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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495320	A. BUILDING _____ B. WING _____	R 08/21/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HALL CLINTWOOD	1225 CLINTWOOD MAIN STREET, ROUTE 607 PO BOX 909 CLINTWOOD, VA 24228

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{E 000}	Initial Comments	{E 000}		
{F 000}	INITIAL COMMENTS An unannounced Medicare/Medicaid revisit to the standard survey conducted 06/18/19 through 06/20/19, was conducted 08/20/19 through 08/21/19. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care Requirements. Uncorrected deficiencies are identified within this report. Corrected deficiencies are identified on the CMS 2567-B. The census in this 100 certified bed facility was 89 at the time of the survey. The survey sample consisted of 13 current Resident reviews (Residents 101 through 113).	{F 000}	RECEIVED SEP 09 2019 VDH/OLC	
{F 645} SS=D	PASARR Screening for MD & ID CFR(s): 483.20(k)(1)-(3) §483.20(k) Preadmission Screening for individuals with a mental disorder and individuals with intellectual disability. §483.20(k)(1) A nursing facility must not admit, on or after January 1, 1989, any new residents with: (i) Mental disorder as defined in paragraph (k)(3)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission, (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of	{F 645}	**F645** **Corrective Action(s)** Resident #108's attending physician and responsible party have been notified that the facility failed to obtain a level I PASRR for the resident prior to their admission. A facility Incident & Accident form has been completed for this incident. Resident #113's attending physician and responsible party have been notified that the facility failed to obtain a level I PASRR for the resident prior to their admission. A facility Incident & Accident form has been completed for this incident.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Glenna Kennedy | TITLE: LNHA | (X6) DATE: 9-5-2019

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

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{F 645}	Continued From page 1 services, whether the individual requires specialized services; or (ii) Intellectual disability, as defined in paragraph (k)(3)(ii) of this section, unless the State intellectual disability or developmental disability authority has determined prior to admission- (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services for intellectual disability. §483.20(k)(2) Exceptions. For purposes of this section- (i)The preadmission screening program under paragraph(k)(1) of this section need not provide for determinations in the case of the readmission to a nursing facility of an individual who, after being admitted to the nursing facility, was transferred for care in a hospital. (ii) The State may choose not to apply the preadmission screening program under paragraph (k)(1) of this section to the admission to a nursing facility of an individual- (A) Who is admitted to the facility directly from a hospital after receiving acute inpatient care at the hospital, (B) Who requires nursing facility services for the condition for which the individual received care in the hospital, and (C) Whose attending physician has certified, before admission to the facility that the individual is likely to require less than 30 days of nursing facility services. §483.20(k)(3) Definition. For purposes of this	{F 645}	**Identification of Deficient Practices & Corrective Action(s):** All other residents who were required to have a PASRR prior to admission may have been affected. The social services director/designee will complete a 100% review of all residents to identify residents without a level 1 PASARR. Physicians and RP's of resident's found to be at risk will be notified at the time of discovery. A facility Incident & Accident form has been completed for each incident. **Systemic Change(s):** The facility policy and procedure has been reviewed and no changes are warranted at this time. The admission director, social worker, DON, and administrator have been inserviced by the regional nurse consultant on the requirement that residents with a mental disorder have a PASRR be completed prior to admission **Monitoring:** The social worker/designee will be responsible for maintaining compliance. Potential new residents will be reviewed prior to their admission to ensure that a PASRR has been completed if indicated. Negative findings will be corrected at the time of discovery. Aggregate findings will be reported to the QA Committee for review, analysis and recommendation for changes in facility policy, procedure and/or practice. **Completion Date: 9/13/19**	

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{F 645}	Continued From page 2	{F 645}		

section-
(i) An individual is considered to have a mental disorder if the individual has a serious mental disorder defined in 483.102(b)(1).
(ii) An individual is considered to have an intellectual disability if the individual has an intellectual disability as defined in §483.102(b)(3) or is a person with a related condition as described in 435.1010 of this chapter.
This REQUIREMENT is not met as evidenced by
Based on staff interview, facility document review, and clinical record review, the facility staff failed to perform a level I PASARR (preadmission screening and resident review) for 2 of 13 Residents, Residents #113 and #108.

The findings included:

1. For Resident #113, the facility staff failed to complete a level I PASARR.

A PASARR is a federal requirement to help ensure that individuals are not inappropriately placed in nursing homes for long-term care.

The Residents face sheet revealed that Resident #113 had been admitted to the facility 12/05/12 and was readmitted on 07/11/19. This face sheet included the following diagnoses depressive disorder, anxiety disorder, essential hypertension, muscle weakness, and pain.

Section C (cognitive patterns) of the Residents quarterly MDS (minimum data set) assessment with an ARD (assessment reference date) of 07/29/19 included a BIMS (brief interview for mental status) summary score of 15 out of a possible 15 points.

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{F 645}	Continued From page 3	{F 645}		

On 08/2/1/19 at 1:10 p.m., during a review of the POC (plan of correction) with the DON (director of nursing), the DON shared with the surveyor the facilities credible evidence regarding this citation. This document was titled "PASSR Audit" beside of this Residents name the facility staff had documented "out of _____ (town in another state)." The DON was asked. for further clarification as to why this was written on the POC the DON referred the surveyor to the facility SW (social worker).

During an interview with the SW on 08/21/19 at 1:23 p.m., the SW verbalized to the surveyor that this Resident did not have a completed PASARR as she was originally admitted in 2012 from out of state.

The survey team shared with the DON a letter from Virginia DMAS (department of medical assistance services) dated 11/19/18 that outlined the process to ensure Residents in nursing facilities had a level I PASARR in place.

On 08/21/19 at 2:20 p.m., the DON verbalized to the surveyor that the SW had been using other information in regards to obtaining PASARR's. No copy of this information was given to the survey team.

