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THE WYBE AND MARIETJE KROONTJE HEALTH CARE CENTER	1000 LITTON LANE BLACKSBURG, VA 24060

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E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 2/5/19 through 02/7/19. The facility was in substantial compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities.	E 000		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 2/5/19 through 2/7/19. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. The census in this 60 certified bed facility was 50 at the time of the survey. The survey sample consisted of 13 current Resident reviews and 3 closed record reviews.	F 000		
F 636 SS=D	Comprehensive Assessments & Timing CFR(s): 483.20(b)(1)(2)(i)(iii) §483.20 Resident Assessment The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. §483.20(b) Comprehensive Assessments §483.20(b)(1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following: (i) Identification and demographic information (ii) Customary routine.	F 636		3/15/19

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

Electronically Signed | 03/14/2019

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F 636	Continued From page 1 (iii) Cognitive patterns. (iv) Communication. (v) Vision. (vi) Mood and behavior patterns. (vii) Psychological well-being. (viii) Physical functioning and structural problems. (ix) Continence. (x) Disease diagnosis and health conditions. (xi) Dental and nutritional status. (xii) Skin Conditions. (xiii) Activity pursuit. (xiv) Medications. (xv) Special treatments and procedures. (xvi) Discharge planning. (xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS). (xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts. §483.20(b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs. (i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility	F 636		

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F 636	Continued From page 2 following a temporary absence for hospitalization or therapeutic leave.) (iii)Not less than once every 12 months. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical review, the facility failed to create a comprehensive assessment for 1 of 16 residents (Resident #35). Resident #35 was admitted to the facility on 10/17/16 with diagnoses including hypertension, dementia, and anxiety disorder. On the admission minimum data set assessment the resident scored 15/15 on the brief interview for mental status and was assessed as without symptoms of delirium, psychosis, or behavior symptoms. On the most recent quarterly minimum data set assessment with assessment reference date 1/8/19, the resident scored 15/15 on the brief interview for mental status and was assessed as without symptoms of delirium, psychosis, or behaviors affecting care. The resident scored 6/27 on the resident mood interview. During an interview on 2/5/19, the resident reported the only concern with care was not getting enough of the food, which was bad. 02/07/19 11:17 AM PRN ativan ordered on 10/17/18 reviewed 12/26/18 and discontinued as staff reported no use for 2 weeks. Clinical record review on 2/7/19 revealed the resident was readmitted 10/17/18. Medication orders included Buspar 5 mg three times per day for anxiety and seroquel 25 mg twice per day since admission and ativan as needed. The physician declined (graduated dose reduction)	F 636	1. The care plan for resident #35 was updated on 2/13/19 to reflect resident focused signs and symptoms of psychotic behavior. 2. All resident care plans will reflect current and past symptoms and/or behaviors in order for staff members to identify resident centered approaches to alleviate symptoms. 3. Monthly audits consisting of 10% average daily resident census will be conducted by the QAA Department of resident care plans for compliance. The audits will ensure care plans identify resident centered approaches to care. Audits will be reviewed monthly at Quality Assessment and Assurance meetings. Monthly audits will be conducted for six months and re-evaluated for necessity of continuation. 4. Target behavioral symptoms tracking forms have been implemented for all residents receiving psychotropic medications. 5. Care Plan/MDS staff to implement plan of correction of Comprehensive Assessments and Timing with oversight by the QAA department beginning April 2019 for a period of six months and then re-evaluate.	

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F 636	Continued From page 3	F 636		

GDRs on both medications due to history of symptom instability. The surveyor was unable to locate documentation of symptoms being treated by the seroquel. There were no behavior or symptom tracking orders or nurse's notes referencing symptoms that might be considered signs of psychosis. The resident's nurse was unable to describe the symptoms for which the resident was taking antipsychotic medications. The surveyor spoke with the director of nursing (DON) about the issue. The DON was able to locate 2 Behavior Monitoring Sheets. One was blank except for documenting trazodone and lorazepam as medications the resident was receiving. No targeted symptoms were indicated. The second sheet indicated monitoring for 14-yelling and 16-c/o anxiety. The form indicated the resident c/o anxiety on 11/15/18 and received a 1-on-1 visit, rest in bed, and ativan and that the interventions were effective. No staff member was able to report the symptoms for which the antipsychotic medication seroquel was ordered.

The Comprehensive Care plan for 1/24/16 through 10/19/17 did not document psychosis, psychotic disorder, or use of antipsychotic medication or symptoms of psychosis or delusion. The care plan initiated 10/19/17 documented "I also have a history of psychosis for which I also take medication".
The surveyor has been unable to locate any expression of symptoms for which the resident was taking an antipsychotic medication other than the physician's statement "increased risk of psychiatric instability".

During a summary meeting on 2/7/19, the surveyor reported to the administrator and DON the concern that the comprehensive assessment

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F 636	Continued From page 4 process had not resulted in a comprehensive care plan that documented and addressed the symptoms being treated by antipsychotic, antidepressant, and antianxiety medication and that staff were able to articulate.	F 636		
F 656 SS=E	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes.	F 656		3/15/19

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F 656	Continued From page 5 (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to develop and or implement a patient centered comprehensive care plan for 7 of 16 residents in the survey sample (Residents #35, 31, 49, 15, 12, 20, and 44). The findings included: 1. For Resident #35, facility staff failed to develop a comprehensive care plan that addressed the symptoms for which the resident was treated with antianxiety, antidepressant, and antipsychotic medications. Resident #35 was admitted to the facility on 10/17/16 with diagnoses including hypertension, dementia, and anxiety disorder. On the admission minimum data set assessment the resident scored 15/15 on the brief interview for mental status and was assessed as without symptoms of delirium, psychosis, or behavior symptoms. On the most recent quarterly minimum data set assessment with assessment reference date 1/8/19, the resident scored 15/15 on the brief interview for mental status and was assessed as without symptoms of delirium,	F 656	1. Staff members, resident and family members were interviewed to identify how resident #35 psychosis, depression and anxiety manifest itself. This information was utilized to develop an individualized care plan. 2. Documentation from nursing notes, Target Behavioral Symptoms tracking forms and staff interviews will be evaluated to gather information about each individual resident□s psychosis, depression, anxiety, and other behavior diagnosis and how it manifest itself as a reference for development and implementation of comprehensive individualized care plans. 3. Monthly audits consisting of 10% average daily resident census will be conducted by the QAA Department of resident care plans for compliance to ensure care plans identify resident centered approaches. Audits will be reviewed monthly at Quality Assessment and Assurance meetings. Monthly audits will be conducted for six months and re-evaluated for necessity of continuation. 4. Care Plan/MDS staff to implement	

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F 656	Continued From page 6 psychosis, or behaviors affecting care. The resident scored 6/27 on the residentr mood interview. During an interview on 2/5/19, the resident reported the only concern with care was not getting enough of the food, which was bad. Clinical record review on 2/7/19 revealed the resident was readmitted 10/17/18. Medication orders included Buspar 5 mg three times per day for anxiety and seroquel 25 mg twice per day since admission and ativan as needed. The physician declined GDRs on both medications due to history of symptom instability. The surveyor was unable to locate documentation of symptoms being treated by the seroquel. There were no behavior or symptom tracking orders or nurse's notes referencing symptoms that might be considered signs of psychosis. The resident's nurse was unable to describe the symptoms for which the resident was taking antipsychotic medications. The surveyor spoke with the director of nursing (DON) about the issue. The DON was able to locate 2 Behavior Monitoring Sheets. One was blank except for documenting trazodone and lorazepam as medications the resident was receiving. No targeted symptoms were indicated. The second sheet indicated monitoring for 14-yelling and 16-c/o anxiety. The form indicated the resident c/o anxiety on 11/15/18 and received a 1-on-1 visit, rest in bed, and ativan and that the interventions were effective. No staff member was able to report the symptoms for which the antipsychotic medication seroquel was ordered. The Comprehensive Care plan for 1/24/16 through 10/19/17 did not document psychosis,	F 656	Development/Implementation of Comprehensive Care Plans with oversight by the QAA department beginning April 2019 for a period of six months and re-evaluate.	

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psychotic disorder, or use of antipsychotic medication or symptoms of psychosis or delusion. The care plan initiated 10/19/17 documented "I also have a history of psychosis for which I also take medication".
The surveyor has been unable to locate any expression of symptoms for which the resident was taking an antipsychotic medication other than the physician's statement "increased risk of psychiatric instability". There were no target symptoms or symptom abatement strategies in the care plan.

The administrator and director of nursing were notified of the concern that the resident's care plan did not address the use of psychotropic and antipsychotic medications.
2. The facility staff failed to develop and or implement a patient centered comprehensive care plan for Resident #31, which included targeted behaviors.

The resident was readmitted to the facility on 2/29/12 with the following diagnoses, but not limited to anemia, high blood pressure, Dementia, Parkinson's disease, depression and psychotic disorder. On the significant change MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 2/29/12, the resident was coded as having a BIMS (Brief Interview for Mental Status) score of 15 out of a possible 15. Resident #31 was also coded as requiring extensive assistance of 1 staff member for dressing and personal hygiene and being totally dependent on 1 staff member for bathing.

During the clinical record review on 2/6/19, the surveyor noted that Resident #31 was receiving the following physician ordered medications:

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" Risperidone 0.25 mg (milligram) 1 tablet by mouth two times a day for psychosis.
" Zoloft 75 mg by mouth one time a day for depression.

The surveyor reviewed the comprehensive care plan for Resident #31. The comprehensive care plan contained the following interventions:
" " ...Give me my medication as ordered.
" Monitor me for side effects from my medication.
" Monitor me for changes in my mood and/or behavior.
" Notify my doctor if it appears my medication is not working ..."

The surveyor requested and received copies of the "Behavior/Intervention Monitoring" sheets. These sheets were dated for 11/1/18 through 2/6/19. Paranoia and delusions were documented for behavioral symptom codes. However, these sheets were blank and had no documentation of the targeted behaviors to assess for with each of the above documented medications. The surveyor also reviewed the nurse's notes and there was no targeted behaviors symptoms documented.

The surveyor notified the administrative team on 2/6/19 at 4:05 pm of the above documented findings. The surveyor requested and received the facility's policy on behavioral monitoring. The policy titled "Behaviors Identification and Interventions" read in part ..."Residents with problematic behavioral symptoms will be promptly assessed and monitored by professional staff. Causative factors influencing behavioral will be identified. Management and appropriate behavioral interventions will be care planned,

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implemented and re-evaluated as changes occur ..."

