eye level in the Visitor's Room readily accessible to those in wheelchairs. Nursing staff make announcements of menu each day, respond to inquiries by individuals/family/visitors regarding menus and provide copies of menus upon request. Copies provided by Unit Secretary each week, pending installation of Plexiglass slide box for menu display at eye level near the Dayroom for those in wheelchairs and/or non-ambulatory.	03/13/19 03/14/19

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

R. Michael Torres Ph.D./LNHA | Director Geriatric Services | 03/29/19

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 558	Continued From page 1 The facility staff failed to post the diet menus at a level that could be viewed by residents seated in wheelchairs and those residents that were non-ambulatory. The surveyor met with the resident council on 3/12/19 at 2:30 p.m. The four members that attended the resident council requested the therapeutic recreational therapist join the meeting. When the surveyor asked the group about the food, one member of the resident council (Resident #16) stated, "You have to call the staff over to find out what's on the menu. If you are in a wheelchair, you can't see the menus." Upon completion of the resident council meeting, the therapeutic recreational therapist and the surveyor viewed the area where the diet menus were kept. The diet menus, along with the Resident Rights poster and state survey results, were kept in a locked Plexiglas display cabinet near the entrance to the unit. The cabinet was above the handrails. The therapeutic recreational therapist stated the menus are "way too high and the font is way too little on the menus for someone in a wheelchair to see." The surveyor was unable to read the menus from a wheelchair. The therapeutic recreational therapist stated the entire bulletin board needed to be lowered so everything would be at eye level. The surveyor informed the administrator, the assistant administrator/licensed clinical social worker and the registered nurse program coordinator of the above concern on 3/13/19 at 4:12 p.m. The R.N. coordinator stated the	F 558	B & G staff constructing and installing a Plexiglass slide box specifically for display of menu at eye level for those in wheelchairs and/or non-ambulatory on the wall near the Dayroom. Unit Secretary to print menu weekly and insert into the Plexiglass slide box. Program Director/designee to visually inspect the menu Plexiglass slide box each week to verify display of current menu. Inspections to continue pending three consecutive month of 100% compliance. Program Director responsible for monitoring/implementation of correction action plan for this finding.	03/27/19 03/27/19 03/29/19 & Ongoing 03/29/19 & Ongoing

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F 558	Continued From page 2 resident rights and the survey results are located in the visitor's room near the front entrance to the unit. The surveyor and the registered nurse program coordinator checked the visitor's room after the end of the day meeting. The survey results were located in a notebook and the Resident Rights poster was placed on the wall at eye level. RN Program Coordinator stated, "The administrator is taking care of the Plexiglas for the menus." No further information was provided prior to the exit conference on 3/14/19.	F 558		
F 622 SS=D	Transfer and Discharge Requirements CFR(s): 483.15(c)(1)(i)(ii)(2)(i)-(iii) §483.15(c) Transfer and discharge- §483.15(c)(1) Facility requirements- (i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless- (A) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility; (B) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility; (C) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident; (D) The health of individuals in the facility would otherwise be endangered; (E) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not	F 622	**F 622** Resident #12 was transferred to the local ER on January 29, 2019. There were daily contacts between nursing staff at the two facilities until resident's return on February 7, 2019. This resident has not had any transfers since that date. The CTP will be sent with or faxed for future transfers. There have been no further transfers to the ER. Each RN assigned to Wards E/F received an educational notification by the UNC with information to send a copy of the CTP with <u>each</u> resident being transferred to the ER or the CTP can be faxed in event of emergent need for transfer to the ER (ER fax # given). Specific	03/15/19 03/19/19 03/19/19

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F 622	Continued From page 3 submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or (F) The facility ceases to operate. (ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose. §483.15(c)(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider. (i) Documentation in the resident's medical record must include: (A) The basis for the transfer per paragraph (c)(1)(i) of this section. (B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s).	F 622	instructions for printing the CTP were given to the RNs. Laminated information regarding the CTP and how to print placed at each nursing desk computer. Printing or faxing of the CTP added to the Emergency Transfer Check List utilized by RNs to ensure completion. Enhancement Ticket submitted for the CTP to be added to the Electronic Health Record Transfer Report. The UNC/designee will audit 100% of transfers for Electronic Health Record (EHR) documentation of CTP being sent or faxed. Monitoring to be continued for six consecutive months for 100% compliance. Facility DON/CNE responsible for the implementation of this element of the Plan of Correction.	03/21/19 03/21/19 03/22/19 & Ongoing 03/22/19 04/26/19 & Ongoing

