STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49E076	A. BUILDING _____ B. WING _____	12/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SNYDER NURSING HOME	11 NORTH BROAD ST SALEM, VA 24153

(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
E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 12/18/18 through 12/20/18. The facility was in substantial compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities. No complaint(s) were investigated during the survey.	E 000		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 12/18/18 through 12/20/18. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. The census in this 45 certified bed facility was 40 at the time of the survey. The final survey sample consisted of 15 current Resident reviews and one (1) closed record review.	F 000		
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to	F 578		2/3/19

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

Electronically Signed | 01/25/2019

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F 578	Continued From page 1 inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State Law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to ensure the DDNR (durable do not resuscitate order) was complete for 1 of 15 residents (Resident #18). The findings included: The facility staff failed to ensure Resident #18's DDNR was accurate. The clinical record of Resident #18 was reviewed 12/18/18 through 12/20/18. Resident #18 was admitted to the facility 7/25/18 with diagnoses that	F 578	Snyder Nursing Home maintains, in accordance with accepted professional standards and practices that facility resident comprehensive assessments do ensure residents have the right to request, refuse and/or discontinue treatment, to participate in experimental research, and to formulate an advanced directive. On December 19, 2018, a Facility Incident Report was filed on behalf of Resident #18's DDNR status seeking clarification and accuracy review from the Facility	

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F 578	Continued From page 2 included but not limited to dementia without behavioral disturbances, chronic obstructive pulmonary disease, chronic kidney disease, hypertension, gastroesophageal reflux disease, and Vitamin D deficiency. Resident #18's quarterly minimum data set (MDS) assessment with an assessment reference date (ARD) of 10/23/18 assessed the resident with a BIMS (brief interview for mental status) summary score of 01/15. Resident #18's clinical record contained a Durable Do Not Resuscitate Order (DDNR) dated 5/15/11. The DDNR was incomplete. Section 1 of the DDNR read in part, "I further certify [must check 1 or 2]: 1. The patient is CAPABLE of making an informed decision... 2. The patient is INCAPABLE of making an informed decision..." The boxes beside #1 and #2 were blank. Section 2 read "If you checked 2 above, check A, B, or C below:" The three boxes below were blank. The surveyor informed the administrator and the director of nursing of the incomplete DDNR in the end of the day meeting on 12/18/18 at 5:13 p.m. No further information was provided prior to the exit conference on 12/20/18.	F 578	Medical Director. On December 19,2018, Resident #18's medical record and DDNR status was reviewed with this resident's Power of Attorney. The resident's Power of Attorney did consent on the resident's behalf to revise/make an accurate and complete DDNR order for Resident #18. On December 20, 2018, an audit was performed by the Director of Nursing on 100% of the medical records to determine the accuracy and completeness of all DDNR orders. This audit determined that all other DDNR orders where accurate and complete. To prevent the reoccurrence of this type of deficiency, the facility policy and procedure pertaining to DDNR orders was reviewed for revision by the Medical Director, Director of Nursing, Administrator, the Interdisciplinary Care Plan team, the QA/QI Team and the QA/PI team. This review was completed on December 28, 2018. To prevent the reoccurrence of this type of deficiency, all Care Plan Team members and Nurses will receive additional training and education pertaining to Advanced Directives and DDNR Orders. This training will include: DDNR accuracy and completeness. This training will be conducted by the Director of Nursing or her designee and Relias Learning Services. This training will be completed by January 31, 2019.	

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F 578	Continued From page 3	F 578	To prevent the reoccurrence of this type of deficiency, the Facility QA/QI and QA/PI teams will review this plan of correction at least quarterly for ongoing compliance. This will be an ongoing QA/QI and QA/PI measure.	
F 758 SS=E	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order	F 758		2/3/19

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F 758	Continued From page 4 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 document review, and clinical record review, the facility staff failed to ensure 8 of 15 residents were free of an unnecessary medication (Resident #20, Resident #15, Resident #29, Resident #35, Resident #33, Resident #5, Resident #8, Resident #38). The findings included: 1. The facility staff failed to document when Resident #20 exhibited behaviors to support the use of the antidepressant Zoloft and failed to ensure the current comprehensive care plan included targeted behaviors for the use of Zoloft (an antidepressant). Resident #20 was admitted to the facility 4/3/2007 and readmitted 12/23/14 with diagnoses that included but not limited to diabetes mellitus,	F 758	Snyder Nursing Home maintains, in accordance with accepted professional standards and practices, that facility resident comprehensive assessments do ensure 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. Furthermore, Snyder Nursing Home maintains that residents who use psychotropic drugs receive gradual dose reductions and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. Snyder Nursing Home also maintains that residents should not receive psychotropic drugs pursuant to the PRN order unless that medication is necessary to treat a	

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F 758	Continued From page 5 COPD (chronic obstructive pulmonary disease), asthma, dementia, and chronic inhaled steroid use. Resident #20's quarterly minimum data set (MDS) assessment with an assessment reference date (ARD) of 10/30/18 assessed the resident with a BIMS (brief interview for mental status) as 10/15. Resident #20 was identified to have inattention daily. Resident #20 was not assessed with any signs or symptoms of psychosis or behaviors that affected others. Section N Medications and specifically N0410 Medications documented Resident #20 had received an antidepressant 7 days during the look back period 10/24/18-10/30/18. Resident #20's current comprehensive care plan initiated 9/18/14 had a focus area that read "Resident #20 receives routine antidepressant med (medication) w/potential (with) for adverse effects. Interventions: Meds as ordered, notify provider of behavioral symptoms and/or adverse effects, observe for and record adverse effects, observe for and record behavioral symptoms, and pharmacist to review meds monthly & (and) as needed." The care plan did not identify any specific targeted behaviors or non-pharmacological interventions to use. Resident #20's December 2018 physician orders were reviewed. Resident #20 currently received Sertraline 100 mg qd (everyday) for depression. The surveyor reviewed the monthly psychoactive medication flow records from September 2018 through December 2018 for Sertraline. Targeted behaviors identified were tearfulness, decrease interest in activities and persistent sadness. Side	F 758	diagnosed specific condition that is documented in the clinical record. On December 21, 2018, a Facility Incident Report was filed on behalf of the Nursing Department and Resident #20, #15, #29, #33, #8, #5, #35 and #38 seeking clarification from the Medical Director, Director of Nursing, Pharmacist Consultant and the Interdisciplinary Care Plan Team pertaining to the need for Gradual Dose Reduction (GDR) of a psychotropic medication and the monitoring and documentation of the resident response to medications, as well as the identification of person centered targeted behaviors for the use of Psychotropic medications. On January 16, 2019, an audit was performed by the Consultant Pharmacist encompassing 100% of medical records including all residents who are currently receiving psychotropic medications. Recommendations were made for residents that currently require a GDR, unless clinically contraindicated. On January 16, 2019 and January 23, 2019, 100% of recommendations made by the consultant Pharmacist, (including GDR's due for review) were considered by the Attending Physician. Physician orders were written for all dose reductions indicated and if not indicated, written rationale for continuation of current therapy was included in the resident's medical record.	

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F 758	Continued From page 6 effects circled to monitor were disorientation, confusion, lethargy, increased agitation, and sedation/drowsiness. The monthly behaviors sheets from September 2018 through December 2018 did not identify any issues with tearfulness, decrease interest in activities, persistent sadness, disorientation, confusion, lethargy, increased agitation, or sedation/drowsiness. Each day was marked with a "0" and the nurse's initials. The surveyor reviewed the September 2018 through the December 2018 nurse's notes. The 10/31/18 nurse's note stated the resident was seen by her physician for s/s (signs/symptoms) of depression; however, there are no signs or symptoms of depression charted. Resident #20's Sertraline had been increased from 50 mg (milligrams) to 100 mg on 10/31/18 without any evidence to support the increase in Sertraline. Resident #20's physician had documented on the medication regimen review for December 2017 "has failed GDRs (gradual dose reductions) in the past with recurrence of depressive sx (symptoms). No further GDRs." The surveyor interviewed the activities director/social worker on 12/20/18 at 8:42 a.m. about Resident #20. The activity director/social worker stated that during the mood interview for the most recent MDS, the resident had been having trouble sleeping, expressed about being sad, lonely, and the resident's fixation on men. The activity director/social worker stated after the men leave, the resident goes back to focusing on her baby dolls.	F 758	On January 23, 2019, an audit of 100% of current MDS/Care Plans was performed by the Director of Nursing and the MDS/Care Plan Coordinator. This audit determined that residents receiving any psychotropic medication were being monitored for appropriate behaviors and side effects with appropriate interventions. To prevent the reoccurrence of this type of deficiency, the facility's policy and procedure pertaining to the administration of psychotropic medications and Gradual Dose Reductions were reviewed for revision by the Medical Director, Director of Nursing, Pharmacist Consultant, Administrator and the Interdisciplinary Care Plan Team. This review was completed on January 23, 2019. To prevent the reoccurrence of this type of deficiency, all Care Plan Team members and Nurses will receive additional training and education pertaining to psychotropic medication use in a long term care setting. This additional training and education will include the use of anti-psychotics, anti-depressants, anti-anxiety and hypnotics in a long term care setting. This training will include; behavior analysis, behavioral triggers and non-drug interventions. This training will be conducted by the Director of Nursing or her designee and Relias Learning Services. Continued education through Relias Learning Services will include, but not limited to the following courses: "Psychotropic Medication Use in a Long-Term Care Setting and Psychotropic	