No further information was provided to the surveyor prior to the exit conference on 2/7/19.

3. The facility staff failed to develop a patient centered comprehensive care plan for Resident #49, which included targeted behaviors.

Resident #49 was admitted to the facility on 12/31/18 with the following diagnoses of, but not limited to atrial fibrillation, high blood pressure, stroke, dementia and anxiety. On the admission, MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 1/7/19 coded the resident as having a BIMS (Brief Interview for Mental Status) score of 5 out of a possible score of 15. Resident #49 was also coded as requiring extensive assistance of 1 staff member for dressing and limited assistance from 1 staff member for personal hygiene. The resident was also coded as being totally dependent on 1 staff member for bathing.

On 2/5/19 at 2:20 pm, the surveyor noted the following physician's order that included:
" Xanax 0.5 mg (milligram) 1 tablet by mouth two times a day for anxiety
" Seroquel 25 mg po (by mouth) at bedtime.

The surveyor reviewed the clinical record for Resident #49 on 2/5/19 and 2/6/19
The surveyor also reviewed the comprehensive care plan for Resident #49. For Psychotropic drug use, the surveyor noted the following interventions:
" ..."Give me my medication as ordered.
" Monitor me for side effects from my

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medication.
" Monitor me for changes in mood and/or behavior ..."
The surveyor notified the administrative team on 2/6/19 at 4:05 pm of the above documented findings. The surveyor requested and received the facility's policy on behavioral monitoring. The policy titled "Behaviors Identification and Interventions" read in part ..."Residents with problematic behavioral symptoms will be promptly assessed and monitored by professional staff. Causative factors influencing behavioral will be identified. Management and appropriate behavioral interventions will be care planned, implemented and re-evaluated as changes occur ..."

No further information was provided to the surveyor prior to the exit conference on 2/7/19.
4. The facility staff failed to implement a person centered comprehensive care plan with targeted behaviors, goals and outcomes for psychotropic medication for depression and decreased appetite identified for Resident #15.

The clinical record of Resident #15 was reviewed 2/5/19 through 2/7/19. Resident #15 was admitted to the facility 9/13/17 with diagnoses that included but not limited to nausea with vomiting, generalized muscle weakness, gastroesophageal reflux disease with esophagitis, hypokalemia, iron deficient anemia, history of kidney stones, left hip surgery, chronic depression, and bilateral lower quadrant pain.

Resident #15'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

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status) as 15/15. There were no assessed signs of delirium, psychosis, or behaviors that affected others.

Resident #15's February 2019 physician orders were reviewed. Resident #15 had orders and received Remeron 7.5 mg (milligrams) tablet one time a day at bedtime for decreased appetite/weight loss (start date 4/14/18) and Citalopram 20 mg tablet by mouth one time a day for depression (start date 4/14/18).

Resident #15 had received both Remeron and Celexa since 4/14/18.

The surveyor reviewed the current comprehensive care plan on 2/6/19. One "Concern and Strength dated 9/10/18" read, "I have a history of depression. I take medicine for this." My preference for care read "1. Give my med (medication) as ordered. 2. Monitor me for s/e (side effects) from my medicine. 3. Monitor me for changes in mood and or behavior. 4. I look forward to visits from my daughter." A second "Concern and Strength dated 9/5/2018" read "1. Watch me to make sure my depression does not get any worse. 2. Administer my medications as ordered. 3. I would like my family to visit as much as possible."

The current person centered care comprehensive care plan did not identify targeted behaviors, outcomes and goals for Citalopram (Celexa) or Remeron.

The surveyor interviewed both minimum data set (MDS) assessment registered nurses on 2/7/19 at 11:33 a.m. Both reviewed the current care plan and when the surveyor asked what

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behaviors the Citalopram and Remeron were targeting, the MDS staff agreed there were no targeted behaviors identified.

The surveyor reviewed the behavior/intervention monitoring tool for Resident #15. On the tool, crying out and c/o (complaints of) depression were circled under the behavioral symptoms codes.

The surveyor informed the administrative staff of the absence to develop a person-centered care-plan with targeted behaviors, goals and desired outcomes for the use of Citalopram and Remeron to treat Resident #15's depression and decreased appetite on 2/7/19 at 3:52 p.m.

The surveyor reviewed the facility policy titled "Behaviors Identification and Interventions" on 2/7/19. The policy read in part: Assessment of identified behaviors will be documented in (but not limited to) nursing notes, behavior tracking forms and social service progress notes to help clarify the underlying cause of the behavior and help develop effective management intervention. The Care Plan will identify behavior problems, have measurable goals, appropriate interventions and be coordinated with the interdisciplinary team, resident and family.

No further information was provided prior to the exit conference on 2/7/19.

5. The facility staff failed to implement a person centered comprehensive care plan with targeted behaviors, goals and outcomes identified for Resident #12 with the use of psychotropic medications (anti-anxiety medications and anti-depressant medication).

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The clinical record of Resident #12 was reviewed 2/5/19 through 2/7/19. Resident #12 was admitted to the facility 10/1/16 and readmitted 1/18/18 with diagnoses that included but not limited to urinary tract infection, diabetes, dehydration, weakness, constipation, abnormal weight loss, atrial fibrillation, rheumatoid arthritis, depression, chronic pain syndrome, adult failure to thrive, and osteoporosis.

Resident #12's quarterly minimum data set (MDS) with an assessment reference date (ARD) of 11/9/18 assessed the resident with a BIMS (brief interview for mental status) as 11/15. The resident had no signs or symptoms of delirium, psychosis or behaviors that affected others.

Resident #12's February 2019 physician orders included Citalopram 10 mg (milligrams) 1 tablet by mouth one time a day in the morning for depression (start date 11/8/18) and Lorazepam 0.5 mg 1 tablet by mouth one time a day at bedtime for anxiety (start date 10/8/18).

Resident #12 received both Citalopram and Lorazepam since November 2018.

Resident #12's current comprehensive care plan dated 8/14/18 had the following "My Concerns and my strengths" for 8/14/18. "I have a history of anxiety and depression. I take medicine for this. My preference for care 1. Give me my medication as ordered. 2. Monitor me for s/e (side effects) from my medications 3. Monitor me for changes in mood and /or behaviors." A second "I Care Plan" dated 8/9/18 read "I have a diagnosis of depression and anxiety. Occasionally I have trouble concentrating. 1.

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Observe me to make sure my mood remains stable and my daily needs are met. 2. I want my family to visit as much as possible. 3. I want to socialize with others and participate in the activities of my choice. 4. Administer my medications as ordered."

The current comprehensive care plan did not identify person centered targeted behaviors, goals, and outcomes for the use of Lorazepam (Ativan) and Citalopram.

The undated behavior/intervention monitoring tools were circled for crying out and c/o (complains of) anxiety as behavior symptoms codes.

The surveyor interviewed both minimum data set (MDS) assessment registered nurses on 2/7/19 at 11:33 a.m. Both reviewed the current care plan and when the surveyor asked what behaviors the Citalopram and Ativan were targeting, the MDS staff agreed there were no targeted behaviors identified.

The surveyor informed the administrative staff of the absence to develop a care-plan with targeted behaviors, goals and desired outcomes for the use of Citalopram and Ativan to treat Resident #12's depression and anxiety on 2/7/19 at 3:52 p.m.

The surveyor reviewed the facility policy titled "Behaviors Identification and Interventions" on 2/7/19. The policy read in part: Assessment of identified behaviors will be documented in (but not limited to) nursing notes, behavior tracking forms and social service progress notes to help clarify the underlying cause of the behavior and

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help develop effective management intervention. The Care Plan will identify behavior problems, have measurable goals, appropriate interventions and be coordinated with the interdisciplinary team, resident and family.

No further information was provided prior to the exit conference on 2/7/19.

6. The facility staff failed to implement a person centered comprehensive care plan with targeted behaviors, outcomes and goals identified for Resident #20 and the use of psychotropic medication.

The clinical record of Resident #20 was reviewed 2/5/19 through 2/7/19. Resident #20 was admitted to the facility 10/15/18 with diagnoses that included but not limited to adult failure to thrive, chronic depression, disruptive behavior, agitation, atrial fibrillation, fractured right femur neck, vascular dementia with behavioral disturbances, hypertension, and chronic diastolic heart failure.

Resident #20's significant change in assessment minimum data set (MDS) with an assessment reference date (ARD) of 12/3/18 assessed the resident with a brief interview for mental status (BIMS) as 9/15. Resident #20 had no behavioral signs or symptoms, no signs or symptoms of delirium, or psychosis.

Resident #20's February physician orders 2019 included "Escitalopram 10 mg 1 tablet by mouth one time a day for depression (start date 12/11/18), Mirtazapine 7.5 mg 1 tablet by mouth one time a day at bedtime for poor appetite and Lorazepam gel 1 mg (milligram)/ml (milliliter)

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Apply topically every 6 hours as needed for psychosis/agitation/anxiety (start date 12/20/18)."

The surveyor reviewed Resident #20's current comprehensive care plan dated 12/3/18. Problem areas included one for mood state with long term goal to have a peaceful sleep and approaches to use were to turn on my white noise machine at night and assure me that my roommate shares the room with me and that I am safe. Also identified as a problem area for mood state that the resident had symptoms of depressionm, a diagnosis of anxiety which is managed by daily medication. Approaches included watch me to make sure my depression does not get any worse, refer me to see the doctor to assess my mood, want my family to visit as much as possible, administer my medications as ordered, and provide me with emotional support as needed.

Resident #20 also had an area dated 12/5/18 for psychotropic drug use with long term goal to show a stable mood and socialize with others. Approaches included give me my medication as ordered, monitorme for side effects from my medication, and monitor me for changes in mood and/or behavior.

The current comprehensive care plan did not identify specific targeted behaviors for the medications, long term measurable goals or individualized approaches to care.

The surveyor reviewed the undated behavior/intervention monitoring sheet for Ativan, Lexapro and Remeron. The behavioral symptoms coded were crying out and yelling out.

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The surveyor interviewed both minimum data set (MDS) assessment registered nurses on 2/7/19 at 11:33 a.m. Both reviewed the current care plan and when the surveyor asked what behaviors the Citalopram and Ativan were targeting, the MDS staff agreed there were no targeted behaviors identified.

The surveyor informed the administrative staff of the absence to develop a care-plan with targeted behaviors, goals and desired outcomes for the use of Escitalopram, Remeron, and Ativan to treat Resident #20's depression and anxiety on 2/7/19 at 3:52 p.m.