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F 622	Continued From page 4 (ii) The documentation required by paragraph (c)(2)(i) of this section must be made by- (A) The resident's physician when transfer or discharge is necessary under paragraph (c) (1) (A) or (B) of this section; and (B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to provide the receiving provider with care plan goals when the resident was transferred for 1 of 15 residents in the survey sample, Resident #12. Findings included: Resident #12 was admitted to the facility on 09/30/2018. Diagnoses included, but were not limited to, major neurocognitive disorder, cerebrovascular disease, diabetes, hypertension, and chronic kidney disease.	F 622		

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F 622	Continued From page 5 Section C (cognitive patterns) of Resident #12's most recent MDS (minimum data set) assessment with an ARD (assessment reference date) of 02/20/18 included a BIMS (brief interview for mental status) summary score of 03 out of a possible 15 points. On 03/12/19 at 12:00pm the surveyor interviewed Resident #12. During the interview, Resident #12 voiced he was recently hospitalized for a heart attack. On 03/13/19 the surveyor reviewed Resident # 12's clinical record. It contained a nurse progress note dated 01/29/19 at 8:56am that read in part: "...evaluation at local hospital via 911/ambulance transport. His LAR (legal authorized representative) was notified of the change in patient condition and ER (emergency room) evaluation at 0830 by RN ...Resident #12 left facility at 0847. Report called to local hospital by RN. Resident #12 left facility at 0847 via local fire and rescue, accompanied by PCT (patient care technician) ..." The surveyor reviewed a physician order dated 01/29/19 at 08:44am which read in part: "Transfer to local hospital er BY AMBULANCE". On 03/13/19 at 4:30 pm, the surveyor spoke to RN (registered nurse) #1 during an end of day meeting with the facilities administrative team. The surveyor asked RN#1, "What health information was sent with Residents upon transfer to the local hospital?" RN #1 stated "MARs (medication administration records), the physician calls report to the ER physician and the nurse calls report to the ER nurse. There is a packet we send. Contact information and code	F 622		

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F 622	Continued From page 6 status is also sent". The surveyor asked if the comprehensive care plan goals are sent with the Resident, RN #1 stated "No, we do not". No further information regarding this issue was provided to the survey team prior to the exit conference on 03/14/19.	F 622		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to ensure an accurate MDS (minimum data set) assessment for 1 of 15 residents (Resident #19). The findings included: The facility staff failed to code Resident #19's fall on the 1/15/19 MDS. The clinical record of Resident #19 was reviewed 3/12/19 through 3/14/19. Resident #19 was admitted to the facility 2/16/18 with diagnosis that included but not limited to bipolar disorder, generalized pain, hyperlipidemia, hypertension, hypothyroidism, osteoporosis, hysterectomy, and cerebral shunt insertion. Resident #19's annual MDS with an assessment reference date (ARD) of 1/15/19 assessed the resident with a brief interview for mental status in Section C0500 as 4/15. Section G Functional Status assessed the resident to need supervision	F 641	**F 641** MDS-Section J Health Conditions for individual #19 corrected by attending physician and Team/MDS Nurse to accurately reflect the fall experience in December 2018. The most recent MDS-Section J Health Conditions for the other 19 individuals reviewed along with Nursing Progress Notes for the 90 day period prior to the respected ARD date of each to determine if any had experienced a fall that had not been accurately coded on the MDS. Team Nurse to reflect any falls, including date of last fall, that have been experienced since the last Review in Focus Area 8 (Medical Issues) Summary of Progress Section in the individual's Treatment Plan. Attending physician present at Quarterly/Annual Treatment Planning Review Conferences will review Nursing Progress Notes for the 90 day period	03/28/19 04/19/19 04/01/19 & Ongoing 03/18/19 & Ongoing