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F 758	Continued From page 7 The surveyor asks the activity director/social worker where the information just provided was located as the surveyor was unable to locate any of this information in the clinical record. The activity director/social worker stated it wasn't charted-"we just know it." The surveyor informed the administrator and the director of nursing of the above concern on 12/20/18 at 12:44 p.m. and requested the facility policy on psychotropic medications. The surveyor reviewed the facility policy titled "Psychotropic Medication Usage" on 12/20/18. The policy read in part, "The facility will ensure psychotropic medications are used only when the medication is appropriate to treat a resident's specific, diagnoses and documented condition and the medication is beneficial to the resident, as demonstrated by monitoring and documentation of the resident's response to the medication. Psychotropic medications will be prescribed at the lowest possible dosage for the shortest period and will be subject to gradual dose reduction and review. The staff will observe, document and report to the Attending Physician information regarding the behaviors, effectiveness of any intervention, and/or any side effects and consequences of psychotropic medications." No further information was provided prior to the exit conference on 12/20/18. 2. The facility staff failed to document when Resident #15 exhibited behaviors to support the use of the antidepressant Zoloft and failed to	F 758	Medications-Antipsychotics and Beyond". This training will be completed by February 1, 2019. To prevent the reoccurrence of this type of deficiency the following performance improvement measure has been initiated. On February 1, 2019, the facility will have secured contracting with a Behavioral Health Provider that specializes in the following area: Geriatric Mental Health; inclusive of, dementia treatment and education, cognitive evaluation, psychiatric evaluation and diagnosis and psychiatric medication management. To prevent the reoccurrence of this type of deficiency the following performance improvement measure has been initiated. Select members of the facility's QA/QI team, QA/PI team, Charge Nurses and Interdisciplinary Care Plan Team will receive training and education required to obtain certification as "Certified Dementia Practitioners". The first certifications will occur on January 26, 2019 and February 9, 2019. This will be on ongoing performance improvement measure. To prevent the reoccurrence of this type of deficiency the facility will have active participation in The National Nursing Home Quality Care Collaborative by partnering with Health Quality Innovators, (formerly known as VHQC) as an active member. Member enrollment with HQI will begin February 1, 2019. To prevent the reoccurrence of this type of	

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F 758	Continued From page 8 ensure the current comprehensive care plan included targeted behaviors for the use of Zoloft (an antidepressant). The clinical record of Resident #15 was reviewed 12/18/18 through 12/20/18. Resident #15 was admitted to the facility 11/9/15 and readmitted 10/16/18 with diagnoses that included but not limited to multiple sclerosis, chronic kidney disease, deep vein thrombosis with pulmonary embolus, restless leg syndrome, gastroesophageal reflux disease, and depression. Resident #15's quarterly minimum data set (MDS) assessment with an assessment reference date (ARD) of 10/16/18 assessed the resident with a BIMS (brief interview for mental status) as 05/15. There were no signs or symptoms of delirium, behaviors affecting others or evidence of psychosis. Section N Medications and specifically N0410 Medications documented Resident #15 received an antidepressant 7 days during the look back period 10/10/18-10/16/18. Resident #15's current comprehensive care plan identified the focus area that read "Resident #15 receives routine antidepressant therapy for diagnosis of depression w/potential (with) for adverse effects. Date initiated: 11/19/2015. Interventions: Administer meds (medications) as ordered, notify provider of behavioral symptoms, adverse effects and/or pharm (pharmacy) rec (recommendations), observe for behavioral symptoms and/or adverse effects, and pharmacist reviews meds monthly & (and) as needed." The current comprehensive care plan did not identify any specific targeted behaviors for the use of Zoloft or identify any non-pharmacological interventions.	F 758	deficiency the facility will expand beyond monthly behavior sheets and the resident clinical record as a source of documenting behaviors, non-pharmacological interventions and outcomes. The facility has developed a "Resident Specific Behavioral Flow Sheet" to be utilized by all staff for the intended purpose of documenting resident behaviors, the introduction of and documentation of non-pharmacological interventions and their outcomes. This information will be incorporated into the resident's clinical record via daily reporting to the shift Charge Nurse. This performance improvement measure will be effective February 1, 2019. To prevent the reoccurrence of this type of deficiency, the Facility QA/QI and QA/PI teams will review this plan of correction at least quarterly for ongoing compliance. This will be an ongoing QA/QI and QA/PI measure.	

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The December 2018 physician's orders were reviewed. Resident #15 had orders that read "Mirtazapine (Remeron) 15 mg (milligrams) take 1 tablet by mouth at bedtime for depression and Sertraline 50 mg take 1 tablet daily for depression (Zoloft)."

The surveyor reviewed the monthly psychoactive medication flow records from September 2018 through December 2018 for Sertraline and Remeron. Targeted behaviors identified were tearfulness, decrease interest in activities and persistent sadness. Side effects circled to monitor were dry mouth, anticholinergic symptoms, sedation/drowsiness and increased falls/dizziness.

The monthly behaviors sheets from September 2018 through December 2018 did not identify any issues with tearfulness, decrease interest in activities, persistent sadness, dry mouth, anticholinergic symptoms, sedation/drowsiness and increased falls/dizziness. Each day was marked with a "0" and the nurse's initials. The surveyor reviewed the September 2018 through the December 2018 nurse's notes. The nurse's notes did not have any documentation of tearfulness, decrease interest in activities, or persistent sadness.

The surveyor informed the director of nursing of the above concern with the prescribed medications (Remeron and Zoloft) and the lack of documentation to support the use of both on 12/20/18 at 10:19 a.m. The DON stated Resident #15's depressive signs and symptoms would come back if a GDR (gradual dose reduction) was done and then the resident would require

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F 758	Continued From page 10	F 758		

more meds. The most recent GDR for Remeron was in 2015 and the last GDR for Sertraline was in 2017.

The administrator and the director of nursing were informed of the above concern on 12/20/18 at 12:44 p.m. The surveyor requested the facility policy on the use of psychotropic medications.

The surveyor reviewed the facility policy titled "Psychotropic Medication Usage" on 12/20/18. The policy read in part, "The facility will ensure psychotropic medications are used only when the medication is appropriate to treat a resident's specific, diagnoses and documented condition and the medication is beneficial to the resident, as demonstrated by monitoring and documentation of the resident's response to the medication. Psychotropic medications will be prescribed at the lowest possible dosage for the shortest period and will be subject to gradual dose reduction and review.

The staff will observe, document and report to the Attending Physician information regarding the behaviors, effectiveness of any intervention, and/or any side effects and consequences of psychotropic medications."

No further information was provided prior to the exit conference on 12/20/18.

3. The facility staff failed to identify targeted behaviors for the use of Remeron for Resident #29.

The clinical record of Resident #29 was reviewed 12/18/18 through 12/20/18. Resident #29 was admitted to the facility 5/20/14 with diagnoses that

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F 758	Continued From page 11	F 758		

included but not limited to Alzheimer's disease, type 2 diabetes mellitus, osteoarthritis, osteoporosis, hyperlipidemia, gastroesophageal reflux disease, adult failure to thrive, glaucoma, and major depressive disorder.

Resident #29's quarterly minimum data set (MDS) assessment with an assessment reference date (ARD) of 11/13/18 assessed the resident with a BIMS (brief interview for mental status) as 13/15. There were no signs or symptoms of delirium, behaviors affecting others, or evidence of psychosis. Section N Medications and specifically N0410 Medications documented Resident #29 received an antidepressant 7 days during the look back period 11/07/18-11/13/18.

Resident #29's current comprehensive care plan had the focus area that read Resident #29 receives Remeron routinely for depression w/potential (with) for adverse effects. Date initiated: 06/04/2014. Interventions: Meds as ordered, notify provider of behavioral symptoms and/or adverse effects, observe for and record adverse effects, observe for and record behavioral symptoms, and pharmacist to review meds monthly & (and) as needed." The care plan did not identify any specific behaviors or non-pharmacological interventions to use.