The facility POC (plan of correction) read in part, "Identification of Deficient Practices & Corrective Action(s)...The social services director and/or Admissions director will complete a 100% review of all residents to identify residents who needed a level II PASRR (sic) completed prior to admission but did not have one. All negative findings will be corrected at the time of discovery...Completion

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{F 645}	Continued From page 4	{F 645}		

Date: 08/04/19."

The administrator, DON (director of nursing), and nurse consultant were notified of the issue regarding Resident #113 not having a level I PASARR on 08/21/19 at approximately 2:25 p.m.

No further information regarding this issue was provided to the survey team prior to the exit conference.

2. For Resident #108 the facility staff failed to ensure a level 1 PASRR (pre-admission screening and Resident review) was completed.

Resident #108's face sheet listed an admission date of 03/20/07 and a readmission date of 02/02/19. The Resident's diagnosis list included diagnoses of, but not limited to, seizure disorder, hypertension, anemia, hyperlipidemia, depression, dysphagia, intellectual disabilities, altered mental status, allergic rhinitis, and gastroesophageal reflux disorder.

Resident #108's most recent quarterly MDS (minimum data set) with an ARD (assessment reference date) of 08/04/19 assigned the Resident a BIMS (brief interview for mental status) score of 11 out of 15 in section C, cognitive patterns.

The social services section of Resident #108's clinical record was reviewed on 08/21/19. The surveyor could not locate a PASRR in this section of the clinical record. Surveyor spoke with the DON (director of nursing) and informed her that a PASRR could not be located. DON stated she would look for it.

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{F 645}	Continued From page 5 The DON informed the surveyor on 08/21/19 at approximately 10:15 am that, per the social worker, Resident #108 would not have a PASRR "because he's been here 31 years". DON stated that Resident #108 did have a UAI (uniform assessment instrument) in his clinical record. The concern of Resident #108 not having a PASRR in his clinical record was discussed with the administrative team (administrator, DON, regional nurse consultant) on 08/21/19 at approximately 14:45. No further information was provided prior to exit.	{F 645}		
{F 684} SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review and facility document review the facility staff failed to ensure that residents received treatment and care for 2 of 13 residents, Residents #104 and #101. The findings included: 1. For Resident #104 the facility staff failed to follow physician's orders for the administration of	{F 684}	**F684** **Corrective Action(s):** Resident #104's attending physician was notified that the facility staff failed to follow physician's orders for the administration of Lonhala Magnair medication. A facility Incident & Accident form was completed for this incident. Residents #101's attending physicians was notified that the facility staff provided restorative nursing services to the resident without a physician's order. A facility Incident & Accident form was completed for this incident.	

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{F 684}	Continued From page 6 the medications Lonhala and Brovana. According to the Physician's Desk Reference, Brovana is an inhaled medication used in the treatment of chronic obstructive pulmonary disease. According to the Physician's Desk Reference, Lonhala is an inhaled medication used in the maintenance treatment of chronic obstructive pulmonary disease. Resident #104's face sheet listed an admission date of 11/29/12 and a readmission date of 03/01/19. The resident's diagnosis list included diagnoses of, but not limited to Vitamin B12 deficiency, hypertension, benign prostatic hyperplasia, coal worker's pneumoconiosis, anxiety, diverticulitis, hearing loss, chronic obstructive pulmonary disease, insomnia, allergic rhinitis, anemia, dysphagia, pain, constipation, and hypothyroidism. The most recent quarterly MDS (minimum data set) with an ARD (assessment reference date) of 07/30/19 assigned the resident a BIMS (brief interview for mental status) score of 14 out of 15 in section C, cognitive patterns. The physician's orders section of Resident #104's clinical record were reviewed and contained a signed physician's order dated 08/08/19, which read in part "Start: Lonhala 25 mcg via neb (nebulizer) q12h (every 12 hours)" and "Brovana 15 mcg/2ml Soln (solution) via neb q12h". Resident #104's eMAR (electronic medication administration record) for August 2019 was reviewed and contained entries, which read in part "Brovana 15 mcg/2 ml solution via neb treatment Q 12 hours" and "Lonhala Magnair 25 mcg starter Q 12 hours". The entry for the	{F 684}	**Identification of Deficient Practices/Corrective Action(s):** All residents may have potentially been affected. A 100% review of all resident's medication orders has been conducted by the DON/designee identify residents at risk. Residents found to be at risk due the medications being unavailable from the pharmacy will be corrected at time of discovery and their attending physicians will be notified. A facility Incident and Accident form has been completed for each. The DON/designee will conduct a 100% review the facility's restorative nursing treatment logs to identify resident who may be receiving Restorative Nursing Services without an appropriate physician's order.Residents identified at risk will be corrected at time of discovery and the attending physician will be notified of each negative finding and a facility Incident & Accident form completed. **Systemic Change(s):** The facility policy and procedures have been reviewed and no revisions are warranted at this time. The nursing assessment process as evidenced by the 24Hour Report and documentation in the medical record /physician orders remains the source document for the development and monitoring of the provision of care, which includes, obtaining, transcribing and administering physician ordered medications, treatments and nursing services. The DON and/or Regional nurse consultant will inservice all licensed nursing staff on the procedure for obtaining, transcribing, and completing physician medication and treatment orders. To include following and	