The surveyor reviewed the facility policy titled "Behaviors Identification and Interventions" on 2/7/19. The policy read in part: Assessment of identified behaviors will be documented in (but not limited to) nursing notes, behavior tracking forms and social service progress notes to help clarify the underlying cause of the behavior and help develop effective management intervention. The Care Plan will identify behavior problems, have measurable goals, appropriate interventions and be coordinated with the interdisciplinary team, resident and family.

No further information was provided prior to the exit conference on 2/7/19.

7. The facility staff failed to implement a person centered comprehensive care plan with targeted behaviors identified for Resident #44 for the use of psychotropic medication.

The clinical record of Resident #44 was reviewed 2/5/19 through 2/7/19. Resident #44 was admitted to the facility 1/18/18 with diagnoses that

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included but not limited to diabetes mellitus, urinary tract infection, constipation, abnormal weight loss, cerebrovascular accident (CVA), coronary artery disease (CAD), atrial fibrillation, hypertension, gastro esophageal reflux disease, and chronic obstructive pulmonary disease.

Resident #44's annual minimum data set (MDS) assessment with an assessment reference date (ARD) of 1/24/19 assessed the resident with a BIMS (brief interview for mental status) as 13/15. Resident #44 was without signs or symptoms of delirium, behaviors affecting others or psychosis.

Resident #44's February 2019 physician orders included orders for Valium 2 mg (milligrams) 1 tablet by mouth one time a day for vertigo start date 12/3/2018, Escitalopram 5 mg 1 tablet by mouth one time a day at bedtime for depression start date 1/7/2019 and Quetiapine (Seroquel) 25 mg (1/2tablet) by mouth one time a day at bedtime for agitation d/t (due to psychosis) start date 4/13/2018.

The surveyor reviewed the current comprehensive care plan for Resident #44 on 2/6/19. The person centered care plan identified a problem area for psychotropic drug use with long term goals of maintaining a stable mood and approaches to use "give me my medication as ordered, monitor me for side effects from my medication, and monitor me for changes in mood and/or behavior. A second care plan identified an issue with mood long term goal was to be comfortable and satisfied and approaches included watch me to make sure my mood does not get any worse, have my family to visit as much as possible, especially my daughter and great granddaughter, and I enjoy playing Bingo

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and going to wine/cheese social. Please continue to remind me as needed about these events and encourage me to go.

The current comprehensive care plan for Resident #44 did not have person centered targeted behaviors, measurable goals or individualized approaches to care.

The undated behavior/intervention monitoring sheets had the following behavioral symptoms circled-crying out and yelling out.

The surveyor interviewed both minimum data set (MDS) assessment registered nurses on 2/7/19 at 11:33 a.m. Both reviewed the current care plan and when the surveyor asked what behaviors the Escitalopram, Diazepam, and Seroquel were targeting, the MDS staff agreed there were no targeted behaviors identified.

The surveyor informed the administrative staff of the absence to develop a care-plan with targeted behaviors, goals and desired outcomes for the use of Escitalopram, Diazepam, and Seroquel to treat Resident #44's on 2/7/19 at 3:52 p.m.

The surveyor reviewed the facility policy titled "Behaviors Identification and Interventions" on 2/7/19. The policy read in part: Assessment of identified behaviors will be documented in (but not limited to) nursing notes, behavior tracking forms and social service progress notes to help clarify the underlying cause of the behavior and help develop effective management intervention. The Care Plan will identify behavior problems, have measurable goals, appropriate interventions and be coordinated with the interdisciplinary team, resident and family.

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F 656	Continued From page 20 No further information was provided prior to the exit conference on 2/7/19.	F 656		
F 744 SS=D	Treatment/Service for Dementia CFR(s): 483.40(b)(3) §483.40(b)(3) A resident who displays or is diagnosed with dementia, receives the appropriate treatment and services to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview, and clinical record review, facility staff failed to ensure a resident with dementia was treated with psychotropic medications only when targeting specific symptoms and that use is monitored for efficacy, risks and harm for 1 of 16 residents in the survey sample (Resident #35). The findings included: Resident #35 was admitted to the facility on 10/17/16 with diagnoses including hypertension, dementia, and anxiety disorder. On the admission minimum data set assessment the resident scored 15/15 on the brief interview for mental status and was assessed as without symptoms of delirium, psychosis, or behavior symptoms. On the most recent quarterly minimum data set assessment with assessment reference date 1/8/19, the resident scored 15/15 on the brief interview for mental status and was assessed as without symptoms of delirium, psychosis, or behaviors affecting care. The resident scored 6/27 on the resident mood interview.	F 744	1. Resident # 35 now has a target behavioral symptoms tracking form in place for monitoring of behaviors. The care plan has been updated to reflect behavior symptoms directly related to resident□s diagnosis of Dementia. Resident #35 preference is to not attend group events and is provided one on one visits from the events department. The physician has instituted a gradual dose reduction for Trazadone and a review of other medications for necessity. 2. All residents will be evaluated for treatment/services related to dementia through therapy referrals as appropriate and resident centered approaches. All residents with a diagnosis of Dementia will be encouraged to participate in facility events and free from unnecessary medications to maintain his/her highest practicable physical, mental and psychosocial well-being. 3. Resident participation in facility events will be monitored/reviewed at resident□s quarterly care plan meetings to ensure	3/15/19

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F 744	Continued From page 21 During an interview on 2/5/19, the resident reported the only concern with care was not getting enough of the food, which was bad. Clinical record review on 2/7/19 revealed the resident was readmitted 10/17/18. Medication orders included Buspar 5 mg three times per day for anxiety and seroquel 25 mg twice per day since admission and ativan as needed. The physician declined GDRs on both medications due to history of symptom instability. The surveyor was unable to locate documentation of symptoms being treated by the seroquel. There were no behavior or symptom tracking orders or nurse's notes referencing symptoms that might be considered signs of psychosis. The resident's nurse was unable to describe the symptoms for which the resident was taking antipsychotic medications. The surveyor spoke with the director of nursing (DON) about the issue. The DON was able to locate 2 Behavior Monitoring Sheets. One was blank except for documenting trazodone and lorazepam as medications the resident was receiving. No targeted symptoms were indicated. The second sheet indicated monitoring for 14-yelling and 16-c/o anxiety. The form indicated the resident c/o anxiety on 11/15/18 and received a 1-on-1 visit, rest in bed, and ativan and that the interventions were effective. No staff member was able to report the symptoms for which the antipsychotic medication seroquel was ordered. The Comprehensive Care plan for 1/24/16 through 10/19/17 did not document psychosis, psychotic disorder, or use of antipsychotic medication or symptoms of psychosis or delusion. The care plan initiated 10/19/17	F 744	residents mental, physical and psychosocial needs are being met and adjust as needed. 4. The QAA department will conduct monthly audits beginning April 2019 consisting of 10% of the average daily census to identify residents with dementia to ensure compliance for a period of six months and then re-evaluate.	

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F 744	Continued From page 22 documented "I also have a history of psychosis for which I also take medication". The surveyor has been unable to locate any expression of symptoms for which the resident was taking an antipsychotic medication other than the physician's statement "increased risk of psychiatric instability". There were no target symptoms or symptom abatement strategies in the care plan. The administrator and director of nursing were notified of the concern that the resident's care plan did not address dementia and the use of psychotropic and antipsychotic medications.	F 744		
F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug,	F 756		3/15/19

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F 756	Continued From page 23 and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to appropriately address gradual dose reductions of psychotropic medications for 1 of 16 residents in the survey sample (Resident #35). The findings included: Resident #35 was admitted to the facility on 10/17/16 with diagnoses including hypertension, dementia, and anxiety disorder. On the admission minimum data set assessment the resident scored 15/15 on the brief interview for mental status and was assessed as without symptoms of delirium, psychosis, or behavior symptoms. On the most recent quarterly minimum data set assessment with assessment reference date 1/8/19, the resident scored 15/15 on the brief interview for mental status and was assessed as without symptoms of delirium, psychosis, or behaviors affecting care. The	F 756	1. After Physician review a Gradual Dose Reduction has been initiated for resident #35 current order of Trazadone. A target behavioral symptoms tracking form has been implemented. 2. All residents have received a target behavioral symptoms tracking form. A medication management review team has been created to review of all resident medications monthly for effectiveness of current resident dose regimen and recommendation for gradual dose reduction as warranted. This practice will be conducted monthly on a continued basis. 3. Monthly resident record audits of 10% average daily census by the Quality Assurance and Assessment department will be completed on residents receiving psychotropic medications to identify any resident requiring a Gradual Dose	

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F 756	Continued From page 24 resident scored 6/27 on the resident mood interview. 02/07/19 02:11 PM The resident started on seroquel 12.5 mg q am and 15 mg q hs on 2/3/17 after a psychiatric note indicated the resident was reporting seeing bugs that weren't there and had written a postcard to the FBI to complain about the monitor in her head. A second order to increase to 25 mg q AM and QPM on 3/9/17. There are no nursing notes concerning either of the items in the 2/3 physician note and there are no behavior monitoring sheets that indicate any incidents occurred during the Jan-Feb 2-17 time period. 02/07/19 02:41 PM Spoke with DON (director of nursing) about concern that the record does not document any symptoms except one psychiatrist note written the day the antipsychotic was ordered, with no documentation of symptoms leading up to the increase in the dose on 3/9/17. The DON (director of nursing) said she remembered the resident used to talk about the CIA a lot. The surveyor noted that no staff members had documented that symptom. The resident's care plan documented a history of psychosis and taking medication to treat it. There were no target symptoms or symptom abatement strategies. On 2/7/18 at 3:52 pm, the surveyor notified the administrative team of the above documented findings. No further information was provided to the surveyor prior to the exit conference on 2/7/19.	F 756	Reduction (GDR). 4. Director of nursing has implemented the target behavioral symptoms tracking form on all residents. The QAA department will monitor for compliance.	