The December 2018 physician's orders were reviewed. Resident #29 had orders for Mirtazapine (Remeron) 7.5 mg (milligrams) every day. A review of the Psychoactive Medication Monthly Flow Records for September 2018 through December 2018 identified the resident was tearful, had decreased interest in activities and had persistent sadness. Side effects to observe were disorientation and confusion,

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reduced social contact, increased agitation, anticholinergic effects, and nausea.

The monthly behaviors sheets from September 2018 through December 2018 did not identify any issues with tearfulness, decrease interest in activities, persistent sadness, disorientation and confusion, reduced social contact, increased agitation, anticholinergic symptoms, and nausea. Each day was marked with a "0" and the nurse's initials. The surveyor reviewed the September 2018 through the December 2018 nurse's notes. The nurse's notes did not have any documentation of tearfulness, decrease interest in activities, or persistent sadness.

The surveyor reviewed the nurse's notes from September 2018 through December 2018. One dated 11/11/18 at 4:30 p.m. stated the resident had vomited a small amount of food when out on leave with son. The nurse's note dated 11/11/18 at 5:30 p.m. stated the resident was still feeling nauseous and refused dinner. The nurse's note dated 11/13/18 at 8a.m. stated the resident continued to complain of (c/o) nausea, MD (medical doctor) was notified, and a urinalysis was obtained and the resident was started on medication for a urinary tract infection. The nurse's note dated 11/16/18 at 2:10 p.m. stated the resident c/o nausea early in the morning.

The surveyor interviewed licensed practical nurse #1 on 12/20/18 10:41a.m. The surveyor showed L.P.N. #1 the monitoring on the behavior sheets with 0 (zero) on all shifts-behavior not observed. L.P.N. #1 stated the resident often refuses food, tends to isolate herself in her room, but blossoms when family come and take her out. Weight has increased. The surveyor stated the targeted

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behaviors on the September 2018 through December 2018 are the same for all the residents. L.P.N. #1 stated she filled out the monthly forms and was told to put something to look at for the residents. L.P.N. #1 stated the monthly records are not person-centered.

The surveyor informed the administrator and the director of nursing of the above concern on 12/20/18 at 12:44 p.m. and requested the facility policy on psychotropic medications.

The surveyor reviewed the facility policy titled "Psychotropic Medication Usage" on 12/20/18. The policy read in part, "The facility will ensure psychotropic medications are used only when the medication is appropriate to treat a resident's specific, diagnoses and documented condition and the medication is beneficial to the resident, as demonstrated by monitoring and documentation of the resident's response to the medication. Psychotropic medications will be prescribed at the lowest possible dosage for the shortest period and will be subject to gradual dose reduction and review.

The staff will observe, document and report to the Attending Physician information regarding the behaviors, effectiveness of any intervention, and/or any side effects and consequences of psychotropic medications."

No further information was provided prior to the exit conference on 12/20/18.

4. The facility staff failed to identify specific targeted behaviors for the use of Paxil and Seroquel on the care plan for Resident #33.

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The clinical record of Resident #33 was reviewed 12/18/18 through 12/20/18. Resident #33 was admitted to the facility 8/29/18 with diagnoses that included but not limited to vascular dementia without behavioral disturbances, hypertension, chronic atrial fibrillation, non-rheumatic mitral valve prolapse, transient ischemic attacks, asthma, osteoarthritis, anxiety, sleep apnea, gastroesophageal reflux disease, major depressive disorder, iron deficiency anemia, Vitamin D deficiency, chronic bronchitis, bilateral hearing loss, obesity and gout.

Resident #33's quarterly minimum data set (MDS) assessment with an assessment reference date (ARD) of 11/27/18 assessed the resident with a BIMS (brief interview for mental status) as 14/15. Resident #33 was not assessed with any signs or symptoms of delirium, behaviors that affected others or psychosis. Section N Medications and specifically N0410 Medications Resident #33 had received antidepressant and antipsychotic medications 7 days during the look back period 11/20/18-11/27/18.

Resident #33's current comprehensive care plan identified the focus area that read "Resident #33 receives Paxil as ordered for depression & (and) Seroquel as ordered for psychosis w/potential (with) for adverse effects. Date initiated: 09/06/2018. Interventions: Administer meds (medications) as ordered, notify provider of behavioral symptoms, adverse effects and/or pharm (pharmacy) rec (recommendations), observe for behavioral symptoms and/or adverse effects, and pharmacist reviews meds monthly & (and) as needed." The current comprehensive care plan did not identify any specific targeted behaviors for the use of Paxil or Seroquel or

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identify any non-pharmacological interventions.

The December 2018 physician's orders were reviewed. Resident #33 had orders for Paroxetine 40 mg (milligrams) take one tablet by mouth every day for depression, Quetiapine 25 mg tablet take one tablet by mouth every day for hallucinations/psychosis, and Quetiapine 25 mg tablet take 3 tablets by mouth at bedtime for hallucinations/psychosis.

The surveyor reviewed the monthly psychoactive medication flow records from September 2018 through November 2018 for Paroxetine and Quetiapine. Targeted behaviors for Paroxetine were tearfulness, decrease interest in activities and persistent sadness. Side effects circled to monitor were dry mouth, weight gain, and tremors. Targeted behaviors for Quetiapine were hallucinations and to monitor for the following side effects: muscle spasm, motor restlessness, involuntary movements, and increased agitation.

The monthly behaviors sheets from September 2018 through November 2018 did not identify any issues with tearfulness, decrease interest in activities, persistent sadness, or hallucinations Each day was marked with a "0" and the nurse's initials. The surveyor reviewed the September 2018 through the December 2018 nurse's notes. The nurse's notes did not have any documentation of tearfulness, decrease interest in activities, persistent sadness or hallucinations.

The surveyor informed the administrator and the director of nursing on 12/20/18 at 12:44 p.m. of the lack of documentation of behaviors that were identified as the targeted behaviors on the psychoactive medication flow records and the

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lack of targeted behaviors on the comprehensive care plan. In addition, the facility has failed to document the use of non-pharmacological interventions on the care plans. The surveyor requested the facility policy on the use of psychotropic medications.

The surveyor reviewed the facility policy titled "Psychotropic Medication Usage" on 12/20/18. The policy read in part, "The facility will ensure psychotropic medications are used only when the medication is appropriate to treat a resident's specific, diagnoses and documented condition and the medication is beneficial to the resident, as demonstrated by monitoring and documentation of the resident's response to the medication. Psychotropic medications will be prescribed at the lowest possible dosage for the shortest period and will be subject to gradual dose reduction and review.

The staff will observe, document and report to the Attending Physician information regarding the behaviors, effectiveness of any intervention, and/or any side effects and consequences of psychotropic medications."

No further information was provided prior to the exit conference on 12/20/18.

5. The facility staff failed to identify targeted behaviors for the use of Citalopram (Celexa), Venlafaxine 75 mg (Effexor), Trazodone 50 mg (Desyrel), and Risperdal 0.5 mg and failed to include targeted behaviors for the antidepressant use on the current comprehensive care plan for Resident #8.

The clinical record of Resident #8 was reviewed

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12/18/18 through 12/20/18. Resident #8 was admitted to the facility 6/1/17 and readmitted 6/28/18 with diagnoses that included but not limited to non-displaced intertrochanteric fracture of the left femur, Alzheimer's disease, psychotic disorder, type 2 diabetes mellitus, hypertension, anxiety, major depressive disorder, osteoarthritis of the knee, atherosclerotic heart disease, and polyneuropathy.

Resident #8's quarterly minimum data set (MDS) assessment with an assessment reference date (ARD) of 10/9/18 assessed the resident with a BIMS (brief interview for mental status) as 5/15. Resident #8 had no signs or symptoms of delirium, no behaviors that affected others and no signs or symptoms of psychosis. Section N Medications assessed the resident to receive an antipsychotic medication and an antidepressant 7 days in the look back period 10/3/18 through 10/9/18.

Resident #8's current comprehensive care plan identified a focus area that read the resident uses psychotropic medications-Risperdal for dementia w/psychosis (with), & (and) Celexa, Trazodone, & Effexor for depression, w/potential for adverse effects. Date initiated: 06/14/2017 Revision on: 05/03/2018. Interventions: Administer psychotropic medications as ordered by physician. Monitor for side effects and effectiveness q shift (every shift). Monitor/document report PRN (as needed) any adverse reactions of Psychotropic medications. Monitor/record occurrence for targeted behavior symptoms and document per facility protocol. Notify provider of behavioral symptoms, adverse effects, and/or pharm (pharmacy) rec (recommendations). Pharmacist to review meds

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(medications) monthly & as needed.

Resident #8 also had the focus area that read the resident has a mood problem-has the following dx (diagnoses): Major Depressive D.O (disorder), Single Episode, Anxiety D.O., Psychotic D.O. with delusions due to known physiological condition, Alzheimer's disease with late onset. Interventions: Assist the resident in developing/provide the resident with a program of activities that is meaningful and of interest music, companionship. Encourage and provide opportunities for exercise, physical activity.