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{F 684}	Continued From page 7 Brovana was coded "N" on 08/10/19 and 08/11/19 at both 8 am and 8 pm. The entry for the Lonhala was coded with "N" on 08/10/19 and 08/11/19 at both 8 am and 8 pm, and on 08/12/19 and 08/13/19 at 8 am. The entry indicated that the medication was not administered. The notes section of the eMAR was reviewed and contained notes, which read in part, "9:06AM, 8/10/19 Brovana 15 mcg/2ml solution via neb tr...scheduled for 08/10/2019 was not administered-Other.pending provider clarification", "9:06AM, 8/10/19 Lonhala Magnair 25 mcg starter Q 12 hou...scheduled for 08/10/2019 8:00 AM was not administered-Other.pending provider clarification", "12:00AM, 08/11/19 Brovana 15 mcg/2ml solution via neb tr...scheduled for 08/10/2019 8:00 PM was not administered-Other.pending provider clarification", "12:00AM, 8/11/19 Lonhala Magnair 25 mcg Starter Q 12 hou...scheduled for 08/10/2019 8:00 PM was not administered-Other.pending provider clarification", "9:30AM, 8/11/19 Brovana 15 mcg/2ml solution via neb tr...scheduled for 08/11/2019 8:00 AM was not administered-Other.pending provider clarification", "9:30AM 8/11/19 Lonhala Magnair 25mcg Starter Q 12 hou...scheduled for 08/11/2019 8:00 AM was not administered-Other pending provider clarification", "11:16PM, 8/11/19 Brovana 15 mcg/2ml solution via neb tr...scheduled for 08/11/2019 8:00 PM was not administered-Other.pending provider clarification", 11:16PM, 8/11/19 Lonhala Magnair 25 mcg starter Q 12 hou...scheduled for 08/11/2019 8:00 PM was not administered-Other.pending provider	{F 684}	providing Restorative nursing services per physician order. The Pharmacy Policy and Procedure has been reviewed and no changes are warranted. All licensed nursing staff have been inserviced on the Policy and Procedure for medication administration to included medications that are unavailable or do not arrive at the facility timely from the pharmacy for administration. The inservice will include the steps the nurses should take should a medication not be delivered timely from the pharmacy **Monitoring:** The DON will be responsible for maintaining compliance. The DON/designee will perform no less than 2 MAR reviews/week to monitor for compliance; and also a weekly review ofRestorative Nursing flow sheets audits to monitor for compliance will be completed.Any/all negative findings and or errors will be corrected at time of discovery and disciplinary action will be taken as needed. Aggregate findings of these audits will be reported to the Quality Assurance Committee quarterly for review, analysis, and recommendations for change in facility policy, procedure, and/or practice. **Completion Date: 9/13/19**	

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clarification", "9:11AM 8/12/19 Lonhala Magnair 25 mcg Starter Q 12 hou...scheduled for 08/12/2019 8:00 AM was not administered-Other.pending provider clarification.medication on order per pharmacy" and "11:43AM, 8/13/19 Lonhala Magnair 25 mcg Starter Q 12 hou...scheduled for 08/13/2019 8:00 AM was not administered-Other.pending provider clarification.pending arrival form pharmacy the device to deliver the dose, MD notified".

The surveyor spoke with LPN (licensed practical nurse) #1 on 08/21/19 at approximately 8:00 am regarding Resident #104's medications. LPN #1 stated that the medication was not available from the pharmacy. Also stated that it took longer for the Lonhala to arrive from pharmacy due to needing a special nebulizer kit.

The surveyor spoke with pharmacist #1 on 08/21/19 at approximately 9:15 am regarding Resident #104's medications. Pharmacist #1 stated the Brovana was sent out on 08/08/19 on the 9 pm pharmacy run. Pharmacist stated that a 30-day supply of the medication was sent at this time. Pharmacist #1 stated that a refill for the Lonhala was sent at the same time as the Brovana. Pharmacist #1 also stated that the Lonhala starter kit was not sent until 08/12/19 on the 1 pm pharmacy run. This was due to having to special order the starter kit, and it did not come in until then.

The surveyor requested a copy of the pharmacy manifest for Resident #104. This was provided to the surveyor on 08/21/19 at approximately 2:10 pm. The pharmacy manifest indicated that Resident #104's Brovana was received at the facility on 08/09/19 at 12:16 AM. The pharmacy

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manifest indicated that Resident #104's Lonhala Magnair Starter kit was received at the facility on 08/12/19 at 6:51 PM.

The surveyor spoke with the DON (director of nursing) on 08/21/19 at approximately 12:55 pm regarding Resident #104. DON stated she could not confirm why Resident #104's medications were not administered.

The concern of not following the physician's order for the administration of medications was discussed with the administrative team (administrator, DON, regional nurse consultant) during a meeting on 08/21/19 at approximately 14:45.

No further information was provide prior to exit.
2. For Resident #101, the facility provided restorative nursing services without a physicians order.

The resident's face sheet revealed that Resident #101 had been admitted to the facility 02/05/18 and had been readmitted on 10/12/18.

The diagnosis tab in the resident's EHR (electronic health record), included the diagnoses encephalopathy, hypothyroidism, dementia dysphagia, and depressive disorder.

Section C (cognitive patterns) of the resident's quarterly MDS (minimum data set) assessment with an ARD (assessment reference date) of 08/13/19 had been coded 1/1/3 to indicate the resident had problems with long and short term memory and was severely impaired in cognitive skills for daily decision making.

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On 08/20/19 at approximately 11:55 a.m., during the entrance conference with the administrator, the surveyor requested a list of residents that were currently receiving restorative nursing services.

On 08/20/19, the DON (director of nursing) provided the surveyor with a copy of a list of residents currently receiving restorative nursing services. Resident #101 was the first resident listed on this facility document. This resident was then placed in the resident sample. This document was part of the facility's credible evidence indicating they had completed weekly audits of the residents receiving restorative nursing. Beside the resident's name the facility staff had placed a check under the dates of 08/02, 08/09, and 08/16.

The resident's EHR (electronic health record) was reviewed on 08/20/19. The surveyor was unable to find any orders in regards to restorative nursing services.

The resident's comprehensive care plan included the problem area total care. Approaches included, but were not limited to, physical therapy/occupational therapy/restorative nursing as needed/ordered.