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F 758	Continued From page 25	F 758		
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 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	F 758		3/28/19

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F 758	Continued From page 26 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 that 7 of 16 residents were free from unnecessary medications (Resident #35, 31, 49, 15, 12, 20, and 44). The findings included: 1. For Resident #35, facility staff failed to ensure that psychotropic and antipsychotic medications were ordered only to address specific symptoms for which the resident was treated with antianxiety, antidepressant, and antipsychotic medications. Resident #35 was admitted to the facility on 10/17/16 with diagnoses including hypertension, dementia, and anxiety disorder. On the admission minimum data set assessment the resident scored 15/15 on the brief interview for mental status and was assessed as without symptoms of delirium, psychosis, or behavior symptoms. On the most recent quarterly minimum data set assessment with assessment reference date 1/8/19, the resident scored 15/15 on the brief interview for mental status and was	F 758	1. Resident #35 has been placed on a gradual dose reduction for Trazadone and a target behavioral symptoms tracking form has been initiated. The resident care plan has been updated to reflect individualized needs and approaches. Resident #31 had a target behavioral symptoms tracking form implemented. Resident #49 cannot be changed as it happened in the past and resident has been discharged from the facility. Resident #15, 12, and 44 now have a target behavioral symptoms tracking form to document any resident behaviors and the care plans have been updated to reflect individualized needs and approaches. Resident #20 had the following medications discontinued Escitalopram 10mg and Mirtazapine 7.5 mg. A current target behavioral symptoms tracking from has been implemented, and resident□s care plan has been updated to reflect individualized needs and approaches. 2. All residents have received a target behavioral symptoms tracking form. A	

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F 758	Continued From page 27 assessed as without symptoms of delirium, psychosis, or behaviors affecting care. The resident scored 6/27 on the resident mood interview. During an interview on 2/5/19, the resident reported the only concern with care was not getting enough of the food, which was bad. Clinical record review on 2/7/19 revealed the resident was readmitted 10/17/18. Medication orders included Buspar 5 mg three times per day for anxiety and seroquel 25 mg twice per day since admission and ativan as needed. The physician declined GDRs on both medications due to history of symptom instability. The surveyor was unable to locate documentation of symptoms being treated by the seroquel. There were no behavior or symptom tracking orders or nurse's notes referencing symptoms that might be considered signs of psychosis. The resident's nurse was unable to describe the symptoms for which the resident was taking antipsychotic medications. The surveyor spoke with the director of nursing (DON) about the issue. The DON was able to locate 2 Behavior Monitoring Sheets. One was blank except for documenting trazodone and lorazepam as medications the resident was receiving. No targeted symptoms were indicated. The second sheet indicated monitoring for 14-yelling and 16-c/o anxiety. The form indicated the resident c/o anxiety on 11/15/18 and received a 1-on-1 visit, rest in bed, and ativan and that the interventions were effective. No staff member was able to report the symptoms for which the antipsychotic medication seroquel was ordered. The Comprehensive Care plan for 1/24/16	F 758	medication management review team has been created to review all resident medications monthly for effectiveness of current resident dose regimen. 3. Monthly resident record audits of 10% average daily resident census by the Quality Assurance and Assessment department will be completed on residents receiving psychotropic medications to identify any resident requiring a Gradual Dose Reduction (GDR). 4. Compliance to be monitored by audits conducted beginning April 2019 by the QAA department for a period of six months and re-evaluate as needed.	

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through 10/19/17 did not document psychosis, psychotic disorder, or use of antipsychotic medication or symptoms of psychosis or delusion. The care plan initiated 10/19/17 documented "I also have a history of psychosis for which I also take medication".
The surveyor has been unable to locate any expression of symptoms for which the resident was taking an antipsychotic medication other than the physician's statement "increased risk of psychiatric instability". There were no target symptoms or symptom abatement strategies in the care plan.

The administrator and director of nursing were notified of the concern that psychotropic medications were not ordered to treat specific symptoms and that those symptoms were not documented in the clinical record and routinely monitored to ensure effectiveness of the medication in treating those symptoms.
2. The facility staff failed to monitor behaviors while Resident #31 was receiving psychotropic medications.

Resident was readmitted to the facility on 2/29/12 with the following diagnoses, but not limited to anemia, high blood pressure, Dementia, Parkinson's disease, depression and psychotic disorder. On the significant change MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 2/29/12, the resident was coded as having a BIMS (Brief Interview for Mental Status) score of 15 out of a possible 15. Resident #31 was also coded as requiring extensive assistance of 1 staff member for dressing and personal hygiene and being totally dependent on 1 staff member for bathing.

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During the clinical record review on 2/6/19, the surveyor noted that Resident #31 was receiving the following physician ordered medications:
" Risperidone 0.25 mg (milligram) 1 tablet by mouth two times a day for psychosis.
" Zoloft 75 mg by mouth one time a day for depression.

The surveyor performed a clinical record review on Resident #31 on 2/6 and 2/7/19. During this review, the surveyor noted that the resident was being given Zoloft daily for depression and Risperidone twice a day for psychosis. The surveyor reviewed the nurses' notes and MAR (Medication Administration Record) for the months of January and February 2019. There was no documentation of behaviors while receiving these medications.

The surveyor notified the administrative team of the above documented findings on 2/6/19 at 4:05 pm in the conference room. The surveyor requested and received the facility's policy on behavioral monitoring. The policy titled "Behaviors Identification and Interventions" read in part ..."Residents with problematic behavioral symptoms will be promptly assessed and monitored by professional staff. Causative factors influencing behavioral will be identified. Management and appropriate behavioral interventions will be care planned, implemented and re-evaluated as changes occur ..."

No further information was provided to the surveyor prior to the exit conference on 2/7/19

3. The facility staff failed to monitor behaviors while Resident #49 was receiving psychotropic medications.

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Resident #49 was admitted to the facility on 12/31/18 with the following diagnoses of, but not limited to atrial fibrillation, high blood pressure, stroke, dementia and anxiety. On the admission, MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 1/7/19 coded the resident as having a BIMS (Brief Interview for Mental Status) score of 5 out of a possible score of 15. Resident #49 was also coded as requiring extensive assistance of 1 staff member for dressing and limited assistance from 1 staff member for personal hygiene. The resident was also coded as being totally dependent on 1 staff member for bathing.

On 2/6/19, the surveyor noted the following physician's order that included:
" Xanax 0.5 mg (milligram) 1 tablet by mouth two times a day for anxiety
" Seroquel 25 mg po (by mouth) at bedtime.

The surveyor reviewed the clinical record for Resident #49 on 2/5/19 and 2/6/19.The surveyor also reviewed the comprehensive care plan for Resident #49. For Psychotropic drug use, the surveyor noted the following interventions:
" ..."Give me my medication as ordered.
" Monitor me for side effects from my medication.
" Monitor me for changes in mood and/or behavior ..."

The surveyor notified the administrative team on 2/6/19 at 4:05 pm of the above documented findings. The surveyor requested and received the facility's policy on behavioral monitoring. The policy titled "Behaviors Identification and Interventions" read in part ..."Residents with

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problematic behavioral symptoms will be promptly assessed and monitored by professional staff. Causative factors influencing behavioral will be identified. Management and appropriate behavioral interventions will be care planned, implemented and re-evaluated as changes occur ..."

No further information was provided to the surveyor prior to the exit conference on 2/7/19.
4. The facility staff failed to ensure Resident #15 was free of unnecessary medications. Resident #15 was administered Remeron and Celexa without identified targeted behaviors and monitoring for effects/side effects.

The clinical record of Resident #15 was reviewed 2/5/19 through 2/7/19. Resident #15 was admitted to the facility 9/13/17 with diagnoses that included but not limited to nausea with vomiting, generalized muscle weakness, gastroesophageal reflux disease with esophagitis, hypokalemia, iron deficient anemia, history of kidney stones, left hip surgery, chronic depression, and bilateral lower quadrant pain.

Resident #15'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 15/15. There were no assessed signs of delirium, psychosis, or behaviors that affected others.

Resident #15's February 2019 physician orders were reviewed. Resident #15 had orders and received Remeron 7.5 mg (milligrams) tablet one time a day at bedtime for decreased appetite/weight loss (start date 4/14/18) and

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Citalopram 20 mg tablet by mouth one time a day for depression (start date 4/14/18).

Resident #15 had received both Remeron and Celexa since 4/14/18.

The surveyor reviewed the current comprehensive care plan on 2/6/19. One "Concern and Strength dated 9/10/18" read, "I have a history of depression. I take medicine for this." My preference for care read "1. Give my med (medication) as ordered. 2. Monitor me for s/e (side effects) from my medicine. 3. Monitor me for changes in mood and or behavior. 4. I look forward to visits from my daughter." A second "Concern and Strength dated 9/5/2018" read "1. Watch me to make sure my depression does not get any worse. 2. Administer my medications as ordered. 3. I would like my family to visit as much as possible."

The current person centered care comprehensive care plan did not identify targeted behaviors, outcomes and goals for Citalopram (Celexa) or Remeron.

The surveyor interviewed both minimum data set (MDS) assessment registered nurses on 2/7/19 at 11:33 a.m. Both reviewed the current care plan and when the surveyor asked what behaviors the Citalopram and Remeron were targeting, the MDS staff agreed there were no targeted behaviors identified.

The surveyor reviewed the undated behavior/intervention monitoring tool for Resident #15. On the tool, crying out and c/o (complaints of) depression were circled under the behavioral symptoms codes. However, there was no

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evidence of crying out or depression documented on the tool. The "Resident Progress Notes" completed for the quarterly MDS were reviewed. The 11/29/18 Social Services Quarterly Assessment read "Resident #15 participated in the BIMS and mood assessment interviews on 11/26/18. She scored a 15/15 on the BIMS. No signs or symptoms of delirium present. Per the mood assessment, she reported no symptoms. Resident #15 is prescribed an antidepressant for depression." The quarterly nutrition assessment dated 11/27/18 read "CBW (current body weight) 138.7 # (pounds) reflects a desired 2.7# weight gain since last review. No significant weight change. Effectiveness of appetite stimulant."

Resident #15 was last seen by geriatric psychiatry on 8/20/18. The note read in part "Patient's current tx (treatment) and nursing report reviewed. Has no specific complaint. No SE (side effects) noted. No psychotic symptoms. Stable. No acute sx (symptoms)."

Resident #15's physician had declined a gradual dose reduction (GDR) in March 2018 and in September 2018, stating "increased risk psych instability"; however, the behavior monitoring sheets have no documentation of crying out or depression. The DON (director of nursing) stated the staff document by exception-only document what they see or hear.

The surveyor interviewed Resident #15 on 2/5/19 at 2:56 p.m. When asked about mood, the resident stated, "I am always happy."

The surveyor informed the administrative staff of the use of Citalopram and Remeron to treat Resident #15's on 2/7/19 at 3:52 p.m. without the

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use of monitoring/documentation to support both. The surveyor requested the facility policy on psychotropic drug use.

The surveyor reviewed the facility policy titled "Psychotropic Drug Use" on 2/7/19. The policy read in part "2. Residents who receive psychotropic medications are required to receive gradual dose reductions and behavioral interventions, unless contraindicated, in an effort to discontinue use of the psychotropic medications."