Resident #8's December 2018 physician's orders included Citalopram 20 mg tablet take one tablet by mouth every day for depression (Celexa), Venlafaxine tab 75 mg take one tablet by mouth twice daily for depression (Effexor), Trazodone 50 mg tablet take one tablet by mouth four times daily for depression, and Risperdal tab 0.5 mg take one tablet by mouth twice daily for dementia with psychosis..

The surveyor reviewed the Psychoactive Medication Monthly Flow Records from September 2018 through December 2018. The Psychoactive Medication Monthly Flow Record for Risperdal identified delusions yet there was no documentation that Resident #8 had experienced delusions. All of the boxes had "0" in them. In Section II: Side Effects, all boxes had "0" in them as well. The Psychoactive Medication Monthly Flow Records for Trazodone, Venlafaxine, and Citalopram all were documented with a "0" no behavior had occurred.

The surveyor reviewed the September 2018 through December 2018 nurse's notes and found

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no documentation of targeted behaviors for the use of Citalopram, Trazodone, Venlafaxine or Risperdal.

The surveyor interviewed licensed practical nurse #1 on 12/20/18 at 12:25 p.m. The surveyor asked what types of behaviors the resident exhibited. L.P.N. #1 stated she curses a lot. "It's one of her outlets." Cursing was not identified as a targeted behavior on the monthly record monitoring or on the comprehensive care plan. The nurse's notes did not have any episodes of cursing documented.

The surveyor informed the administrator and the director of nursing on 12/20/18 at 12:44 p.m. of the lack of documentation of behaviors that were identified as the targeted behaviors on the psychoactive medication flow records and the lack of targeted behaviors on the comprehensive care plan. In addition, the facility has failed to document the use of non-pharmacological interventions on the care plans. The surveyor requested the facility policy on the use of psychotropic medications.

The surveyor reviewed the facility policy titled "Psychotropic Medication Usage" on 12/20/18. The policy read in part, "The facility will ensure psychotropic medications are used only when the medication is appropriate to treat a resident's specific, diagnoses and documented condition and the medication is beneficial to the resident, as demonstrated by monitoring and documentation of the resident's response to the medication. Psychotropic medications will be prescribed at the lowest possible dosage for the shortest period and will be subject to gradual dose reduction and review.

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The staff will observe, document and report to the Attending Physician information regarding the behaviors, effectiveness of any intervention, and/or any side effects and consequences of psychotropic medications."

No further information was provided prior to the exit conference on 12/20/18.

6. The facility staff failed to identify appropriate person centered target behaviors to support the use of Seroquel for Resident # 5.

Resident # 5 was a 92-year-old-female who was admitted to the facility on 3/2/15. Diagnoses included but were not limited to: Alzheimer's disease, major depressive disorder, anxiety disorder, and chronic kidney disease stage 3.

The clinical record for Resident # 5 was reviewed on 12/18/18 at 5:06 pm. The most recent MDS (minimum data set) assessment for Resident # 5 was a quarterly assessment with an ARD (assessment reference date) of 10/9/18. Section C of the MDS assesses cognitive patterns. In Section C1000, the facility staff documented that Resident # 5's cognitive status was severely impaired. Section N of the MDS assesses medications. In Section N0410, the facility staff documented that Resident # 5 had received antipsychotic medication for 7 days during the lookback period for the 10/9/18 ARD.

The plan of care for Resident # 5 was reviewed and revised on 10/11/18. The facility staff documented a focus area for Resident # 5 as, "The resident receives Zoloft as ordered for depression, Buspar as ordered for anxiety &

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Seroquel as ordered for psychosis w (with)/potential for adverse effects." Interventions included but were not limited to, Observe for behavioral symptoms q (every) shift & prn (as needed)."

Resident # 5 had current orders that included but was not limited to, "Quetiapine 200 mg tablet Take 1 tablet by mouth twice a day for delusional psychosis For Seroquel." This order was initiated by the physician on 6/27/18. Upon further review of the current orders for Resident # 5, the surveyor observed that Resident # 5 did not have any current orders for medications to manage or treat dementia.

On 12/20/18 at 9:15 am, the surveyor observed a pharmacy recommendation in Resident # 5's clinical record dated 5/16/18. The pharmacy recommendation was documented as, "This resident has had failed GDR (gradual dose reduction) attempts for Seroquel in the past. It has been discussed that no further GDR attempts be requested due to previous failed attempts. Please document if no further GDR attempts are indicated for Seroquel for this resident." The surveyor observed that the physician documented an (X) next to agree and handwrote, "Her condition is fragile and likely to worsen with any further GDR attempts."

On 12/20/18 at 9:20 am, the surveyor reviewed the "Psychoactive Medication Monthly Flow Record" for Resident # 5. The surveyor observed that the facility staff had circled delusions and paranoia as target behavioral symptoms for Quetiapine (Seroquel). The surveyor reviewed the "Psychoactive Medication Monthly Flow Record" for Resident # 5 from 12/2017 through 12/2018.

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The surveyor observed that the facility staff had documented that Resident # 5 had no behaviors of delusions or physical aggression on day, evening, or night shift from 12/2017 through 2/2018, and no behaviors of delusions or paranoia on day evening or night shift from 3/2018 through 12/2018.

On 12/20/18 at 9:25 am, the surveyor interviewed the director of nursing. The surveyor asked the director of nursing what types of behaviors Resident # 5 displayed during delusional and paranoid episodes. The director of nursing stated that Resident # 5 would attempt to get up and believed that a baby was at home alone and would try to get home to the baby. The director of nursing also stated that Resident # 5 would cry out loudly at times and become agitated.

On 12/20/18 at 9:34 am, the surveyor interviewed LPN # 1 (licensed practical nurse) The surveyor asked LPN # 1 what types of behaviors did Resident # 5 display during delusional and paranoid episodes. LPN # 1 stated that Resident # 5 resisted care. LPN # 1 stated, "She will fight and she will hit." "She thinks a baby is left at home all alone." "She thinks all of her family has died." "She will talk about her mom and dad and how her mother hates her, but most often talks about a baby boy being left." The surveyor asked LPN # 1 if Resident # 5 became combative often. LPN # 1 stated, "Maybe every 2 weeks we will hear of her hitting out." "Just in the last 2 weeks she got one of the CNAs (certified nursing assistant) pretty good." "She did not break the skin but she did leave marks." The surveyor asked LPN # 1 if she felt that the behaviors that Resident # 5 displayed were due to psychosis or if they were behaviors related to dementia. LPN #

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1 stated, "Dementia." The surveyor reviewed the "Psychoactive Medication Monthly Flow Record" along with LPN # 1. LPN # 1 agreed that combative behaviors was not listed as a target behavior to support the use of Seroquel. The surveyor reviewed the nurse's notes in Resident # 5's clinical record from 12/2017 through 12/2018. The surveyor did not locate any documentation of combative, paranoid, or delusional episodes.

The facility policy for "Psychotropic Medication Usage" contained documentation that included but was not limited to;
..."Policy: The facility will ensure psychotropic medications are only used when the medication is appropriate to treat a resident's specific, diagnosed and documented condition and the medication is beneficial to the resident, as demonstrated by monitoring and documentation of the resident's response to the medication.

For any resident who is receiving a psychotropic medication to treat a disorder other than expressions or indications of distress related to dementia (for example schizophrenia, bipolar mania, depression with psychotic features, or other medical condition other than dementia, which may cause psychosis), the GDR may be considered clinically contraindicated for reasons that include but are not limited to:
a) The continued use is in the accordance with relevant current standards of practice and the physician has documented the clinical rationale for why any attempted dose reduction would be likely to impair the resident's function or exacerbate an underlying medical or psychiatric disorder; or
b) The resident's target symptoms returned or worsened after the most recent attempt at a GDR

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within the facility and the physician documented the clinical rationale for why an additional attempted dose reduction at the time would be likely to impair the resident's function or exacerbate an underlying medical or psychiatric disorder.
Antipsychotic medications shall generally only be used for the following conditions/diagnoses as documented in the record:
f) psychosis in the absence of dementia" ...

On 12/20/18 at 2:30 pm, the administrator and director of nursing was made aware of the findings as stated above.

No further information regarding this issue was presented to the survey team prior to the exit conference on 12/20/18.

7. The facility staff failed to identify person centered target behaviors for support the use of Haldol for Resident # 35.

Resident # 35 was a 89-year-old-female who was admitted to the facility on 7/22/15. Diagnoses included but were not limited to, Alzheimer's disease, major depressive disorder, chronic kidney disease, and hypothyroidism.