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F 641	Continued From page 7 of one person for transfers and supervision only to walk in room. Section J Health Conditions did not have any falls coded. The nursing progress note dated 12/28/18 11:46 a.m. read "Resident #19 was in her room sitting in wheelchair and reports she leaned over to retrieve some items off of the floor and fell out of chair onto her knees. Not witnessed. Denies pain. Assessed by staff, assisted back into wheelchair." The comprehensive MDS with an ARD of 1/15/19 did not have any falls coded. The surveyor interviewed registered nurse #1 on 3/14/19 at 9:15 a.m. R.N. #1 reviewed the nursing progress note and the MDS. R.N. #1 stated in the computer there were no falls coded for the 1/15/19 MDS. R.N. #1 stated the psychiatrist are responsible for Section I, J, N and some of S. R.N. #1 stated a "locum" was the psychiatrist responsible for the 1/15/19 MDS. The surveyor informed the administrator, the registered nurse program coordinator, and the assistant administrator/licensed clinical social worker of the above concern of Resident #19's inaccurate MDS assessment in the end of the day meeting on 3/14/19 at 12:35 p.m. No further information was provided prior to the exit conference on 3/14/19.	F 641	immediately prior to the date of the Review to determine the existence of any falls and, if present, accurately code on respective MDS-Section J Health Conditions. Respective attending physician will attest to Medical director the accuracy of each MDS-Section J. LCSW/LNHA or designee will review 50% of completed MDS-Section J Health Conditions each month to determine accuracy of coding of falls. Any identified inaccuracies to be reported to Medical director for correction. Review to continue for six consecutive months of 100% compliance. Facility Medical Director responsible for monitoring/implementation of corrective action plan for this finding.	04/26/19 & Ongoing 04/26/19 & Ongoing
F 758 SS=E	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that	F 758		

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F 758	Continued From page 8 affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive 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.	F 758		

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F 758	Continued From page 9 §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 and clinical record review, the facility staff failed to ensure 4 of 15 residents were free of unnecessary psychotropic medications that affected Resident #4, Resident #7, Resident #19, and Resident #20. The findings included: 1. The facility staff failed to discontinue or review the use of the prn (as needed) medication Olanzapine for Resident #4. Resident #4 was admitted to the facility on 3/28/14. Diagnoses included but not limited to unspecified schizophrenia, major neurocognitive disorder with behavioral disturbances, anemia, chronic kidney disease, constipation, chronic obstructive pulmonary disease, hypertension, diabetes and prolapsed rectum. Resident #4's most recent quarterly MDS (minimum data set) assessment with an assessment reference date (ARD) of 1/24/19 assessed the resident with a brief interview for mental status (BIMS) as 1/15. There were signs of delusions, inattention and disorganized thinking. Resident #4's clinical record was reviewed 3/12/19 through 3/14/19. The March 2019 physician's order had an order that read in part	F 758	**F 758** The prior Physician's Order for Olanzapine 5 mg every 12 hours PRN for agitation/restlessness for individual #4 exceeded the 14 day limit. The order was corrected by Dr. E. Jones to reflect limit to 14 days. Medication Orders for the other 19 individuals reviewed by Medical staff to identify and correct any anti-psychotic PRN medication orders that did not reflect limit of 14 days. Pharmacy Director submitted a ticket to OneMind Sorian Clinicals/Cerner Pharmacy EHR to establish a "pop-up" or "reminder" to the prescriber of the 14 day limit of PRN orders. Pharmacist completing Drug Regimen	03/14/19 04/05/19 03/25/19 03/25/19