During an interview with the DON on 08/20/19, the DON verbalized to the surveyor that the resident's restorative nursing services had been discontinued on 07/26/19. However, she was still being seen by restorative as the discontinue order did not make it to the restorative tracking book due to human error. The DON stated the QA (quality assurance) nurse was responsible for the follow-up/monitoring for the POC (plan of

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correction). The DON provided the surveyor with copies of handwritten orders transcribed on 07/26/19 by the facility occupational therapist to discontinue restorative nursing as the resident would be receiving OT (occupational therapy) services. The DON stated this order was located in the resident's hard chart.

On 08/20/19 during an interview with the QA nurse, the QA nurse verbalized to the surveyor that she had not seen the phone order to discontinue the resident's restorative nursing. When asked if everyone at the facility that received restorative nursing services had a physicians order the QA nurse stated yes. When asked how she completed the audits for the restorative nursing part of the POC audits the QA nurse states she went by the book at the desk the "Restorative book."

The DON provided the surveyor with a copy of the resident's "Restorative Care Flow Record" for the month of August 2019. This flow sheet indicated that this resident had passive range of motion to the right upper and lower extremities from 08/01-08/19/19 and transfer training on 08/01-08/07 and 08/08-08/15/19.

Under the heading of "Monitoring" on the facility POC the facility had documented that the "DON will be responsible for maintaining compliance. The DON, ADON (assistant director of nursing) and/or Unit Manager will perform weekly Restorative Nursing flow sheets audits to monitor for compliance. Any/all negative findings and errors will be corrected at time of discovery and disciplinary action will be taken as needed...Completion Date: 08/04/19."

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{F 684}	Continued From page 12 The administrator, DON (director of nursing), and nurse consultant were notified of the issue regarding Resident #101 receiving restorative services without a physicians order and the issue with their POC audits on 08/21/19 at approximately 2:25 p.m. No further information regarding this issue was provided to the survey team prior to the exit conference.	{F 684}		
{F 755} SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in	{F 755}	**F755** **Corrective Action(s):** Resident 104's attending physician has been notified that the facility failed to ensure that the physician ordered Lonhala Magnair wasavailable from pharmacy for administration. A facility Incident and Accident form has been completed for this incident. **Identification of Deficient Practices & Corrective Action(s):** All residents may have potentially been affected. A 100% review of all resident's medication orders has been conducted by the DON/designee identify residents at risk. Residents found to be at risk due the medications being unavailable from the pharmacy will be corrected at time of discovery and their attending physicians will be notified. A facility Incident and Accident form has been completed for each.	

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{F 755}	Continued From page 13 sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review and facility document review the facility staff failed to ensure that routine medications were available for administration for 1 of 13 residents, Resident #104 The findings included: The facility staff failed to ensure the medication Lonhala Magnair was available for administration. According to the Physician's Desk Reference, Lonhala is an inhaled medication used in the maintenance treatment of chronic obstructive pulmonary disease. Resident #104's face sheet listed an admission date of 11/29/12 and a readmission date of 03/01/19. The resident's diagnosis list included diagnoses of, but not limited to Vitamin B12 deficiency, hypertension, benign prostatic hyperplasia, coal worker's pneumoconiosis, anxiety, diverticulitis, hearing loss, chronic obstructive pulmonary disease, insomnia, allergic rhinitis, anemia, dysphagia, pain, constipation, and hypothyroidism. The most recent quarterly MDS (minimum data set) with an ARD (assessment reference date) of 07/30/19 assigned the resident a BIMS (brief	{F 755}	**Systemic Changes:** The Pharmacy Policy and Procedure has been reviewed and no changes are warranted. All licensed nursing staff have been inserviced on the Policy and Procedure for medication administration to included medications that are unavailable or do not arrive at the facility timely from the pharmacy for administration. The inservice will include the steps the nurses should take should a medication not be delivered timely from the pharmacy. **Monitoring:** The DON is responsible for maintaining compliance. The DON/designee will conduct weekly audits of resident MAR's each week to confirm the availability of all ordered drugs. All negative findings will be corrected at the time of discovery. Results of the reviews will be reported to the Quality Assurance Committee for review, analysis, and recommendations for change in facility policy, procedure, and/or practice. **Completion Date: 9/13/19**	

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interview for mental status) score of 14 out of 15 in section C, cognitive patterns.

The physician's orders section of Resident #104's clinical record was reviewed and contained a signed physician's order dated 08/08/19, which read in part "Start: Lonhala 25 mcg via neb (nebulizer) q12h (every 12 hours)".

Resident #104's eMAR (electronic medication administration record) for August 2019 was reviewed and contained an entry, which read in part "Lonhala Magnair 25 mcg starter Q 12 hours". The entry for the Lonhala was coded with "N" on 08/10/19 and 08/11/19 at both 8 am and 8 pm, and on 08/12/19 and 08/13/19 at 8 am. The entry indicated that the medication was not administered.

The notes section of the eMAR was reviewed and contained notes, which read in part, "9:06AM, 8/10/19 Lonhala Magnair 25 mcg starter Q 12 hou...scheduled for 08/10/2019 8:00 AM was not administered-Other.pending provider clarification", "12:00AM, 8/11/19 Lonhala Magnair 25 mcg Starter Q 12 hou...scheduled for 08/10/2019 8:00 PM was not administered-Other.pending provider clarification", "9:30AM 8/11/19 Lonhala Magnair 25mcg Starter Q 12 hou...scheduled for 08/11/2019 8:00 AM was not administered-Other pending provider clarification", "11:16PM, 8/11/19 Lonhala Magnair 25 mcg starter Q 12 hou...scheduled for 08/11/2019 8:00 PM was not administered-Other.pending provider clarification", "9:11 AM 8/12/19 Lonhala Magnair 25 mcg Starter Q 12 hou...scheduled for 08/12/2019 8:00 AM was not administered-Other.pending provider

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clarification.medication on order per pharmacy" and "11:43AM, 8/13/19 Lonhala Magnair 25 mcg Starter Q 12 hou...scheduled for 08/13/2019 8:00 AM was not administered-Other.pending provider clarification.pending arrival form pharmacy the device to deliver the dose. MD notified".