The clinical record for Resident # 35 was reviewed on 12/18/18 at 4:37 pm. The most recent MDS (minimum data set) assessment for Resident # 35 was a quarterly assessment with an ARD (assessment reference date) of 12/4/18. Section C of the MDS assesses cognitive patterns. In Section C1000, the facility staff documented that Resident # 35's cognitive status was moderately impaired. Section N of the MDS assesses medications. In Section N0410, the

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facility staff documented that Resident # 35 had received antipsychotic medications for 7 days during the look-back period for the 12/4/18 ARD.

The current plan of care for Resident # 35 was reviewed and revised on 12/7/18. The facility staff documented a focus area for Resident # 35 as "The resident uses psychotropic medications w (with)/ potential for adverse effects." Interventions included but were not limited to, "Monitor/record occurrence of behavior symptoms and document per facility protocol." The surveyor did not observe any documented target behaviors associated with antipsychotic use on the current plan of care for Resident # 35.

The physician signed the current orders for Resident # 35 on 11/28/18. Orders included but were not limited to, "Haloperidol Con 2 mg (milligram)/ml (milliliter) Take 1 ml by mouth twice daily at noon and 6 pm for psychosis For Haldol." The surveyor observed that Resident # 35 did not have current orders for medications to manage dementia.

On 12/20/18 at 10:35 am, the surveyor reviewed the December 2018 "Psychoactive Medication Monthly Flow Record" for Resident # 35. The surveyor observed that the facility staff had identified delusions, paranoia, and increased anxiety as target behaviors associated with the use of Haldol for Resident # 35.

On 12/20/18 at 10:37 am, the surveyor observed a pharmacy recommendation in Resident # 35's clinical record dated 11/13/18. The pharmacy recommendation contained documentation that included but was not limited to, ..."The resident receives antipsychotic Haloperidol 2 mg po (by

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mouth) BID (twice daily) since a dose decrease October 2015. *Please Note: Resident's family has refused medication changes in the past." ... The physician/prescriber Response was documented as, "Stable, no adverse effects and family refuses any change to her current regimen."

On 12/20/18 at 10:40 am, the surveyor interviewed LPN # 1(licensed practical nurse). The surveyor asked LPN # 1 what behaviors Resident # 35 displayed during delusional episodes, paranoid episodes, and during episodes of increased anxiety. LPN # 1 stated, "She can be combative and resists care." "She can be really feisty." The surveyor reviewed the "Psychoactive Medication Monthly Flow Record" for Resident # 35 along with LPN # 1 and LPN # 1 agreed that combativeness was not listed as a target behavior associated with the use of physician ordered Haldol.

On 12/20/18 at 10:55 am, the surveyor reviewed the "Psychoactive Medication Monthly Flow Record" for Haldol for Resident # 35 from December 2017 through December 2018. The surveyor observed that the facility staff documented that Resident # 35 had no behaviors on day, evening, and night shift from December 2017 through December 2018.

On 12/20/18 at 11:00 am, the surveyor reviewed the nurse's notes for Resident # 35 from December 2017 through December 2018. The surveyor did not locate any documentation of combativeness, resistance of care, increased anxiety, paranoia, or delusions in the nurse's notes for Resident # 35.

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The facility policy for "Psychotropic Medication Usage" contained documentation that included but was not limited to;
..."Policy: The facility will ensure psychotropic medications are only used when the medication is appropriate to treat a resident's specific, diagnosed and documented condition and the medication is beneficial to the resident, as demonstrated by monitoring and documentation of the resident's response to the medication.

For any resident who is receiving a psychotropic medication to treat a disorder other than expressions or indications of distress related to dementia (for example schizophrenia, bipolar mania, depression with psychotic features, or other medical condition other than dementia, which may cause psychosis), the GDR may be considered clinically contraindicated for reasons that include but are not limited to:
a) The continued use is in the accordance with relevant current standards of practice and the physician has documented the clinical rationale for why any attempted dose reduction would be likely to impair the resident's function or exacerbate an underlying medical or psychiatric disorder; or
b) The resident's target symptoms returned or worsened after the most recent attempt at a GDR within the facility and the physician documented the clinical rationale for why an additional attempted dose reduction at the time would be likely to impair the resident's function or exacerbate an underlying medical or psychiatric disorder.
Antipsychotic medications shall generally only be used for the following conditions/diagnoses as documented in the record:
f) psychosis in the absence of dementia" ...

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On 12/20/18 at 2:30 pm, the administrator and director of nursing was made aware of the findings as stated above.

No further information regarding this issue was presented to the survey team prior to the exit conference on 12/20/18.

8. The facility staff failed to identify appropriate person centered target behaviors to justify the use of Seroquel for Resident # 38.

Resident # 38 was an 84-year-old-female who was admitted to the facility on 1/4/17. Diagnoses included but were not limited to, unspecified dementia without behavioral disturbance, depression, psychosis, and mood disorder.

The clinical record for Resident # 38 was reviewed on 12/19/18 at 8:55 am. The most recent MDS (minimum data set) assessment for Resident # 38 was a quarterly assessment with an ARD (assessment reference date) of 12/11/18. Section C of the MDS assesses cognitive patterns. In Section C0500, the facility staff documented that Resident # 38 had a BIMS (brief interview for mental status) score of 3 out of 15, which indicated that Resident # 38's cognitive status was severely impaired. Section N of the MDS assesses medications. In Section N0410, the facility staff documented that Resident # 38 had received antipsychotic medication for 7 days during the look-back period for the 12/11/18 ARD.

The plan of care for Resident # 38 was reviewed and revised on 12/13/18. The facility staff documented a focus area for Resident # 38 as,

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"The resident uses psychotropic medications: Buspar for anxiety, Trazodone for depression, & Seroquel for psychosis, w (with)/potential for adverse effects. Res (Resident) displays s/s (signs and symptoms) of sun downing daily; makes multiple calls to family members in evening hrs (hours) (distressed/upset, wanting them to come get her)." Interventions included but were not limited to, "Observe for/document behavioral symptoms &/or adverse effects."

The physician signed the current orders for Resident # 38 on 11/28/18. Orders included but were not limited to, "Quetiapine tab (tablet) 100 mg (milligram) take one tablet by mouth every day at 2 pm for psychosis For Seroquel," and "Quetiapine 50 mg tablet take one by mouth at bedtime for psychosis For Seroquel."

On 12/19/18 at 9:35 am, the surveyor reviewed the "Psychoactive Medication Monthly Flow Record" for December 2018 for Resident # 38. The surveyor observed that the facility staff had documented delusions and paranoia as target behaviors for physician ordered Seroquel. The surveyor observed that the facility staff had documented that Resident # 38 had no delusions or paranoia during the day, evening, or night shift from December 1, 2018 through December 18, 2018.

On 12/19/18 at 9:40 am, the surveyor reviewed the nurse's notes in the clinical record for Resident # 38. The surveyor did not locate any documentation in the nurse's notes for Resident # 38 to support delusional or paranoid behaviors. The surveyor did observe the following documentation in Resident # 38's clinical record; a nurse's note documented on 1/21/18 at 4:45 pm

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was documented as, "Resident anxious, upset, daughter with resident wheeling around facility. Resident exit seeking, requesting to leave stating "I'm in that room alone." Per daughter she has phoned several family members requesting rides to get home. Daughter unplugged resident's phone in room, per daughter resident has been very anxious and upset since death of her roommate. Daughter requesting MD (medical doctor) be notified."

A nurse's note documented 1/21/18 at 4:50 pm was documented as, "(Facility medical director's name withheld) notified of resident status and behaviors along with daughter's concerns. N.O. (new order) received for Seroquel 100 mg po now and one for psychosis/delusional."

A nurse's note documented on 1/21/18 at 6:00 pm was documented as "Resident less agitated at this time but continues to talk about "going home", ate dinner, on resident phone dialing several numbers stating "I'm going to call 911" phone removed at this time."

A nurse's note documented on 1/21/18 at 7:00 pm was documented as, "Resident refuses to go to room to get ready for bed sitting at nurse's station stating "I need to call my mother and tell her where I am." Unable to redirect. Offered snacks, fluids, bathroom but refused."

A nurse's note documented on 1/21/18 at 9:00 pm was documented as "Resident finally agreed to go down to room. Staff assisted resident with ADL (activities of daily living) care. Resident informed staff that she doesn't want to stay in that room alone. Resident from another room moved

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in that room temporarily overnight and resident very happy and talking with resident."

A nurse's note documented on 1/23/18 at 7:00 am was documented as "Nurse given report this am of resident having delusions/ being anxious at beginning of 11-7 shift. Rolling around in wheelchair looking for her mother so they could go home and not wanting to be alone. Will have NP (nurse practitioner) assess on rounds."