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F 758	Continued From page 10 "Olanzapine 5 mg (milligrams) = 1 tab q 12h (every 12 hours) PRN agitation/restlessness for 365". The order for the prn Olanzapine did not have an end date and there was no documentation in Resident #4's clinical record that the physician had re-evaluated the resident for continued use of the prn medication. The surveyor informed the registered nurse unit coordinator, the administrator, and the assistant administrator/licensed clinical social worker of the above concern on 3/13/19 at 4:12 p.m. regarding Resident #4. The registered nurse unit coordinator informed the surveyor on 3/14/19 at 8:08 a.m. that the order had been changed 3/14/19. The R.N. unit coordinator stated Resident #4 had a locum but never got the prn medication. No further information was provided prior to the exit conference on 3/14/19. 2. The facility staff failed to document the indications for use and the targeted behaviors when Resident #7 was administered Olanzapine on 2/28/19 and 3/8/19. The clinical record of Resident #7 was reviewed 3/12/19 through 3/14/19. Resident #7 was admitted to the facility 12/22/17 with diagnoses that included but not limited to bipolar disorder, degenerative joint disease, diabetes mellitus, generalized pain, hyperlipidemia, hypertension, obesity, osteoarthritis, breast cancer, Parkinson's disease and gastrointestinal obstruction. Resident #7's quarterly minimum data set (MDS) assessment with an assessment reference date	F 758	Reviews to include an alert to the prescribing physician and Medical Director of any anti-psychotic PRN medication orders not reflecting the 14 day limit. Medical Director to address/correct any identified anti-psychotic PRN medication orders not reflecting the 14 day limit with the prescribing physician. Facility Medical Director responsible for monitoring/implementation of corrective action plan for this element of the finding. **F 758** Residents #7, #19, and #20 EHR MAK (EHR Medication Administration Check) were reviewed for Psychiatric PRN medication administration. EHR does not provide for post event documentation. Therefore, documentation of rationale for PRN administration or non-pharmacological interventions attempted for these residents on the referenced dates cannot be completed in the EHR. None of these residents have received	& Ongoing 03/25/19 & Ongoing 04/26/19 & Ongoing 03/15/19

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F 758	Continued From page 11 (ARD) of 2/11/19 assessed the resident with a brief interview for mental status (BIMS) as 13/15. There were no signs of delirium. Resident #7 was assessed with inattention, disorganized thinking, verbal and physical behaviors directed towards others, and other behaviors not directed at others. Resident #7's February 2019 and March 2019 physician orders included "Olanzapine 5 mg (milligrams) =1 tab oral q12h (every 12 hours) psychotic agitation for 14 days for mood disorder or schizophrenia." The surveyor reviewed the February 2019 and March 2019 electronic medication administration record. Resident #7 was administered Olanzapine 5 mg on 2/28/19 at 11:36 a.m. and on 3/8/19 at 7:52 a.m. The surveyor was unable to locate the indications for use or the targeted behaviors in the clinical record. The surveyor informed the head nurse registered nurse #2 on 3/14/19 at 10:27 a.m. The head nurse R.N. #2 stated there were no notes written for those specific days. The surveyor asked if the nursing staff should document why medications were administered and the head nurse R.N. #2 stated "yes." The surveyor informed the administrator, the registered nurse program coordinator, and the assistant administrator/licensed clinical social worker of the above concern with administration of antipsychotic medication to Resident #7 without adequate monitoring and indication for use in the end of the day meeting on 3/14/19 at 12:35 p.m.	F 758	any psychiatric PRN medications in the interim of this review date. UNC conducted a review of PRN medications administered with EHR documentation for 100% of residents. Documentation of the PRN medication and EHR note were present. Each LPN and RN assigned to Ward E/F received an educational notification by the UNC with information to document specific behaviors and interventions attempted prior to the need for a PRN medication. Laminated instructions placed in unit medication room for need of documentation with each PRN medication administration. Notification to facility leaders sent for pulled and float medication nurses. The UNC/designee will audit 100% of psychiatric PRN medications administered for EHR documentation. Monitoring to be continued for six consecutive months of 100% compliance. Facility DON/CNE responsible for the implementation of this element of the Plan of Correction.	03/15/19 03/14/19 03/21/19 03/21/19 03/15/19 & Ongoing 03/15/19 04/26/19 & Ongoing