The surveyor spoke with LPN (licensed practical nurse) #1 on 08/21/19 at approximately 8:00 am regarding Resident #104's medications. LPN #1 stated that the medication was not available from the pharmacy. Also stated was that it took longer for the Lonhala to arrive from pharmacy due to needing a special nebulizer kit.

The surveyor spoke with pharmacist #1 on 08/21/19 at approximately 9:15 am regarding Resident #104's medications. Pharmacist #1 stated the Brovana was sent out on 08/08/19 on the 9 pm pharmacy run. Pharmacist stated that a 30-day supply of the medication was sent at this time. Pharmacist #1 stated that a refill for the Lonhala was sent out on 08/08/19 on the 9 pm pharmacy run. Pharmacist #1 also stated that the Lonhala starter kit was not sent until 08/12/19 on the 1 pm pharmacy run. This was due to having to special order the starter kit, and it did not come in until then.

The surveyor requested a copy of the pharmacy manifest for Resident #104. This was provided to the surveyor on 08/21/19 at approximately 2:10 pm. The pharmacy manifest indicated that Resident #104's Lonhala refill was received at the facility on 08/09/19 at 12:16 AM. The pharmacy manifest indicated that Resident #104's Lonhala Magnair Starter kit was received at the facility on 08/12/19 at 6:51 PM.

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The surveyor spoke with the DON (director of nursing) on 08/21/19 at approximately 12:55 pm regarding Resident #104. The DON stated that if the resident's medications were not available for administration, she would expect the nurse to notify the pharmacy for delivery. If the medication cannot not be delivered, call the MD to let them know the medication is not available, and to see if they want to order a different medication. The surveyor asked the DON if the facility has a physician on call 24/7, and she stated that they do. The DON could offer no explanation as to why the physician was not notified of Resident #104's medications not being available.

The surveyor requested and was provided with a copy of a facility policy entitled "Medication Shortages/Unavailable Medications" which read in part, "1. Upon discovery that facility has an inadequate supply of a medication to administer to a resident, facility staff should immediately initiate action to obtain the medication from pharmacy. 4. If an emergency delivery is unavailable, facility nurse should contact the attending physician to obtain orders or directions. 5. If the medication is unavailable from pharmacy or a third party pharmacy, and cannot be supplied from the manufacturer, facility should obtain alternate physician/prescriber orders, as necessary".

The concern of the medications not being available for administration was discussed with the administrative team (administrator, DON, regional nurse consultant) during a meeting on 08/21/19 at approximately 2:45 pm.

No further information was provided prior to exit.

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{F 758}	Continued From page 17	{F 758}	**F 758**	
{F 758} SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that— §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}	**Corrective Action(s):** Resident 107's attending physician was notified that facility staff failed to monitor the resident for side effects of the physician ordered Lexapro (escitalopram). A facility Incident & Accident form was completed for this incident. Resident 106's attending physician was notified that facility staff failed to monitor the resident for side effects of the physician ordered trazadone. A facility Incident & Accident form was completed for this incident. Resident 108's attending physician was notified that facility staff failed to monitor the resident for side effects of the physician ordered citalopram. A facility Incident & Accident form was completed for this incident. **Identification of Deficient Practice(s) and Corrective Action(s):** All other residents receiving antidepressant medications may have been potentially affected. The DON/designee will review the medication orders of all residents receiving antidepressent medication to identify residents without appropriate psychotropic medication monitoring. Any/all negative findings will be communicated to the attending physicians for corrective action. A Facility Incident & Accident form will be completed for each negative finding.	

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{F 758}	Continued From page 18 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 psychotropic medications were not given unless the medications were necessary to treat a specific condition by monitoring for side effects of the psychotropic medications for 3 of 13 residents, Residents #107, #106, and #108. The findings included: 1. For Resident #107, the facility failed to monitor for the side effects of the anti-depressant medication lexapro (escitalopram). This resident (previously identified as #45) was cited at the annual survey for failing to monitor for side effects associated with this same medication. The residents EHR (electronic health record) was reviewed on 08/20 and 08/21/19. A review of the resident's face sheet revealed that Resident #107 had been admitted to the facility 06/09/15 and had been readmitted on 01/09/15. Diagnoses on this face sheet included, but were not limited to, altered mental status, essential	{F 758}	**Systemic Change(s):** The facility Policy and Procedure has been reviewed. No revisions are warranted at this time. All nursing staffwill be inserviced by the DON and/or regional nurse consultant and issued a copy of the facility policy and procedure for proper administration and monitoring for behaviors, side effects and effectiveness of psychotropic medications. **Monitoring:** The DON is responsible for maintaining compliance. The DON, ADON and/or Unit Manager will complete weekly physician orders and MAR audits on all residents receiving psychotropic medications to monitor compliance. All negative findings will be corrected immediately and appropriate disciplinary action will be taken as necessary. Aggregate findings of these audits will be provided to the Quality Assurance Committee for review, analysis, and recommendations for change in facility policy, procedure, and/or practice. **Completion Date: 9/13/19**	

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hypertension, sleep apnea, generalized anxiety disorder, major depressive disorder, cognitive communication deficit, and delusional disorders.

Section C (cognitive patterns) of the resident's quarterly MDS (minimum data set) assessment with and ARD (assessment reference date) of 07/12/19 included a BIMS (brief interview for mental status) summary score of 9 out of a possible 15 points.