No further information was provided prior to the exit conference on 2/7/19.

5. The facility staff failed to ensure Resident #12 was free of unnecessary medications. Resident #12 was administered Citalopram and Lorazepam (Ativan) without monitoring for effects and side effects and without targeted behaviors.

The clinical record of Resident #12 was reviewed 2/5/19 through 2/7/19. Resident #12 was admitted to the facility 10/1/16 and readmitted 1/18/18 with diagnoses that included but not limited to urinary tract infection, diabetes, dehydration, weakness, constipation, abnormal weight loss, atrial fibrillation, rheumatoid arthritis, depression, chronic pain syndrome, adult failure to thrive, and osteoporosis.

Resident #12's quarterly minimum data set (MDS) with an assessment reference date (ARD) of 11/9/18 assessed the resident with a BIMS (brief interview for mental status) as 11/15. The resident had no signs or symptoms of delirium, psychosis or behaviors that affected others.

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Resident #12's February 2019 physician orders included Citalopram 10 mg (milligrams) 1 tablet by mouth one time a day in the morning for depression (start date 11/8/18) and Lorazepam 0.5 mg 1 tablet by mouth one time a day at bedtime for anxiety (start date 10/8/18).

Resident #12 received both Citalopram and Lorazepam since November 2018.

Resident #12's current comprehensive care plan dated 8/14/18 had the following "My Concerns and my strengths" for 8/14/18. "I have a history of anxiety and depression. I take medicine for this. My preference for care 1. Give me my medication as ordered. 2. Monitor me for s/e (side effects) from my medications 3. Monitor me for changes in mood and /or behaviors." A second "I Care Plan" dated 8/9/18 read "I have a diagnosis of depression and anxiety. Occasionally I have trouble concentrating. 1. Observe me to make sure my mood remains stable and my daily needs are met. 2. I want my family to visit as much as possible. 3. I want to socialize with others and participate in the activities of my choice. 4. Administer my medications as ordered."

The current comprehensive care plan did not identify person centered targeted behaviors, goals, and outcomes for the use of Lorazepam (Ativan) and Citalopram.

The undated behavior/intervention monitoring tools were circled for crying out and c/o (complains of) anxiety as behavior symptoms codes. The behavior/intervention monitoring sheet did not have any documentation of Resident #12 having crying out or c/o anxiety.

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There was no documentation to support the use of both Lorazepam and Citalopram (Celexa). The surveyor reviewed the quarterly MDS progress notes. The social services quarterly note dated 11/12/18 read "Resident #12 participated in the BIMS mood assessment interview on 11/7/2018. Resident #12 scored an 11/15 on the BIMS; she could not recall two words. No signs or symptoms of delirium present. Per the mood assessment, Resident #12 reported feeling tired. Resident #12 is prescribed an antidepressant and anti-anxiety medication with no adverse effects noted. No behaviors noted."

The surveyor reviewed the interdisciplinary progress notes from December 2018 through 2/6/19 and found no evidence to support the use of Celexa and Ativan. Documentation identified included that 24-hour chart checks were done and weekly skin assessments were completed.

The surveyor interviewed both minimum data set (MDS) assessment registered nurses on 2/7/19 at 11:33 a.m. Both reviewed the current care plan and when the surveyor asked what behaviors the Citalopram and Ativan were targeting, the MDS staff agreed there were no targeted behaviors identified.

The surveyor reviewed the medication regimen review from 11/14/17 through 2/6/19. The surveyor was unable to locate any recommendations for gradual dose reductions for Celexa or Ativan.

The last two physician progress notes dated 11/12/18 and 1/9/19 read in part "Resident #12's mood as follows: Depression-mood is stable, continue on Celexa w/prn (with as needed).

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Ativan available for anxiety."

The surveyor informed the administrative staff of the lack of monitoring/documentation for the use of Citalopram and Ativan to treat Resident #12's depression and anxiety on 2/7/19 at 3:52 p.m.

The surveyor reviewed the facility policy titled "Psychotropic Drug Use" on 2/7/19. The policy read in part "2. Residents who receive psychotropic medications are required to receive gradual dose reductions and behavioral interventions, unless contraindicated, in an effort to discontinue use of the psychotropic medications."

No further information was provided prior to the exit conference on 2/7/19.

6. The facility staff failed to ensure Resident #20 was free of unnecessary medications. Resident #20 was administered Escitalopram, Remeron, and Lorazepam without proper indications for use, monitoring and documentation of effects/side effects.

The clinical record of Resident #20 was reviewed 2/5/19 through 2/7/19. Resident #20 was admitted to the facility 10/15/18 with diagnoses that included but not limited to adult failure to thrive, chronic depression, disruptive behavior, agitation, atrial fibrillation, fractured right femur neck, vascular dementia with behavioral disturbances, hypertension, and chronic diastolic heart failure.

Resident #20's significant change in assessment minimum data set (MDS) with an assessment reference date (ARD) of 12/3/18 assessed the

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THE WYBE AND MARIETJE KROONTJE HEALTH CARE CENTER	1000 LITTON LANE BLACKSBURG, VA 24060

(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
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resident with a brief interview for mental status (BIMS) as 9/15. Resident #20 had no behavioral signs or symptoms, no signs or symptoms of delirium, or psychosis.

Resident #20's February physician orders 2019 included "Escitalopram 10 mg 1 tablet by mouth one time a day for depression (start date 12/11/18), Mirtazapine 7.5 mg 1 tablet by mouth one time a day at bedtime for poor appetite and Lorazepam gel 1 mg (milligram)/ml (milliliter) Apply topically every 6 hours as needed for psychosis/agitation/anxiety (start date 12/20/18)."

The surveyor reviewed Resident #20's current comprehensive care plan dated 12/3/18. Problem areas included one for mood state with long-term goal to have a peaceful sleep and approaches to use were to turn on my white noise machine at night and assure me that my roommate shares the room with me and that I am safe. Also identified as a problem area for mood state that the resident had symptoms of depression, a diagnosis of anxiety which is managed by daily medication. Approaches included watch me to make sure my depression does not get any worse, refer me to see the doctor to assess my mood, want my family to visit as much as possible, administer my medications as ordered, and provide me with emotional support as needed.

Resident #20 also had an area dated 12/5/18 for psychotropic drug use with long-term goal to show a stable mood and socialize with others. Approaches included give me my medication as ordered, monitor me for side effects from my medication, and monitor me for changes in mood and/or behavior.

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The current comprehensive care plan did not identify specific targeted behaviors for the medications, long-term measurable goals or individualized approaches to care.

The surveyor reviewed the undated behavior/intervention monitoring sheet for Ativan, Lexapro and Remeron. The behavioral symptoms coded were crying out and yelling out. The most recent episode of behavior occurred 1/8/19 and the resident received Ativan gel 0.5 mg (milligrams). The behavioral symptom code read that the resident had 5 episodes of yelling out, crying out, and delusions (no documentation of what the delusions were). Intervention codes read that 1 -1 visits, a snack was given, and resident was in bed yet Resident #20 received Ativan as an intervention.

The physician note dated 1/14/19 read "After adjustments with her medications, symptoms appear to have improved. Her level of agitation is under better control."

The surveyor interviewed both minimum data set (MDS) assessment registered nurses on 2/7/19 at 11:33 a.m. Both reviewed the current care plan and when the surveyor asked what behaviors the Citalopram and Ativan were targeting, the MDS staff agreed there were no targeted behaviors identified.

The surveyor informed the administrative staff of the lack of monitoring for the use of Escitalopram, Remeron, and Ativan to treat Resident #20's depression and anxiety on 2/7/19 at 3:52 p.m.

The surveyor reviewed the facility policy titled

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"Psychotropic Drug Use" on 2/7/19. The policy read in part "2. Residents who receive psychotropic medications are required to receive gradual dose reductions and behavioral interventions, unless contraindicated, in an effort to discontinue use of the psychotropic medications.

No further information was provided prior to the exit conference on 2/7/19.

7. The facility staff failed to ensure Resident #44 was free of unnecessary medications. Resident #44 was administered Valium, Escitalopram, and Quetiapine (Seroquel) without monitoring the use of the psychotropic medications effects/side effects and identified targeted behaviors.

The clinical record of Resident #44 was reviewed 2/5/19 through 2/7/19. Resident #44 was admitted to the facility 1/18/18 with diagnoses that included but not limited to diabetes mellitus, urinary tract infection, constipation, abnormal weight loss, cerebrovascular accident (CVA), coronary artery disease (CAD), atrial fibrillation, hypertension, gastro esophageal reflux disease, and chronic obstructive pulmonary disease.

Resident #44's annual minimum data set (MDS) assessment with an assessment reference date (ARD) of 1/24/19 assessed the resident with a BIMS (brief interview for mental status) as 13/15. Resident #44 was without signs or symptoms of delirium, behaviors affecting others or psychosis.

Resident #44's February 2019 physician orders included orders for Valium 2 mg (milligrams) 1 tablet by mouth one time a day for vertigo start date 12/3/2018, Escitalopram 5 mg 1 tablet by

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mouth one time a day at bedtime for depression start date 1/7/2019 and Quetiapine (Seroquel) 25 mg (1/2 tablet) by mouth one time a day at bedtime for agitation d/t (due to psychosis) start date 4/13/2018.

The surveyor reviewed the current comprehensive care plan for Resident #44 on 2/6/19. The person centered care plan identified a problem area for psychotropic drug use with long term goals of maintaining a stable mood and approaches to use "give me my medication as ordered, monitor me for side effects from my medication, and monitor me for changes in mood and/or behavior. A second care plan identified an issue with mood long term goal was to be comfortable and satisfied and approaches included watch me to make sure my mood does not get any worse, have my family to visit as much as possible, especially my daughter and great granddaughter, and I enjoy playing Bingo and going to wine/cheese social. Please continue to remind me as needed about these events and encourage me to go.

The current comprehensive care plan for Resident #44 did not have person centered targeted behaviors, measurable goals or individualized approaches to care.

The undated behavior/intervention monitoring sheets had the following behavioral symptoms circled-crying out and yelling out. Resident #44 had documentation on 5/26/18, 9/28/18, and 11/3/18 of behaviors. On 5/26/18, yelling occurred x1. Intervention included 1-1 and activity, which improved outcome. On 7/28/18, yelling and screaming (screaming not circled as a behavioral symptom) occurred x1 but did not

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improve with 1-1 and speak with family; however, no more interventions were attempted. On 11/3/18, yelling and screaming occurred x2 and 1-1 intervention was tried with positive outcome. The clinical record had no documentation of what the incident was on 11/3/18.