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F 758	Continued From page 12 No further information was provided prior to the exit conference on 3/14/19. 3. The facility staff failed to document reasons in the nursing notes for the administration of prn (as needed) Zyprexa (an antipsychotic) for Resident #19. Resident #19 received Olanzapine on 3/8/19 at 8:26 a.m., 3/10/19 at 8:53 a.m., 3/11/19 at 11:02 a.m., and 3/12/19 at 7:29 a.m. without indications for use. The comprehensive treatment plan did not include targeted behaviors for Olanzapine administration, and did not include non-pharmacological interventions prior to administration. The clinical record of Resident #19 was reviewed 3/12/19 through 3/14/19. Resident #19 was admitted to the facility 2/16/18 with diagnosis that included but not limited to bipolar disorder, generalized pain, hyperlipidemia, hypertension, hypothyroidism, osteoporosis, hysterectomy, and cerebral shunt insertion. Resident #19's annual MDS with an assessment reference date (ARD) of 1/15/19 assessed the resident with a brief interview for mental status in Section C0500 as 4/15. Resident #19 was assessed with signs of delusions and behaviors affecting others included physical and verbal. Resident #19's comprehensive treatment plan dated 1/30/19 included focus area for psychiatric/psychological areas. Active: paranoid, delusional, preoccupied with religion and having babies, intrusiveness, agitation and threatening behaviors toward staff and other residents. Interventions/goals included to take medications as prescribed, be free of intruding in	F 758	Treatment Team to complete review of the Comprehensive Treatment Plan for individual #19 to incorporate specific non-pharmacological interventions to address the clinical issues associated with the utilization of psychiatric PRN medications. Respective Treatment Teams to review the Comprehensive Treatment Plans for all of the other individuals to ensure the presence of or incorporate specific non-pharmacological interventions to address any clinical issues for which psychiatric PRN medications are utilized. An inquiry regarding the presence of non-pharmacological interventions in Treatment Plans will be added to the Clinical Pertinence Review Forms that are completed on a random sample of individuals each month. Program Director to address any deficiencies identified during these monthly Reviews with the respective Department Director. Monitoring of this item to continue pending six consecutive months of 100% compliance. Program Director responsible for monitoring and implementation of corrective action plan for this element of the finding.	04/09/19 04/26/19 04/26/19 & Ongoing 04/26/19 & Ongoing

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F 758	Continued From page 13	F 758		

others rooms, personal space, and be free of verbal aggression. Resident #19 will share one coping skill she can use when she feels upset in the community. Above interventions discussed with the resident.

There were no specific non-pharmacological interventions on the comprehensive treatment plan dated 1/30/19.

The March 2019 physician's orders read "Olanzapine 5 mg (milligrams) 1 tab oral every eight hours as needed for anxiety/agitation/aggression for mood disorder or schizophrenia. Start date: 2/5/19 and Stop date: 12/30/19."

The physician order for Olanzapine was greater than 14 days.

The surveyor was unable to locate the reasons for the administration of Olanzapine on 3/8/19, 3/10/19, 3/11/19 and 3/12/19 and informed the head nurse of the unit registered nurse #2 on 3/13/19 at 9:28 a.m.

R.N. #2 informed the surveyor on 3/13/19 at 9:55 a.m. the nurses who administered the Olanzapine failed to document the reasons the medication was administered. R.N. #2 stated some of the nurses were part time but expected the nursing staff to document the reasons why medications were administered.

The surveyor informed the administrator, the registered nurse program coordinator, and the assistant administrator/licensed clinical social worker of the above concern with administration of antipsychotic medication to Resident #19

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F 758	Continued From page 14 without adequate monitoring, no end date to the current physician order and the lack of non-pharmacological interventions on the comprehensive treatment plan in the end of the day meeting on 3/14/19 at 12:35 p.m. No further information was provided prior to the exit conference on 3/14/19. 4. The facility staff failed to document the reasons Resident #20 was administered Olanzapine. The clinical record of Resident #20 was reviewed 3/12/19 through 3/14/19. Resident #20 was admitted to the facility 1/21/17 with diagnoses that included but not limited to adjustment disorder with anxiety, mild intellectual disability, schizoaffective disorder, depression type, history of Hepatitis C, uterine cancer, recurrent urinary tract infections, and hypothyroidism. Resident #20's quarterly minimum data set (MDS) assessment with an assessment reference date (ARD) of 1/28/19 assessed the resident with a brief interview for mental status (BIMS) as 7/15. There were no signs or symptoms of delirium or psychosis. Resident #20 was assessed to have verbal behaviors, other behavioral symptoms, and rejection of care during the look back period. Resident #20's comprehensive treatment plan dated 12/28/18 identified behaviors of aggression, agitation, yelling, and suicidal ideation and thoughts of self-harm. Interventions: Observe and document behaviors by ward staff, engage in conversation every shift and 1-1, and weekly reminiscing road trip.	F 758		