The resident's comprehensive care plan included the problems area mood/behavior/psychosocial wellbeing and psychotropic drug use. Approaches included, but were not limited to, notify MD of any changes, pharmacy reviews as needed, GDR (gradual dose reduction) as recommended, and administer medications as ordered by the physician.

The resident's EHR included a physicians order for the anti-depressant medication escitalopram 20 mg tablet one po (by mouth) everyday. The diagnosis was documented as depression.

A review of the resident's eMARs (electronic medication administration records) revealed that this medication was being administered daily at 8:00 a.m. The eMAR did not include any information to indicate the facility was monitoring for side effects of this medication.

On 08/20/19 at 3:45 p.m., the DON (director of nursing) was asked for evidence of monitoring for side effects of the resident's psychotropic medications.

On 08/20/19, the DON stated to the surveyor that they had failed to monitor for side effects of the

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lexapro.

On 08/21/19 at 9:30 a.m., the DON verbalized to the surveyor that their system (computer system) did not let them key in the side effects and we would not "...see any..." for lexapro. The DON then added when they held their care plan meetings they asked this resident what her goals were. We would capture side effects. When asked for evidence of anything since the facility AOC (allegation of compliance) date of 08/04/19 the DON stated they did not have anything.

A review of the facility policy/procedures regarding adverse consequence and medication errors read in part, "...residents receiving any medication that has a potential for an adverse consequence will be monitored to ensure that any such consequences are promptly identified and reported. An "adverse consequence" is defined as an unpleasant symptom or event...An adverse consequence may include...side effect..."

The facility policy/procedure in regards to psychotropic medication use read in part, "...A psychotropic drug is any medication that affects brain activities associated with mental processes and behavior...All medications used to treat behaviors should be monitored for...harm or adverse consequences..."

The facility POC (plan of correction) read in part, "Corrective action: Resident #45's (now known as Resident #107) attending physician was notified that facility staff failed to monitor Resident #45 for side effects and effectiveness of the physician ordered Lexapro...Monitoring...The DON is responsible for maintaining compliance. The DON, ADON (assistant director of nursing) and/or

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Unit Manager will complete weekly physician orders and MAR (medication administration record) audits on all residents receiving psychotropic medications to monitor compliance. All negative findings will be corrected immediately...Completion Date: 08/04/19."

The facility provided the surveyor with evidence that audits had been completed on 08/01, 08/08, and 08/15/19.

The administrator, DON (director of nursing), and nurse consultant were notified of the issue regarding monitoring for side effects for the antidepressant medication lexapro on 08/21/19 at approximately 2:25 p.m.

No further information regarding this issue was provided to the survey team prior to the exit conference.

2. The facility staff failed to monitor Resident #106 for side effects associated with the use of Trazodone (an antidepressant).

Resident #106's "face sheet" noted the resident was originally admitted to the facility on 12/10/10 with a re-admission date of 12/09/11. Diagnoses included but were not limited to, chronic obstructive pulmonary disease (COPD), emphysema, unspecified psychosis, paranoid schizophrenia, major depressive disorder, and anxiety.

The clinical record for Resident # 106 was reviewed on 08/21/19. The most recent MDS (minimum data set) assessment was a quarterly assessment with an ARD (assessment reference date) of 08/05/19. Section C of the MDS assessed cognitive patterns and Resident #106

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had a BIMS (brief interview for mental status) score of 15 out of 15.

The current plan of care for Resident #106 was reviewed and revised with facility staff signatures documented on 08/06/19. The facility staff documented a problem area as, "Mood/behavior/psychotropic drug use: (Resident's name) has dx (diagnosis) psychosis, paranoid schizophrenia, anxiety, mental d/o (disorder), conduct d/o (disorder), depression, (Resident #106's name) does exhibit behaviors such as yelling from door of room up hall to nursing staff instead of using CB (call bell), she exhibits with persistant [sic] thoughts of fantasy ie: male vendors comes to building she gravitates to them, she has germ phobia[sic] will ask staff not to put things in her trash can, doesn't [sic] like when room mates using [sic] the commode in room. No behaviors documented this r [sic]." The care plan's interventions/"approaches" included but were not limited to, "Evaluate effectiveness and side effects of medications for possible decrease/elimination of psychotropic drug."

Resident #106's physician orders included but were not limited to, "Trazodone 150mg (milligram) tablet 1 po (by mouth) qhs (every night at bedtime)." On 08/21/19, one surveyor reviewed the August 2019 medication administration record (MAR) for Resident #106. The MAR included documentation that Trazodone had been given every night in August by a check mark and staff initials noted every night. The MAR included an area for staff comments or notes. For each dose of Trazodone given, staff documented an answer for "Pre Admin Antidepressant Medication Monitoring." The MAR did not include evidence

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of monitoring for side effects of Trazodone.

The director of nursing (DON) was interviewed on 08/21/19 at 12:42 p.m. regarding Resident #106's MAR documentation of Trazodone side effects. The DON stated the facility's computer system, through their corporation, was set up for anti-depressant behavior monitoring, not side effects monitoring. The DON stated the expectation was to discuss side effects of any medication during care plan meetings which were documented in the nursing notes. One surveyor reviewed Resident #106's nurses notes for August 2019. The nurses "Annual Care Plan Meeting" was documented on 08/08/19 and noted the resident's behaviors however, did not address side effects specifically.

The facility's pharmacy (Omnicare) policy titled, "3.8 Psychotropic Medication Use" was reviewed on 08/21/19. The policy read in part, "7. All medications used to treat behaviors must have a clinical indication and be used in the lowest possible dose to achieve the desired therapeutic effect. All medications used to treat behaviors should be monitored for: 7.1 Efficacy, 7.2 Risks, 7.3 Benefits, and 7.4 Harm or adverse consequences."

The facility's director of nursing, administrator, and nurse consultant were notified of the above referenced findings during a meeting with the survey team on 08/21/19 at 2:28 p.m.