The clinical record revealed when Resident #44 was admitted to the facility 1/18/18, the resident was not administered any psychotropic medications. The February 2018 medication regimen review also indicated no high-risk medications prescribed to include psychotropic medication.

Resident #44 was seen by the neurologist on 2/12/18 and prescribed Prozac 10 mg (milligrams) every day and Aricept 5mg every day for pseudo dementia with vascular cognitive impairment.

The March 2018 medication regimen review indicated the resident had been prescribed Seroquel, Lexapro, and Aricept; however, the resident refused to take and the medications were discontinued. Seroquel was restarted in April 2018. A GDR was requested in August 2018 but the physician declined the GDR.

Resident #44 was seen by the geriatric psychiatrist 11/19/18 and the consult read "Patient's present tx (treatment) and nursing report reviewed. Continues to c/o (complain of) being dizzy. Very withdrawn. Keeps room dark. Makes frequent and negative remarks. No psychotic thoughts today (on Seroquel)."

The MDS progress notes by the social worker were reviewed. The 10/23/18 quarterly

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F 758	Continued From page 43 assessment read in part "Resident #44 participated in the BIMS and mood assessment interviews on 10/22/18. She scored a 15/15 on the BIMS. No signs or symptoms of delirium present. Per the mood assessment she reported little interest in doing things and feeling down. Resident #44 is prescribed an antipsychotic for psychosis. She has rejected care by not allowing skin assessments to be completed. The surveyor interviewed both minimum data set (MDS) assessment registered nurses on 2/7/19 at 11:33 a.m. Both reviewed the current care plan and when the surveyor asked what behaviors the Escitalopram, Diazepam, and Seroquel were targeting, the MDS staff agreed there were no targeted behaviors identified. The surveyor informed the administrative staff of the absence of targeted behaviors, goals and desired outcomes for and the monitoring of effects/side effects with the use of Escitalopram, Diazepam, and Seroquel to treat Resident #44 on 2/7/19 at 3:52 p.m. The surveyor reviewed the facility policy titled "Psychotropic Drug Use" on 2/7/19. The policy read in part "2. Residents who receive psychotropic medications are required to receive gradual dose reductions and behavioral interventions, unless contraindicated, in an effort to discontinue use of the psychotropic medications. No further information was provided prior to the exit conference on 2/7/19.	F 758		
F 777 SS=D	Radiology/Diag Srvcs Ordered/Notify Results CFR(s): 483.50(b)(2)(i)(ii)	F 777		3/15/19

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F 777	Continued From page 44 §483.50(b)(2) The facility must- (i) Provide or obtain radiology and other diagnostic services only when ordered by a physician; physician assistant; nurse practitioner or clinical nurse specialist in accordance with State law, including scope of practice laws. (ii) Promptly notify the ordering physician, physician assistant, nurse practitioner, or clinical nurse specialist of results that fall outside of clinical reference ranges in accordance with facility policies and procedures for notification of a practitioner or per the ordering physician's orders. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to obtain the physician ordered x-ray for 1 of sixteen residents (Resident #20). The findings included: The facility staff failed to obtain a chest x-ray with 2 views as ordered by the physician for Resident #20 and failed to inform the physician that a single view was obtained instead of the 2 view as ordered. The clinical record of Resident #20 was reviewed 2/5/19 through 2/7/19. Resident #20 was admitted to the facility 10/15/18 with diagnoses that included but not limited to adult failure to thrive, chronic depression, disruptive behavior, agitation, atrial fibrillation, fractured right femur neck, vascular dementia with behavioral disturbances, hypertension, and chronic diastolic heart failure. Resident #20's significant change in assessment	F 777	1. Documentation for this infraction cannot be corrected for this resident #20 as it occurred in the past. The Radiology company has been notified of this discrepancy. 2. Facility nursing staff will verify results received in relation to diagnostic orders written. 3. After each Radiology test is performed, the technician will be required to communicate with nursing about specific test performed and sign accordingly attesting the correct test has been completed. 4. Audits will be conducted monthly by the Quality Assessment and Assurance department on 10% of resident population. 5. Compliance will be monitored by DON for a period of six months and then re-evaluate as needed.	

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minimum data set (MDS) with an assessment reference date (ARD) of 12/3/18 assessed the resident with a brief interview for mental status (BIMS) as 9/15. Resident #20 had no behavioral signs or symptoms, no signs or symptoms of delirium, or psychosis.

A telephone order dated 10/26/18 read "C (chest) x-ray 2 view for gen (generalized) weakness. I am not feeling well per resident (diminished lung sounds, low level 90-91 % sats (oxygen saturation)."

The surveyor reviewed the results of the chest x-ray obtained 10/26/18. The results read "Chest X-ray 1V (view): Chest AP (anterior/posterior): AP chest reveal cardiac silhouette is normal in size. Bibasilar infiltrates with small bilateral effusions present. IMPRESSION: Interval development of bibasilar infiltrates and small pleural effusion since 2-09-2018."

The surveyor informed the administrative staff of the above finding on 2/6/19 at 4:05 p.m.

The director of nursing (DON) provided the surveyor with documentation from the x-ray company on 2/7/19 at 8:00 a.m. The DON stated the x-ray technician (tech) was unable to do a 2 view of the chest due to unresponsiveness. The note read, "Hi DON, Our tech was unable to perform the lateral view ordered for Resident #20 on Oct 26, 2018. What follows is the internal note our tech made regarding this patient: Patient unresponsive, held for view."

The surveyor reviewed the interdisciplinary progress notes for 10/26/18 were reviewed. The note timed 0840 read "N.O. (new order) C x-ray

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F 777	Continued From page 46 written. MD (medical doctor) and responsible party aware. 10:15 Late entry for 0700. BP (blood pressure) 148/90, T (temperature) 97.8, R (respirations) 22, P (pulse) 69, O2 (oxygen) sats (saturations) 90. Resident appears lethargic but easily awakens. Able to answer with a yes and no. Then goes back to sleep again. Breathing even and unlabored. Lung sounds diminished throughout all fields. Resident stated, "I am not feeling well." No SOB (shortness of breath) /distress noted. For breakfast, resident was moderate assist. C.N.A. (certified nursing assistant) and resident takes turn to put the fork with food in her mouth. No coughing noted on every bite at this time." The director of nursing was asked if the physician should be informed of the inability to obtain the 2-view chest x-ray since the order was current. The DON stated "Yes." No further information was provided prior to the exit conference on 2/7/19.	F 777		
F 842 SS=E	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	F 842		3/28/19

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professional standards and practices, the facility must maintain medical records on each resident that are-
(i) Complete;
(ii) Accurately documented;
(iii) Readily accessible; and
(iv) Systematically organized

§483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is-
(i) To the individual, or their resident representative where permitted by applicable law;
(ii) Required by Law;
(iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;
(iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, 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.

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F 842	Continued From page 48 §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: The facility staff failed to maintain a complete and accurate clinical record for 7 of 16 residents in the survey sample (Residents #35, 31, 49, 15, 12, 20, and 44). The findings included: 1. For Resident #35, facility staff failed to ensure that psychotropic and antipsychotic medications were ordered only to address specific symptoms for which the resident was treated with antianxiety, antidepressant, and antipsychotic medications. Resident #35 was admitted to the facility on 10/17/16 with diagnoses including hypertension, dementia, and anxiety disorder. On the admission minimum data set assessment the resident scored 15/15 on the brief interview for mental status and was assessed as without symptoms of delirium, psychosis, or behavior symptoms. On the most recent quarterly minimum data set assessment with assessment reference date 1/8/19, the resident scored 15/15	F 842	1. Resident #35 has been placed on a gradual dose reduction for Trazadone and a target behavioral symptoms tracking form has been initiated. The resident care plan has been updated to reflect individualized needs and approaches. Resident #31 now has a target behavioral symptoms tracking form implemented. Resident #49 cannot be changed as it happened in the past and resident has been discharged from the facility. Resident #15, 12, and 44 now have a target behavioral symptoms tracking form to document any resident behaviors and the care plans have been updated to reflect individualized needs and approaches. Resident #20 has the following medications discontinued Escitalopram 10mg and Mirtazapine 7.5 mg. A target behavioral symptoms tracking form has been implemented, and residents care plans has been updated to reflect individualized needs and approaches.	

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F 842	Continued From page 49 on the brief interview for mental status and was assessed as without symptoms of delirium, psychosis, or behaviors affecting care. The resident scored 6/27 on the resident mood interview. During an interview on 2/5/19, the resident reported the only concern with care was not getting enough of the food, which was bad. Clinical record review on 2/7/19 revealed the resident was readmitted 10/17/18. Medication orders included Buspar 5 mg three times per day for anxiety and seroquel 25 mg twice per day since admission and ativan as needed. The physician declined GDRs on both medications due to history of symptom instability. The surveyor was unable to locate documentation of symptoms being treated by the seroquel. There were no behavior or symptom tracking orders or nurse's notes referencing symptoms that might be considered signs of psychosis. The resident's nurse was unable to describe the symptoms for which the resident was taking antipsychotic medications. The surveyor spoke with the director of nursing (DON) about the issue. The DON was able to locate 2 Behavior Monitoring Sheets. One was blank except for documenting trazodone and lorazepam as medications the resident was receiving. No targeted symptoms were indicated. The second sheet indicated monitoring for 14-yelling and 16-c/o anxiety. The form indicated the resident c/o anxiety on 11/15/18 and received a 1-on-1 visit, rest in bed, and ativan and that the interventions were effective. No staff member was able to report the symptoms for which the antipsychotic medication seroquel was ordered.	F 842	2. All residents have received a target behavioral symptoms tracking form. A medication management review team has been created to review all resident medications monthly for effectiveness of current resident dose regimen. 3. Monthly resident record audits of 10% average census by the Quality Assurance and Assessment department will be completed on residents receiving psychotropic medications to identify any resident requiring a Gradual Dose Reduction (GDR). Staff education will provide in-services on the documentation of behaviors and the use of non-pharmacologic interventions during competency training and as needed. 4. Compliance to be monitored by Medication Management Review Team for six months and re-evaluate as needed.	

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The Comprehensive Care plan for 1/24/16 through 10/19/17 did not document psychosis, psychotic disorder, or use of antipsychotic medication or symptoms of psychosis or delusion. The care plan initiated 10/19/17 documented "I also have a history of psychosis for which I also take medication".
The surveyor has been unable to locate any expression of symptoms for which the resident was taking an antipsychotic medication other than the physician's statement "increased risk of psychiatric instability". There were no target symptoms or symptom abatement strategies in the care plan.