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F 758	Continued From page 15 Resident #20's February 2019 and March 2019 physician's orders include the following: Olanzapine 2.5 mg (milligrams) oral q (every) 12 h (hours) prn (as needed) for psychotic agitation for 14 days bid (twice a day) prn (as needed)-start date 3/12/19, end state 3/26/19. The March electronic medication administration record (eMAR) was reviewed. Resident #20 was administered Olanzapine 2.5 mg on 2/2/19 at 10:00 a.m., 2/5/19 at 14:49 (2:29 p.m.), 2/17/19 at 8:44 a.m., and 3/12/19 at 8:40 a.m. The surveyor was unable to locate any documentation in the nursing progress notes for the reasons Resident #20 received prn Olanzapine (an antipsychotic). The surveyor informed the head nurse registered nurse #2 on 3/13/19 at 2:57 p.m. of the above concern. The head nurse R.N. #2 informed the surveyor on 3/13/19 at 3:10 p.m. that the nurses had failed to document the reasons for the administration of Olanzapine to Resident #20 on 2/2/19, 2/5/19, 2/17/19 and 3/12/19. The surveyor asked if the nurses who administered Resident #20 Olanzapine should document the reasons why, R.N. #2 stated yes and the nursing staff would be receiving education. The surveyor informed the administrator, the registered nurse program coordinator, and the assistant administrator/licensed clinical social worker of the above concern with administration of antipsychotic medication to Resident #20 without adequate monitoring and indication for use in the end of the day meeting on 3/14/19 at 12:35 p.m.	F 758		

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F 758	Continued From page 16 No further information was provided prior to the exit conference on 3/14/19.	F 758	**F 842**	
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings,	F 842	Resident #1 DNR form obtained from prior facility residence. DNR form scanned into EHR. Record appropriately labeled as DNR. UNC reviewed 100% of charts and EHR for DNR status, forms, Physician orders, chart flagged, and DNR form scanned into the EHR for each resident. Instructions sent to treatment teams for each new DNR completed form to be given to the Ward Clerk by the Team Nurse/designee. The physician shall order the DNR status into the EHR. The Ward Clerk will deliver to HIM for scanning into the EHR. The Ward Clerk will bring the DNR form back to the chart. The chart will be appropriately labeled as DNR as will the Patient Profile information form for shift report. UNC/designee is to be informed by the Team Nurse/designee and Ward Clerk for any DNR status changes when they occur. Monitoring to be continued for six consecutive months of 100% compliance. Facility DON/CNE responsible for the implementation of this element of the Plan of Correction.	03/20/19 03/20/19 03/21/19 03/20/19 & Ongoing 03/22/19 04/26/19 & Ongoing

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F 842	Continued From page 17 law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review the facility staff failed to sustain an accurate clinical record for 1 of 15 Residents, Resident #15. Findings included:	F 842		

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F 842	Continued From page 18 For Resident #15, the facility failed to ensure accurate code status in physician's orders. The Resident is a DNR (Do Not Resuscitate) and the physician's orders indicated the Resident was a full code. Per clinical record review Resident #15 was admitted to the facility on 10/21/18. Diagnosis included but were not limited to major neurocognitive disorder, cerebrovascular disease, gastro esophageal reflux disease, hypertension, and history of head injury. Section C (cognitive patterns) of Resident #15's admission MDS (minimum data set) assessment with an ARD (assessment reference date) of 12/18/18 included a BIMS (brief interview for mental status) summary score of 15 out of a possible 15 points. On 03/12/19 at 2:59pm the surveyor reviewed Resident 15's clinical record. The Resident's clinical record included a DDNR (durable do not resuscitate) order form dated 09/26/18 from the Virginia Department of Health. The clinical record included an active Physician's order dated 10/22/18 which read in part: "Code Status: Full Code". On 03/13/19 at 12:15pm the surveyor asked RN (registered nurse) #1 if Resident #15 was a DNR and voiced the concern of Resident #15's inaccurate clinical record. RN#1 stated "I will have to look into this and see". RN #1 verified that Resident #15's clinical record was inaccurate. RN#1 stated "This was an oversight and did not get changed. I will have that done".	F 842		

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F 842	Continued From page 19 The administrative team was made aware of the above findings on 03/13/19 at 4:30pm at the end of day meeting. No further information regarding this issue was provided to the survey team prior to the exit conference on 03/14/19.	F 842		