No further information was provided to the survey team prior to the exit conference.
3. For Resident #108 the facility staff failed to monitor for the side effects of the psychotropic medication citalopram HBR.

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According to the Physician's Desk Reference, citalopram is a medication used to treat depression.

Resident #108's face sheet listed an admission date of 03/20/07 and a readmission date of 02/02/19. The resident's diagnosis list indicated diagnoses, which included, but not limited to seizure disorder, hypertension, anemia, hyperlipidemia, depression, dysphagia, intellectual disabilities, altered mental status, allergic rhinitis, and gastroesophageal reflux disorder.

Resident #108's most recent quarterly MDS (minimum data set) with an ARD (assessment reference date) of 08/04/19 assigned the resident a BIMS (brief interview for mental status) score of 11 out of 15 in section C, cognitive patterns.

The physician's orders section of the resident's clinical record was reviewed on 08/21/19. It contained a physician's order summary for the month of August 2019, which read in part "Citalopram HBR 20 mg tablet. 1 tablet po (by mouth) daily for depression)".

Resident #108's eMAR (electronic medication administration record) for the month of August was reviewed and contained an entry, which read in part "Citalopram HBR 20 mg tablet. 1 Tablet po daily for depression. This entry was initialed as given per physician's orders. The surveyor could not locate any monitoring off side effects of this medication.

Surveyor spoke with the DON (director of nursing) on 08/21/19 at approximately 12:40 pm

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{F 758}	Continued From page 25 regarding Resident #108's medications. DON stated, "We are not monitoring for side effects". Surveyor requested and was provided with a policy entitled "Adverse Consequences and Medication Errors" which read in part, "1. Residents receiving any medication that has a potential for an adverse consequence will be monitored to ensure that any such consequences are promptly identified and reported. 2. An 'adverse consequence' is defined as an unpleasant symptom or event that is due to or associated with a medication, such as an impairment or decline in an individual's mental or physical condition or functional or psychosocial status. An adverse consequence may include: b. Side effect" The concern of not monitoring for side effects of the psychotropic medication citalopram was discussed with the administrative team (administrator, DON, regional nurse consultant) during a meeting on 08/21/19 at approximately 2:45 pm. No further information was provided prior to exit.	{F 758}		
{F 761} SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals	{F 761}	**F761** **Corrective Action(s):** The undated vial of lidocaine; and expired niacin, vancomycin, ABH gel, bisacodyl stimulant laxative and ibuprofen were discarded on 8/21/19. A facility incident and accident form has been completed for this incident. The lockbox in the left side med room has been permanently affixed to the interior of the refrigerator.	

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{F 761}	Continued From page 26 §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations, staff interview, and facility document review the facility staff stored expired medications in 1 of 2 medication rooms and 2 of 4 medication carts and also failed to ensure the narcotic box was permanently affixed to the refrigerator in 1 of 2 medication rooms. The findings included: The facility staff failed to date opened lidocaine HCl 1% vials, failed to discard outdated niacin, vancomycin, ABH gel, bisacodyl stimulant laxative, and ibuprofen and failed to secure refrigerated ABH gel. On 8/21/19 at 10:35 a.m. two surveyors along with one facility employee, a licensed practical nurse (LPN #1), observed medication storage and labeling in a locked medication storage room referred to as the "left side medication room." In one upper cabinet, two bottles of Niacin (an over	{F 761}	**Identification of Deficient Practices & Corrective Action(s):** All unit medication rooms,medication refrigerators and medication carts used for the storage medications may have been potentially affected. The DON, ADON and/or Unit Manager will conduct a 100% review of the medication room, medication carts, and medication refrigerators to identify any expired, undated or loose medications; and will review all med room refrigerators to ensure that the narcotic lock boxes are permanently affixed to the inside of the refrigerator. Any/all negative findings will be corrected at time of discovery. A Facility Incident and Accident Form will be completed for each incident identified. **Systemic Change(s):** Facility policy and procedure for medication and biological storage have been reviewed and no changes are warranted at this time. All licensed nurses will be inserviced by the DON on the facility policy and procedure for storing medications and biologicals. The nursing staff will also be inserviced on the Medication Administration Policy and Procedure to include weekly review of all Medication rooms, medication refrigerators and medication carts for medications to include injectables and unrefrigerated medications and biologicals that may be expired or opened with no date or laying loose in the medication carts. In addition, The Pharmacy consultant will check each medication room and each medication cart for improper storage of medications during scheduled visits	

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{F 761}	Continued From page 27 the counter dietary supplement) 100 mg, 100 tablets each were found and both bottles had expiration dates printed as "07/19." The locked medication refrigerator had a bottle of liquid Vancomycin 7.5 g (an antibiotic) that read to discard after 7/31/19. The bottle was labeled for un-sampled Resident #115. The LPN stated Resident #115 was no longer receiving the medication, acknowledged that both medications were expired, and said another nurse would waste the Niacin and Vancomycin with her in either the "drug buster" or sharps container. The refrigerator contained a locked box with a brown bag inside which contained "ABH Gel Topical" (ABH = Ativan 1mg, Benadryl 12.5 mg, and Haldol 2mg) that had an expiration date of 05/30/19 and was labeled for un-sampled Resident #114. The LPN emptied the brown bag and counted 28 syringes, 1 ml each, of the ABH gel. LPN #1 acknowledged the medication had expired and stated the process of handling the expired ABH gel was the facility director of nursing (DON) would waste it with another nurse. The locked box that contained the ABH gel was not permanently affixed to the refrigerator; the LPN was able to pick the box up and place it on the counter while observing and counting the contents. LPN #1 acknowledged the locked box was supposed to be bolted within the refrigerator. On 08/21/19 at 8:35 a.m., two surveyors observed medication storage and labeling with a facility employee (LPN #2) on a medication cart referred to as the "right hall back cart." Bisacodyl Stimulant Laxative (an over the counter medication) was found with an expiration date reading "07/19." LPN #2 acknowledged the medication was expired and said she would take it off the cart, replace it with a new bottle, and	{F 761}	**Monitoring:** The DON is responsible for maintaining compliance. The DON/designee will perform weekly Medication room and Medication cartaudits to monitor for compliance. All discrepancies found in these audits will be corrected at the time of discovery and disciplinary action taken as appropriate. Results of these audits will be reported to the Quality Assurance Committee for review, analysis, and recommendations for change in facility policy, procedure, and/or practice. **Completion Date: 9/13/19**	

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waste the vial with the DON in the "drug buster" making sure there were two witnesses.