Physician progress note on 9/26/18 listed under history "continues to have intermittent paranoia and anxiety". No symptoms of paranoia were documented in the resident's nursing notes or behavior monitoring sheets. Only one instance of reported anxiety was listed in the resident's nursing notes or behavior monitoring sheet.

The administrator and director of nursing were notified of the concern that symptoms were not documented in the clinical record and routinely monitored to ensure effectiveness of the medication in treating those symptoms.
2. The facility staff failed to have a complete and accurate clinical record in regards to having no monitoring of behaviors while Resident #31 was receiving psychotropic medications.

Resident was readmitted to the facility on 2/29/12 with the following diagnoses, but not limited to anemia, high blood pressure, Dementia, Parkinson's disease, depression and psychotic disorder. On the significant change MDS (Minimum Data Set) with an ARD (Assessment

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Reference Date) of 2/29/12, the resident was coded as having a BIMS (Brief Interview for Mental Status) score of 15 out of a possible 15. Resident #31 was also coded as requiring extensive assistance of 1 staff member for dressing and personal hygiene and being totally dependent on 1 staff member for bathing.

During the clinical record review on 2/6/19, the surveyor noted that Resident #31 was receiving the following physician ordered medications:
" Risperidone 0.25 mg (milligram) 1 tablet by mouth two times a day for psychosis.
" Zoloft 75 mg by mouth one time a day for depression.

The surveyor performed a clinical record review on Resident #31 on 2/6 and 2/7/19. During this review, the surveyor noted that the resident was being given Zoloft daily for depression and Risperidone twice a day for psychosis. The surveyor reviewed the nurses' notes and MAR (Medication Administration Record) for the months of January and February 2019. There was no documentation of behaviors while receiving these medications.

The surveyor notified the administrative team of the above documented findings on 2/6/19 at 4:05 pm in the conference room. The surveyor requested and received the facility's policy on behavioral monitoring. The policy titled "Behaviors Identification and Interventions" read in part ..."Residents with problematic behavioral symptoms will be promptly assessed and monitored by professional staff. Causative factors influencing behavioral will be identified. Management and appropriate behavioral interventions will be care planned, implemented

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and re-evaluated as changes occur ..."
No further information was provided to the surveyor prior to the exit conference on 2/7/19

3. The facility staff failed to a complete and accurate clinical record in regards to having no monitoring of behaviors while Resident #49 was receiving psychotropic medications.

Resident #49 was admitted to the facility on 12/31/18 with the following diagnoses of, but not limited to atrial fibrillation, high blood pressure, stroke, dementia and anxiety. On the admission, MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 1/7/19 coded the resident as having a BIMS (Brief Interview for Mental Status) score of 5 out of a possible score of 15. Resident #49 was also coded as requiring extensive assistance of 1 staff member for dressing and limited assistance from 1 staff member for personal hygiene. The resident was also coded as being totally dependent on 1 staff member for bathing.
On 2/6/19, the surveyor noted the following physician's order that included:
" Xanax 0.5 mg (milligram) 1 tablet by mouth two times a day for anxiety
" Seroquel 25 mg po (by mouth) at bedtime.

The surveyor reviewed the clinical record for Resident #49 on 2/5/19 and 2/6/19.The surveyor also reviewed the comprehensive care plan for Resident #49. For Psychotropic drug use, the surveyor noted the following interventions:
" ..."Give me my medication as ordered.
" Monitor me for side effects from my medication.
" Monitor me for changes in mood and/or behavior ..."

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The surveyor notified the administrative team on 2/6/19 at 4:05 pm of the above documented findings. The surveyor requested and received the facility's policy on behavioral monitoring. The policy titled "Behaviors Identification and Interventions" read in part ..."Residents with problematic behavioral symptoms will be promptly assessed and monitored by professional staff. Causative factors influencing behavioral will be identified. Management and appropriate behavioral interventions will be care planned, implemented and re-evaluated as changes occur ..."

No further information was provided to the surveyor prior to the exit conference on 2/7/19.
4. The facility staff failed to document the symptoms for which Resident #15 was administered Remeron and Celexa. There was no ongoing behavior monitoring of a resident on two antidepressants.

The clinical record of Resident #15 was reviewed 2/5/19 through 2/7/19. Resident #15 was admitted to the facility 9/13/17 with diagnoses that included but not limited to nausea with vomiting, generalized muscle weakness, gastroesophageal reflux disease with esophagitis, hypokalemia, iron deficient anemia, history of kidney stones, left hip surgery, chronic depression, and bilateral lower quadrant pain.

Resident #15'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 15/15. There were no assessed signs of delirium, psychosis, or behaviors that affected

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others.

Resident #15's February 2019 physician orders were reviewed. Resident #15 had orders and received Remeron 7.5 mg (milligrams) tablet one time a day at bedtime for decreased appetite/weight loss (start date 4/14/18) and Citalopram 20 mg tablet by mouth one time a day for depression (start date 4/14/18).

Resident #15 had received both Remeron and Celexa since 4/14/18.

The surveyor reviewed the current comprehensive care plan on 2/6/19. One "Concern and Strength dated 9/10/18" read, "I have a history of depression. I take medicine for this." My preference for care read "1. Give my med (medication) as ordered. 2. Monitor me for s/e (side effects) from my medicine. 3. Monitor me for changes in mood and or behavior. 4. I look forward to visits from my daughter." A second "Concern and Strength dated 9/5/2018" read "1. Watch me to make sure my depression does not get any worse. 2. Administer my medications as ordered. 3. I would like my family to visit as much as possible."

The current person centered care comprehensive care plan did not identify targeted behaviors, outcomes and goals for Citalopram (Celexa) or Remeron.

The surveyor interviewed both minimum data set (MDS) assessment registered nurses on 2/7/19 at 11:33 a.m. Both reviewed the current care plan and when the surveyor asked what behaviors the Citalopram and Remeron were targeting, the MDS staff agreed there were no

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targeted behaviors identified.

The surveyor reviewed the undated behavior/intervention monitoring tool for Resident #15. On the tool, crying out and c/o (complaints of) depression were circled under the behavioral symptoms codes. However, there was no evidence of crying out or depression documented on the tool. The surveyor reviewed the January and February 2019 interdisciplinary progress notes and found no documented behaviors.

The surveyor interviewed Resident #15 on 2/5/19 at 2:56 p.m. When asked about mood, the resident stated, "I am always happy."

The surveyor informed the administrative staff of the lack of documentation of the behavior monitoring and the effects/side effects with the use of Citalopram and Remeron to treat Resident #15 on 2/7/19 at 3:52 p.m. The director of nursing stated the facility only documented behavior by exception. The surveyor requested the facility policy on behavior documentation.

The facility policy titled "Behavior Identification and Intervention" was reviewed 2/7/19. The policy read in part "Assessment of identified behaviors will be documented in (but not limited to) nursing notes, behavior tracking forms and social service progress notes to help clarify the underlying cause of the behavior and help develop effective management interventions."

No further information was provided prior to the exit conference on 2/7/19.

5. The facility staff failed to document the symptoms for which the Citalopram and Ativan

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were used to treat Resident #12's behaviors. There was no ongoing behavior monitoring of a resident administered an antidepressant and antianxiety.

The clinical record of Resident #12 was reviewed 2/5/19 through 2/7/19. Resident #12 was admitted to the facility 10/1/16 and readmitted 1/18/18 with diagnoses that included but not limited to urinary tract infection, diabetes, dehydration, weakness, constipation, abnormal weight loss, atrial fibrillation, rheumatoid arthritis, depression, chronic pain syndrome, adult failure to thrive, and osteoporosis.

Resident #12's quarterly minimum data set (MDS) with an assessment reference date (ARD) of 11/9/18 assessed the resident with a BIMS (brief interview for mental status) as 11/15. The resident had no signs or symptoms of delirium, psychosis or behaviors that affected others.

Resident #12's February 2019 physician orders included Citalopram 10 mg (milligrams) 1 tablet by mouth one time a day in the morning for depression (start date 11/8/18) and Lorazepam 0.5 mg 1 tablet by mouth one time a day at bedtime for anxiety (start date 10/8/18).

Resident #12 received both Citalopram and Lorazepam since November 2018.

Resident #12's current comprehensive care plan dated 8/14/18 had the following "My Concerns and my strengths" for 8/14/18. "I have a history of anxiety and depression. I take medicine for this. My preference for care 1. Give me my medication as ordered. 2. Monitor me for s/e (side effects) from my medications 3. Monitor me

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for changes in mood and /or behaviors." A second "I Care Plan" dated 8/9/18 read "I have a diagnosis of depression and anxiety. Occasionally I have trouble concentrating. 1. Observe me to make sure my mood remains stable and my daily needs are met. 2. I want my family to visit as much as possible. 3. I want to socialize with others and participate in the activities of my choice. 4. Administer my medications as ordered."

The current comprehensive care plan did not identify person centered targeted behaviors, goals, and outcomes for the use of Lorazepam (Ativan) and Citalopram.

The undated behavior/intervention monitoring tools were circled for crying out and c/o (complains of) anxiety as behavior symptoms codes. The behavior/intervention monitoring sheet did not have any documentation of Resident #12 having crying out or c/o anxiety. There was no documentation to support the use of both Lorazepam and Citalopram (Celexa). The surveyor reviewed the quarterly MDS progress notes. The social services quarterly note dated 11/12/18 read "Resident #12 participated in the BIMS mood assessment interview on 11/7/2018. Resident #12 scored an 11/15 on the BIMS; she could not recall two words. No signs or symptoms of delirium present. Per the mood assessment, Resident #12 reported feeling tired. Resident #12 is prescribed an antidepressant and anti-anxiety medication with no adverse effects noted. No behaviors noted."

The surveyor reviewed the interdisciplinary progress notes from December 2018 through 2/6/19 and found no evidence to support the use

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of Celexa and Ativan. Documentation identified included that 24-hour chart checks were done and weekly skin assessments were completed.

The surveyor interviewed both minimum data set (MDS) assessment registered nurses on 2/7/19 at 11:33 a.m. Both reviewed the current care plan and when the surveyor asked what behaviors the Citalopram and Ativan were targeting, the MDS staff agreed there were no targeted behaviors identified.

The surveyor informed the administrative staff of the lack of monitoring/documentation for the use of Citalopram and Ativan to treat Resident #12's depression and anxiety on 2/7/19 at 3:52 p.m. The director of nursing stated the facility documents behaviors by exception.