A nurse's note documented on 1/23/18 at 4:15 pm was documented as "V/S (vital signs) 97.2, 74, 18, 138/76, 95 % on room air. Rsd (resident) was seen by (Nurse practitioner's name withheld) New order noted to increase Seroquel: Seroquel 50 mg po (by mouth) at 2 pm and Seroquel 25 mg po qhs (every night at bedtime) for psychosis. 2) CBC (complete blood count) CMP (complete metabolic panel) TSH (thyroid stimulating hormone) next lab day for increased agitation. POA (power of attorney) (POA's name withheld) notified."

A nurse's note documented on 8/31/18 at 2:00 pm was documented as "Res (resident) upset with family and blaming them for her being here. Also calling family multiple times on the phone each day. (Medical director's name withheld) notified. N.O. noted to increase Seroquel POA informed."

A nurse's note documented on 10/18/18 at 11:20 am was documented as "Res refused to take tub bath. Had dresses herself and stated "I'm going to take my bath when I get home." Staff attempted to redirect persuade resident to take bath, but were unsuccessful."

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A nurse's note documented on 12/6/18 at 2:20 pm was documented as "Res refused to take tub bath this morning-"I'm going to take a bath when I get home." Had already gotten up to be toileted and wanted to put clothes on then. Would not go into tub room."

On 12/19/18 at 11:33 am, the surveyor interviewed the facility medical director regarding Resident # 38 being on Seroquel. The surveyor asked the facility medical director what was the indication for use of Seroquel for Resident # 38. The facility medical director stated that Resident # 38 displayed behaviors that she wanted to go home especially during the evening hours. The surveyor asked the facility medical director if the behaviors that Resident # 38 was displaying were behaviors associated with sun downing and dementia. The facility medical director stated that Resident # 38 would get to the point that she would become combative and exit seeking. The surveyor informed the facility medical director that the documentation in Resident # 38's clinical record did not reflect that Resident # 38 had delusions, paranoia, or psychosis. The surveyor asked the facility medical director why psychiatric services were not being utilized for Resident # 38. The facility medical director stated that the facility did have a contract for psychiatric services but went on to explain that the cost associated with the services and stated that it would be too costly to the facility. The facility medical director stated that he felt perfectly comfortable prescribing and monitoring antipsychotic medications.

On 12/20/18 at 8:06 am, the surveyor interviewed LPN # 1 (licensed practical nurse) The surveyor asked LPN # 1 what behaviors Resident # 38

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displayed. LPN # 1 stated, "She packs her clothing almost every night." "She constantly calls her family wanting to go home." "She resists care at times and refuses her meds at times because she forgets that she takes certain medications." The surveyor asked LPN # 1 if she had known Resident # 38 to be combative. LPN # 1 stated, "No." "She will threaten to but I have never known her to be combative." The surveyor asked LPN # 1 if she felt that the behaviors that Resident # 38 displayed are related to dementia or psychosis. LPN # 1 stated, "Dementia." The surveyor asked LPN # 1 if Resident # 38 displayed and delusional behaviors. LPN # 1 stated she was not aware of any delusional behaviors displayed by Resident # 38.

On 12/20/18 at 8:20 am, the surveyor reviewed the clinical record for Resident # 38 following the interview that was conducted with the facility medical director on 12/19/18 at 11:33 am, to determine when Resident # 38 was initially prescribed Seroquel and the rationale for the antipsychotic. The surveyor observed a progress note in Resident # 38's clinical record dated 1/4/17, which was the day Resident # 38 was admitted to the facility. The progress note contained documentation that included but was not limited to, ..." Plan: She is admitted to (facility name withheld), screened lab work pending and will include B-12, Vitamin D levels. Following a lengthy discussion with her daughter reviewing her care, advanced care plans, her prognosis. We will try to reduce her medications as much as possible and I will remove the Ativan. I will place her on Seroquel for her psychosis given daily at 2 p.m. prior to her sun downing behaviors." ...

The facility policy for "Psychotropic Medication

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F 758	Continued From page 34 Usage" contained documentation that included but was not limited to; ..."Policy: The facility will ensure psychotropic medications are only used when the medication is appropriate to treat a resident's specific, diagnosed and documented condition and the medication is beneficial to the resident, as demonstrated by monitoring and documentation of the resident's response to the medication. For any resident who is receiving a psychotropic medication to treat a disorder other than expressions or indications of distress related to dementia (for example schizophrenia, bipolar mania, depression with psychotic features, or other medical condition other than dementia, which may cause psychosis), the GDR may be considered clinically contraindicated for reasons that include but are not limited to: a) The continued use is in the accordance with relevant current standards of practice and the physician has documented the clinical rationale for why any attempted dose reduction would be likely to impair the resident's function or exacerbate an underlying medical or psychiatric disorder; or b) The resident's target symptoms returned or worsened after the most recent attempt at a GDR within the facility and the physician documented the clinical rationale for why an additional attempted dose reduction at the time would be likely to impair the resident's function or exacerbate an underlying medical or psychiatric disorder. Antipsychotic medications shall generally only be used for the following conditions/diagnoses as documented in the record: f) psychosis in the absence of dementia" ...	F 758		

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F 758	Continued From page 35 On 12/20/18 at 2:30 pm, the administrator and director of nursing was made aware of the findings as stated above. No further information regarding this issue was presented to the survey team prior to the exit conference on 12/20/18.	F 758		
F 760 SS=D	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to ensure 1of 15 residents was free of a significant medication error (Resident #17). The findings included: The facility staff failed to administer insulin as ordered by the physician for Resident #17. Resident #17 was administered Novolog insulin on two occassions when the medication should have been held. The clinical record of Resident #17 was reviewed 12/18/18 through 12/20/18. Resident #17 was admitted to the facility 2/8/18 with diagnoses that included but not limited to type 2 diabetes mellitus, hypertension, hypothyroidism, osteoarthritis, anemia, dizziness and giddiness, gastroesophageal reflux disease, synovial cyst of popliteal space, low back pain, anxiety, and irritable bowel syndrome.	F 760	Snyder Nursing Home maintains, in accordance with accepted professional standards and practices, that the facility's residents are free of significant medication errors. On December 19, 2018, a Facility Incident Report was filed on behalf of Resident #17 and the Nursing Department. Clarification was sought from the Medical Director, Director of Nursing and the Nurses assigned to Resident #17 pertaining to the administration and documentation of Insulin. On December 19, 2018, Resident #17 was seen by the facility Medical Director and identified no adverse outcomes pertaining to the administration of Insulin. In addition, Resident #17's POA was informed of the Physician's visit and the Insulin error.	2/3/19

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F 760	Continued From page 36 Resident #17's quarterly minimum data set (MDS) with an assessment reference date (ARD) of 10/23/18 assessed the resident with a BIMS (brief interview for mental status) as 15/15. The surveyor reviewed the physician's orders for diabetic management beginning with the September 2018 physician's orders. The September 2018 and November 2018 physician's orders for insulin read "Lantus 5 units sub-q (subcutaneous) at bedtime, Novolog 100 u/ml (units/milliliter) Inject 3 units sub-q with breakfast and lunch Hold if blood sugar less than 120, and accuchecks before meals and at bedtime." Resident #17's blood sugar on 9/20/18 at 6:30 a.m. was recorded as 94. Resident #17 was administered Novolog 3 units at 8:00 a.m. As per the physician order, Novolog 3 units should have been held. Resident #17's blood sugar on 11/28/18 at 11:30 a.m. was recorded as 108. Resident #17 was administered Novolog 3 units at 11:30 a.m. As per the physician order, Novolog 3 units should have been held. Resident #17's current comprehensive care plan was reviewed. One focus area read "Resident #17 has potential for elevated blood sugar due to (d/t) diabetes. Date initiated 2/21/2018. Interventions: Accuchecks as ordered. Administer meds (medications) as ordered." The surveyor interviewed licensed practical nurse #1 on 12/19/18 at 11:30 a.m. L.P.N. #1 reviewed the insulins administered and the physician orders and stated she was responsible for the insulin on 11/28/18 and stated she did not know	F 760	On December 21, 2018, the Nurses assigned to Resident #17 received from the Director of Nursing counseling and the assignment of additional training and continued education pertaining to the administration and documentation of Insulin. To prevent the reoccurrence of this type of deficiency, all Nurses will receive additional training and education pertaining to the administration and documentation of Insulin. This training will be conducted by the Director of Nursing or her designee, the Pharmacy Quality Assurance Nurse and Relias Learning Services. Subject matter will include, but not limited to: "The Prevention of Medical Errors and Adverse Events" and "Preventing Medical Errors in Long-term Care Facilities." This training and education will be completed by January 31, 2019. On December 28, 2018, an audit of all current Resident Medication Administration Records was performed by the Director of Nursing. This audit determined that there were no additional infractions pertaining tot he administration or documentation of insulin. To prevent the reoccurrence of this type of deficiency the Director of Nursing or her designee will perform an Insulin administration and documentation compliance audit, weekly for four weeks and then monthly for two months. Any records not in compliance will be identified	

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F 760	Continued From page 37 why she gave the insulin. The surveyor informed the administrator and the director of nursing of the above insulin concern during the end of the day meeting on 12/19/18 at 4:42 p.m. No further information was provided prior to the exit conference on 12/20/18.	F 760	and the Nurse responsible will be counseled in accordance to established facility policy. This compliance audit will begin on February 1, 2019. To prevent the reoccurrence of this type of deficiency, the facility's Policy and Procedure pertaining to the administration and documentation of Insulin was reviewed for revision by the Medical Director, Director of Nursing, Pharmacist Consultant and the Administrator. This review was completed on December 28, 2018. To prevent the reoccurrence of this type of deficiency, the Facility QA/QI and QA/PI teams will review this plan of correction at least quarterly for ongoing compliance. This will be an ongoing QA/QI and QA/PI measure.	
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	F 761		2/3/19

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	49E076	A. BUILDING _____ B. WING _____	12/20/2018

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F 761	Continued From page 38 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 and staff interview, the facility staff failed to remove expired items in the facility medication room and failed to label and date food in the refrigerator. The findings included: The facility staff failed to remove expired medical items from the facility medication room and failed to label and date a bag of candy. The surveyor and registered nurse #1 checked the medication room on 12/18/18 at 1:55 p.m. The refrigerator contained an opened 40-ounce bag of Hershey kisses. There was no date or resident name on the bag. R.N. #1 stated the name and date should be on the bag when opened. The surveyor checked the cabinets with R.N. #1. One closed system Foley catheter tray had expired 2/18. One IV (intravenous) Latex free start kit had expired 10/30/18. One 22-gauge 0.9 x 25 mm (millimeter) syringe expired 11/2018. R.N. #1 stated the expired items should be removed and proceeded to do this.	F 761	Snyder Nursing Home maintains, in accordance with accepted professional standards and practices, that facility does have in place measures to properly Label and Store Drugs and Biologicals, as well as, safe practices for handling food. On December 20, 2018, a Facility Incident Report was filed on behalf of the following departments: Nursing, Central Supply, and Food Service. Clarification and direction pertaining to the proper labeling and storage of drugs and biologicals, as well as proper labeling and storage of food was sought from the Administrator, Director Nursing, Central Supply Supervisor, Director of Food Service, Registered Dietitian and the Pharmacist Consultant. On December 20, 2018, an inspection of the facility's Medication Room and Central Supply areas was conducted by the Administrator, Director of Nursing and the Central Supply Supervisor. This inspection determined that there were no	

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F 761	Continued From page 39 The surveyor informed the director of nursing of the above expired items found in the medication room on 12/18/18 at 5:13 p.m. The surveyor requested the facility policy for dating/removing expired items. The administrator stated the facility does not have a policy on labeling and dating medical items. When asked if he expected staff to remove items that had expired, he stated yes. No further information was provided prior to the exit conference on 12/20/18.	F 761	additional infractions pertaining to the proper labeling and storage of drugs and biologicals. In addition, no other infractions were noted pertaining to proper food safety practices. To prevent the reoccurrence of this type of deficiency, facility Policy and Procedure pertaining to the proper labeling and storage of drugs, biologicals and food, were reviewed for placement and/or revision by the Administrator, Director of Nursing, Central Supply Supervisor, Pharmacist Consultant, Food Service Director and Registered Dietitian. This review was completed on December 28, 2018. To prevent the reoccurrence of this type of deficiency the following facility staff will receive additional training and education: Central Supply Supervisor, Charge Nurses, Medication Nurses and Dietary Aides. This training will be conducted by the Director of Nursing or her designee, the Director of Food Service and Relias Learning Services. This training will be specific to the labeling and storage of drugs, biologicals and food. emphasizing critical differences arising from the use of expiration dates vs. manufactured dates and "best used by dates". This training will be completed by February 18, 2019. To prevent the reoccurrence of this type of deficiency the following measure for performance improvement will be initiated by February 18, 2019. Daily Shift Temperature Logs located at all	

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F 761	Continued From page 40	F 761	medication room refrigerators and freezers will be revised to reflect the daily recording of inspections for the proper storage, labeling and "use by Expiration date" compliance. The monthly medication room inspections conducted by the Pharmacist Consultant and Registered Dietitian will encompass this new measure. To prevent the reoccurrence of this type of deficiency, the Facility QA/QI and QA/PI teams will review this plan of correction at least quarterly. This will be an ongoing QA/QI and QA/PI measure.	
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced	F 812		2/3/19

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F 812	Continued From page 41 by: Based on observation, staff interview, and facility document review, the facility staff failed to store, prepare, distribute, and serve food in accordance with professional standards for food safety. The findings included: The facility staff failed to ensure that food items were secured and labeled properly, failed to ensure that expired food items were discarded, and failed to ensure that dietary staff members hair was appropriately secured in the food service area. On 12/18/18 at 10:45 am, an initial tour of kitchen was conducted with the facility dietary manager. The surveyor observed the following items upon inspection of the walk in freezer; a plastic bag of mixed vegetables that had been opened with no documented open date on the bag, a plastic bag of corn dog nuggets that had been opened with no documented open date on the bag, sausage links opened on 10/22/18 that were not securely closed, riblets with no documented open date on the bag. The dietary manager was asked by the surveyor if the items mentioned above should have been dated. The dietary manager stated, "They probably should have." The surveyor observed a frozen red ring in a plastic bag that was not labeled and dated. The dietary manager identified the frozen red ring as a punch ring for the Resident Christmas party. The surveyor asked the dietary services manager if the punch ring should have been labeled and dated. The dietary manager stated, "It probably should have, but I know when it's going out." The surveyor observed a large container with frozen substance that was not labeled or dated. The dietary	F 812	Snyder Nursing Home maintains that the storage, preparation, distribution and service of food is in accordance with accepted professional standards and practices for food service safety. On December 18, 2018, a Facility Incident Report was filed on behalf of the Food Service Department's food service safety practices. Clarification and direction pertaining to Food Service Safety Practices was sought from the facility Administrator, Director of Food Service and the facility Registered Dietitian. On the evening of December 18, 2018, an inspection of the Food Service Department was conducted by the Administrator, Food Service Director and Food Service Staff. This inspection determined that there were no additional infractions pertaining to food safety practices. To prevent the reoccurrence of this type of deficiency, facility policy and procedure pertaining to the operations of the Food Service Department was reviewed for revision by the Administrator, Director of Food Service and the facility Registered Dietitian. This review was completed on December 28, 2018. To prevent the reoccurrence of this type of deficiency, all Food Service Staff did receive additional training and education pertaining to the proper storage, preparation, distribution and service of	

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F 812	Continued From page 42 manager identified the frozen substance in the container as vegetable soup. The surveyor asked the dietary manager if the vegetable soup should be labeled and dated. The dietary manager stated, "Yes," and removed the vegetable soup from the freezer. On 12/18/18 at 10:55 am, the surveyor inspected the walk in cooler. Upon inspection of the walk in cooler, the surveyor observed 3 large items wrapped in tan wrapping that was not labeled or dated. The dietary manager identified these items as cheese balls that she had just made for the Resident Christmas party. The dietary manager was asked if these items should have been labeled and dated. The dietary manager stated, "Yes." The surveyor also observed a bag of lettuce with 3 heads of lettuce that was open and was not securely contained. The surveyor also observed that there was no open date documented on the bag of lettuce. On 12/18/18 at 11:01 am, the surveyor inspected the dry storage area. Upon inspection of the dry storage area, the surveyor observed the following items: Biscuit and gravy mix that had been opened with no open date documented on the package, prewashed pinto beans 20 lb. (pound) box that was open to air. The dietary manager stated, "I don't have any way to seal that box that is how they come." The surveyor also observed a 20 lb. box of split peas that was open to air, a 50 lb. bag of Panko bread crumbs that had been opened with no open date documented on the package, and a box of baking soda open on top shelf in dry storage with a use by date of 10/13/18 printed on the box. The dietary manager stated, "We use	F 812	food. This additional training encompassed infection control guidelines specific to the Food Service Department. This training was conducted by the Director of Food Service and the facility Registered Dietitian. Additional training and education included educational courses through Relias Learning Services, specifically the completion of the following courses, "Safe Food Handling Part I and Part II." This portion of our continued education was completed on January 10, 2019. It was also determined that all Food Service Staff will obtain ServSafe certification as offered through US Food Services. This will be an ongoing performance improvement measure with the first class offered on February 18, 2019. To prevent the reoccurrence of this type of deficiency, on January 10, 2019, the following measures for performance improvement were initiated: (1) Daily Shift Temperature logs located at Freezer, Walk-in cooler, Reach-in cooler and other food storage areas were updated to reflect daily shift inspections for proper food storage, labeling and compliance with "use by" dating. (2) Food storage containers for such items as dried beans, peas, bread crumbs, powdered gravy mixes, etc. were purchased and installed. (3)The Facility Registered Dietitian's monthly kitchen inspection report and inspection process was also revised on January 10, 2019. To prevent the reoccurrence of this type of	