The facility policy titled "Behavior Identification and Intervention" was reviewed 2/7/19. The policy read in part "Assessment of identified behaviors will be documented in (but not limited to) nursing notes, behavior tracking forms and social service progress notes to help clarify the underlying cause of the behavior and help develop effective management interventions."

No further information was provided prior to the exit conference on 2/7/19.

6. The facility staff failed to document the symptoms for which Resident #20 was administered Escitalopram, Remeron, and Lorazepam. There was no ongoing behavior monitoring and documentation of behaviors for a resident receiving two antidepressants and an antianxiety medication.

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The clinical record of Resident #20 was reviewed 2/5/19 through 2/7/19. Resident #20 was admitted to the facility 10/15/18 with diagnoses that included but not limited to adult failure to thrive, chronic depression, disruptive behavior, agitation, atrial fibrillation, fractured right femur neck, vascular dementia with behavioral disturbances, hypertension, and chronic diastolic heart failure.

Resident #20's significant change in assessment minimum data set (MDS) with an assessment reference date (ARD) of 12/3/18 assessed the resident with a brief interview for mental status (BIMS) as 9/15. Resident #20 had no behavioral signs or symptoms, no signs or symptoms of delirium, or psychosis.

Resident #20's February physician orders 2019 included "Escitalopram 10 mg 1 tablet by mouth one time a day for depression (start date 12/11/18), Mirtazapine 7.5 mg 1 tablet by mouth one time a day at bedtime for poor appetite and Lorazepam gel 1 mg (milligram)/ml (milliliter) Apply topically every 6 hours as needed for psychosis/agitation/anxiety (start date 12/20/18)."

The surveyor reviewed Resident #20's current comprehensive care plan dated 12/3/18. Problem areas included one for mood state with long-term goal to have a peaceful sleep and approaches to use were to turn on my white noise machine at night and assure me that my roommate shares the room with me and that I am safe. Also identified as a problem area for mood state that the resident had symptoms of depression, a diagnosis of anxiety which is managed by daily medication. Approaches included watch me to make sure my depression

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does not get any worse, refer me to see the doctor to assess my mood, want my family to visit as much as possible, administer my medications as ordered, and provide me with emotional support as needed.

Resident #20 also had an area dated 12/5/18 for psychotropic drug use with long-term goal to show a stable mood and socialize with others. Approaches included give me my medication as ordered, monitor me for side effects from my medication, and monitor me for changes in mood and/or behavior.

The current comprehensive care plan did not identify specific targeted behaviors for the medications, long-term measurable goals or individualized approaches to care.

The surveyor reviewed the undated behavior/intervention monitoring sheet for Ativan, Lexapro and Remeron. The behavioral symptoms coded were crying out and yelling out. The most recent episode of behavior occurred 1/8/19 and the resident received Ativan gel 0.5 mg (milligrams). The behavioral symptom code read that the resident had 5 episodes of yelling out, crying out, and delusions (no documentation of what the delusions were). Intervention codes read that 1 -1 visits, a snack was given, and resident was in bed yet Resident #20 received Ativan as an intervention.

The surveyor interviewed both minimum data set (MDS) assessment registered nurses on 2/7/19 at 11:33 a.m. Both reviewed the current care plan and when the surveyor asked what behaviors the Citalopram and Ativan were targeting, the MDS staff agreed there were no

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targeted behaviors identified.

The surveyor informed the administrative staff of the lack of documentation of the behavior monitoring and the effects/side effects with the use of Escitalopram, Ativan and Remeron to treat Resident #20 on 2/7/19 at 3:52 p.m. The director of nursing stated the facility only documented behavior by exception. The surveyor requested the facility policy on behavior documentation.

The facility policy titled "Behavior Identification and Intervention" was reviewed 2/7/19. The policy read in part "Assessment of identified behaviors will be documented in (but not limited to) nursing notes, behavior tracking forms and social service progress notes to help clarify the underlying cause of the behavior and help develop effective management interventions."

No further information was provided prior to the exit conference on 2/7/19.

7. The facility staff failed to document the symptoms for which Resident #44 was administered Valium, Escitalopram, and Quetiapine (Seroquel). There was no ongoing behavior monitoring of a resident on an antidepressant, an antipsychotic and an antianxiety medication.

The clinical record of Resident #44 was reviewed 2/5/19 through 2/7/19. Resident #44 was admitted to the facility 1/18/18 with diagnoses that included but not limited to diabetes mellitus, urinary tract infection, constipation, abnormal weight loss, cerebrovascular accident (CVA), coronary artery disease (CAD), atrial fibrillation, hypertension, gastro esophageal reflux disease,

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and chronic obstructive pulmonary disease.

Resident #44's annual minimum data set (MDS) assessment with an assessment reference date (ARD) of 1/24/19 assessed the resident with a BIMS (brief interview for mental status) as 13/15. Resident #44 was without signs or symptoms of delirium, behaviors affecting others or psychosis.

Resident #44's February 2019 physician orders included orders for Valium 2 mg (milligrams) 1 tablet by mouth one time a day for vertigo start date 12/3/2018, Escitalopram 5 mg 1 tablet by mouth one time a day at bedtime for depression start date 1/7/2019 and Quetiapine (Seroquel) 25 mg (1/2 tablet) by mouth one time a day at bedtime for agitation d/t (due to psychosis) start date 4/13/2018.

The surveyor reviewed the current comprehensive care plan for Resident #44 on 2/6/19. The person centered care plan identified a problem area for psychotropic drug use with long term goals of maintaining a stable mood and approaches to use "give me my medication as ordered, monitor me for side effects from my medication, and monitor me for changes in mood and/or behavior. A second care plan identified an issue with mood long term goal was to be comfortable and satisfied and approaches included watch me to make sure my mood does not get any worse, have my family to visit as much as possible, especially my daughter and great granddaughter, and I enjoy playing Bingo and going to wine/cheese social. Please continue to remind me as needed about these events and encourage me to go.

The current comprehensive care plan for

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Resident #44 did not have person centered targeted behaviors, measurable goals or individualized approaches to care.

The undated behavior/intervention monitoring sheets had the following behavioral symptoms circled-crying out and yelling out. Resident #44 had documentation on 5/26/18, 9/28/18, and 11/3/18 of behaviors. On 5/26/18, yelling occurred x1. Intervention included 1-1 and activity, which improved outcome. On 7/28/18, yelling and screaming (screaming not circled as a behavioral symptom) occurred x1 but did not improve with 1-1 and speak with family; however, no more interventions were attempted. On 11/3/18, yelling and screaming occurred x2 and 1-1 intervention was tried with positive outcome. The clinical record had no documentation of what the incident was on 11/3/18.

The surveyor interviewed both minimum data set (MDS) assessment registered nurses on 2/7/19 at 11:33 a.m. Both reviewed the current care plan and when the surveyor asked what behaviors the Escitalopram, Diazepam, and Seroquel were targeting, the MDS staff agreed there were no targeted behaviors identified.

The surveyor informed the administrative staff of the lack of ongoing behavior monitoring documentation and no documentation of effects/side effects with the use of Escitalopram, Diazepam, and Seroquel to treat Resident #44 on 2/7/19 at 3:52 p.m.

The facility policy titled "Behavior Identification and Intervention" was reviewed 2/7/19. The policy read in part "Assessment of identified behaviors will be documented in (but not limited

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495406	A. BUILDING _____ B. WING _____	02/07/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE WYBE AND MARIETJE KROONTJE HEALTH CARE CENTER	1000 LITTON LANE BLACKSBURG, VA 24060

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 842	Continued From page 64 to) nursing notes, behavior tracking forms and social service progress notes to help clarify the underlying cause of the behavior and help develop effective management interventions." No further information was provided prior to the exit conference on 2/7/19.	F 842		
F 867 SS=F	QAPI/QAA Improvement Activities CFR(s): 483.75(g)(2)(ii) §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; This REQUIREMENT is not met as evidenced by: Based on observation, staff interview , resident interview, clinical record review, facility document review, and review of the prior survey report, facility staff failed to develop and implement appropriate plans of action to correct identified quality deficiencies in the area of comprehensive care planning and unnecessary medication (monitoring use of psychotropic medication medications). The facility's QA (Quality Assurance) plan failed to correct two deficiencies cited during the annual certification survey conducted 10/24/2017 through 10/26/17. The problem cited still existed for the resident cited in the prior survey and extends to all psychotropic medications and for 6 additional residents in the sample. Surveyors found general lack of documentation of symptoms and behaviors either in the nursing notes or in behavior monitoring sheets.	F 867	1. Resident #35 has been reviewed by the Physician and a gradual dose reduction has been initiated for Trazadone, and other medications will be adjusted as needed. 2. All residents have received a target behavioral symptoms tracking form. A medication management review team has been created to review all resident medications monthly for effectiveness of current resident dose regimen. 3. Based on information received during medication management review, recommendations will be submitted to Medical Director/Nurse Practitioner for consideration and/or implementation. 4. All findings and/or recommendations will be submitted to Quality Assessment and Assurance department for compliance this will be an ongoing	3/28/19

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F 867	Continued From page 65 During the course of the survey, surveyors identified a pattern with a potential for harm level deficient practice in the area of comprehensive care planning related to the use of psychotropic medications and a pattern with a potential for harm level deficient practice in the area of monitoring target behaviors in the use of psychotropic medications. Review of the survey report from the prior survey revealed that the facility had been cited for deficient practice in care planning at a level E (pattern of deficient practice with potential for harm). One of the residents affected by the original deficient practice is in the sample (Resident #35; Resident #6 in the original survey) and continues to be affected by the deficient practice. Review of the survey report from the prior survey revealed that the facility had been cited for deficient practice in monitoring target behaviors in the use of psychotropic medications at a level D (isolated incidents of deficient practice with potential for harm). The resident affected by the original deficient practice is in the sample (Resident #35; Resident #6 in the original survey) and continues to be affected by the deficient practice. Surveyors found this deficient practice affected 6 additional residents in the current survey sample, increasing scope to a pattern. Review of the prior plan of correction revealed the facility had stated that the deficient practices in care planning and monitoring targeted behaviors could not be corrected for the resident (Resident #6 in the original survey) and that no plan would be put in place to ensure that residents receiving psychotropic medications would have care plans for their use or that targeted behavior monitoring would be performed by nursing staff.	F 867	practice for this facility. 5. Compliance to be monitored by audits submitted beginning April 2019 to the QAA department.	

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F 867	Continued From page 66 The administrator and director of nursing were notified during a summary meeting on 2/7/19 of the failure of the Quality Assurance program to correct identified deficient practices.	F 867		