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F 812	Continued From page 43 that for odors." The dietary manager discarded the box of baking soda. The dietary manager also observed a 48 oz. (ounce) container of vegetable shortening with no documented date opened and a use by date of 9/23/16 printed on the bottom of the container. The surveyor observed a 25 lb. box of Thick & Easy that was opened with no opened dated documented on the package. The surveyor observed 2 plastic storage containers on the top shelf in the dry storage room. The dietary manager stated that the items inside the container was used for activities by the activities department and that the dietary staff did not monitor those items. The surveyor reviewed the items inside the plastic containers and observed the following items: Waffle cones best if used by 3/19/16 documented on the package Graham Cracker piecrust 6oz Best by 1/21/15 documented on the package Waffle cones 5 oz. box best by April 13 2018 documented on the package Kraft Jet Puff Marshmallow 5/10/18 documented on the package Sugar cones unopened 5 oz. box best by 9/13/`18 documented on the package Vanilla candy coating best by 1/21/15 documented on the package Light corn syrup unopened best by 2/14/16 documented on the package Light corn syrup unopened best by 10/25/13 documented on the package Grissine Rosemary 4.41 oz. opened no opened date 12/13/17 documented on the package Focaccia opened best by 18 May 2018 documented on the package On 12/18/18 at 11:24 am, the surveyor inspected the spices located on the spice rack in the	F 812	deficiency, the Facility QA/QI and QA/PI teams will review this plan of correction at least quarterly for ongoing compliance. This will be an ongoing QA/QI and QA/PI measure.	

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F 812	Continued From page 44	F 812		

kitchen. Upon inspection of the spice rack in the kitchen, the surveyor observed a container of bay leaves with no opened date or dispensed date. The surveyor asked the dietary manager how she would know if the bay leaves were still good to use. The dietary manager stated, "I use my judgement as a nutritional professional." The surveyor observed a 16 oz. container of all spice with no open or dispensed date. The surveyor asked the dietary manager how she knows if the all spice is still good to use. The dietary manager stated, "As long as you can still smell it it's good." The surveyor observed a small glass jar of Lemon peel 1.5 oz. with a best by date of 10/9/06 printed on the container. The surveyor observed a bottle of lemon juice with a best by date of 8/7/2018 printed on the bottle, and Gluten free chocolate chip cookies that were unopened with a best by date of 7/23/18 printed on the package.

On 12/18/18 at 11:45 am, while checking tray line temperatures, the surveyor observed dietary aide # 1 as she checked the tray line temperatures. The surveyor observed that dietary aide # 1's hair was pulled back into a bun and the bun was not secured under the hairnet. The surveyor also observed dietary aide # 2 in the food service area. The surveyor observed that dietary aide # 2's hair in the front was not secured underneath her hairnet.

On 12/18/18 at 12:02 pm, the surveyor observed a gallon of milk in the reach in cooler with a use by date of 12/10 printed on the container and a ½-gallon of buttermilk with a use by date of 12/13 printed on the container.

On 12/19/18 at 2:47 pm, the surveyor inspected the unit refrigerator. Upon inspection of the unit

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F 812	Continued From page 45 refrigerator, the surveyor observed an opened carton of milk with a use by date of 12/17 printed on the container. The facility policy on "Infection Control "Dietary Services" contained documentation that included but was not limited to, ..." IV Personal Hygiene a. Proper attire for food handlers should include a hair covering (hair net or caps) VI Proper Food Handling I. Leftovers must be labeled, dated, covered." ... On 12/18/18 at 5:30 pm, the administrator and director of nursing was made aware of the findings as stated above. No further information regarding this issue was provided to the survey team prior to the exit conference on 12/20/18.	F 812		
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	F 842		2/3/19

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F 842	Continued From page 46	F 842		

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, 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-

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F 842	Continued From page 47 (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 ensure an accurate clinical record for 1 of 15 Residents in the survey sample, Resident # 24. The findings included: The facility staff improperly documented insulin administration for Resident # 24. Resident # 24 was a 94-year-old-female who was admitted to the facility on 11/4/10. Diagnoses included but were not limited to: Alzheimer's disease, Type 2 diabetes mellitus, hypertension, and osteoarthritis. The clinical record for Resident # 24 was reviewed on 12/18/18 at 4:52 pm. The most recent MDS (minimum data set) assessment was a quarterly assessment with an ARD (assessment reference date) of 11/6/18. Section C of the MDS assesses cognitive patterns. In Section C0500, the facility staff documented that Resident # 24 had a BIMS (brief interview for mental status) score of 6 out of 15, which indicated that Resident # 24's cognitive status	F 842	Snyder Nursing Home maintains, in accordance with accepted professional standards and practices, that a complete, accurately documented, readily accessible and systematically organized clinical record is maintained for its Residents. On December 20, 2018, a Facility Incident Report was filed on behalf of Resident #24 and the Nursing Department. Clarification was sought from the Medical Director, Director of Nursing and Nurse assigned to Resident #24 pertaining to the administration and documentation of Insulin. On December 21, 2018, the Nurse assigned to Resident #24 received from the Director of Nursing counseling and the assignment of additional training and continued education pertaining to the administration and documentation of Insulin. To prevent the reoccurrence of this type of deficiency, all Nurses will receive	

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F 842	Continued From page 48 was severely impaired. Section N of the MDS assesses medications. In Section N0350, the facility staff documented that Resident # 24 had insulin injections for 7 days during the lookback period for the 11/6/18 ARD. The current plan of care for Resident # 24 was reviewed and revised on 11/13/18. The facility staff documented a focus area for Resident # 24 as, "Resident # 24 has potential for hyper or hypoglycemic episodes secondary to diabetes." Interventions included but were not limited to, "Meds as ordered." Resident # 24 had current orders that were signed by the physician on 11/28/18. Orders included but were not limited to, "Novolog 100U (units)/ML (milliliter) Inject 15 units sub-q (subcutaneously) three times daily with meals *Hold if BS (blood sugar) <110*." On 12/18/18 at 4:55 pm, the surveyor reviewed the facility accucheck flow sheet for Resident # 24. The surveyor observed that facility staff had documented a blood sugar of "97" for the 6:30 am blood sugar on 10/26/18 for Resident # 24. The surveyor reviewed the October 2018 medication administration record for Resident # 24. The surveyor observed that facility staff had documented that Novolog 15 units was given at 8 am and documented the site given as "18 (to left and above level of umbilicus)." The surveyor reviewed the back of the October 2018 medication administration record and observed documentation documented as, "10/26/18 8AM-Held Novolog 15 u R/T (related to) BS of 97." On 12/18/18 at 5:30 pm, the administrator and director of nursing was made aware of the findings as stated above.	F 842	additional training and education pertaining to the administration and documentation of Insulin. This training will be conducted by the Director of Nursing or her designee, the Pharmacy Quality Assurance Nurse and Relias Learning Services. Subject matter will include, but not limited to: "How to Avoid Medical Documentation Error" and "The In and Outs of Medical Documentation." This training and education will be completed by January 31, 2019. On December 28, 2018, an audit of all current Resident Medication Administration Records was performed by the Director of Nursing. This audit determined that there were no additional infractions pertaining to the administration or documentation of Insulin. To prevent the reoccurrence of this type of deficiency the Director of Nursing or her designee will perform an Insulin administration and documentation compliance audit, weekly for four weeks and then monthly for two months. Any records not in compliance will be identified and the Nurse responsible will be counseled in accordance to established facility policy. This compliance audit will begin on February 1, 2019. To prevent the reoccurrence of this type of deficiency, the facility's Policy and Procedure pertaining to the administration and documentation of insulin was reviewed for revision by the Medical Director, Director of Nursing, Pharmacist	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49E076	A. BUILDING _____ B. WING _____	12/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SNYDER NURSING HOME	11 NORTH BROAD ST SALEM, VA 24153

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F 842	Continued From page 49 On 12/19/18 at 10:29 am, the director of nursing informed the surveyor that she had spoken to the nurse that was responsible for medication administration on 10/26/18. The director of nursing stated that the nurse stated that she did not give the medication. The director of nursing agreed that the documentation of Novolog on 10/26/18 for Resident # 24 was inaccurate. No further information regarding this issue was presented to the survey team prior to the exit conference on 12/20/18.	F 842	Consultant and the Administrator. This review was completed on December 28, 2018. To prevent the reoccurrence of this type of deficiency, the Facility QA/QI and QA/PI teams will review this plan of correction at least quarterly for ongoing compliance. This will be an ongoing QA/QI and QA/PI measure.	