On 08/21/19 at 1:02 p.m., one surveyor observed medication storage and labeling with a facility employee (LPN #3) on a medication cart referred to as the "left hall front cart." Two vials of Lidocaine HCL 1% 200mg/20 cc (multi dose vials) were observed with both lids/tops off and both rubber septums visible. There was no date written on either vial that would indicate when it had been opened. One of the vials had a manufacturer's printed expiration date that read, "1 Feb 2021" and the other read, "1 Aug 2020." When asked how the nurse would know when the open vials expired, LPN #3 said they could be used until the date that was printed on them. LPN #3 acknowledged the vials were open and there was no way of knowing what date they had been opened. Ibuprofen Oral Suspension 100mg/5ml was observed on the medication cart with an expiration date that read, "05/19." LPN #3 acknowledged the medication was expired and said she would return it to the medication room and see another nurse to dispose of the expired medications.

On 08/21/19 at 2:05 p.m., the facility's quality assurance (QA) nurse, LPN #4, was interviewed in the conference room. LPN #4 acknowledged being the nurse responsible to check for expired medications and stated she performed the checks on a weekly basis. When informed there were expired medications found, LPN #4 stated, "I guess I just missed them when I checked last time."

The facility's director of nursing, administrator, and nurse consultant were notified of the

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medication storage and labeling findings during a meeting with the survey team on 08/21/19 at 2:28 p.m.

On 08/21/19 at 3:12 p.m., the facility's consultant pharmacist was interviewed in person in the facility's conference room. The pharmacist stated the expectation for multi-dose vials, such as Lidocaine HCl 1%, was that once the top was "popped" on it, whether the septum was punctured or not, it must be dated and then it expired in 28 or 30 days.

The facility's nurse consultant provided a pharmacy (Omnicare) policy titled, "5.3 Storage and Expiration of Medications, Biologicals, Syringes and Needles" on 08/21/19 at 3:20 p.m. that read in part, "4. Facility should ensure that medications and biologicals that: (1) have an expired date on the label; (2) have been retained longer than recommended by manufacturer or supplier guidelines; or (3) have been contaminated or deteriorated, are stored separate from other medications until destroyed or returned to the pharmacy or supplier." And "5. Once any medication or biological package is opened, Facility should follow manufacturer/supplier guidelines with respect to expiration dates for opened medications. Facility staff should record the date opened on the medication container when the medication has a shortened expiration date once opened. 5.1 Facility staff may record the calculated expiration date based on date opened on the medication container." The facility's policy titled, "Storage of Medications" was reviewed on 08/21/19. The policy did not address the locked narcotic box within the refrigerators needing to be permanently affixed. On 08/21/19 at 2:50 p.m., the nurse

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{F 761}	Continued From page 30 consultant said there was no other policy that addressed the locked narcotics box in the refrigerator. No further information was provided to the survey team prior to the exit conference.	{F 761}		
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, facility document review, and clinical record review, the facility staff failed to ensure the quality assurance program meet the needs of the facility as evidenced by repeated deficiencies in the areas of Resident Assessment, Quality of Care, and Pharmacy Services and failed to effectively monitor the effects of implemented changes and make needed revisions to the action plans as needed for the prevention of further deficiencies. The findings included: As part of the survey process, the survey team identified deficient practice in the areas of Resident Assessment, Quality of Care, and Pharmacy Services. The surveyor and the DON (director of nursing) reviewed the facility QA (quality assurance) program and QAPI (quality assurance and	F 867	**F867** **Corrective Action(s)** The QA Committee of the facility has reviewed all policies and procedures regarding administrative/clinical operations of the facility to include Psychotropic Medication Usage, PASARR requirements, Restorative Nursing Prorgram, Medication storage and expired meds; and medication availability. An action plan has been developed to address this item. **Identification of Deficient Practices & Corrective Action(s):** All residents have the potential to be affected by the inconsistent monitoring of company policies and procedures. All resident concerns will be addressed by the QA Committee via ongoing audits and action plans. A QA Action Plan will be implemented to address and resolve concerns.	

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F 867	Continued From page 31 performance improvement) plan/program on 08/21/19 at 1:00 p.m. The facility policy titled, "Quality Assurance Performance Improvement" read in part, "Our Quality Assurance and Performance Improvement Program (QAPI) represent our facility's commitment to continuous quality improvement. The program ensures a systematic performance evaluation, problem analysis and implementation of improvement strategies to achieve our performance goals..." The administrator, DON (director of nursing), and nurse consultant were notified of the issues regarding their quality assurance program during a meeting with the survey team on 08/21/19 at approximately 2:25 p.m. No further information regarding the areas of deficient practice were provided to the survey team prior to the exit conference.	F 867	**Systemic Change(s):** The QA Committee will take a more visible role in the day-to-day operations of the facility. Routine weekly QA audits of the medical records focusing on Psychotropic Medication usage, Dementia Care and Staff training related to Dementia Management, Comprehensive Resident Care Plans, Resident Assessment will be conducted to assure compliance. All negative findings will be addressed via a QA Action Plan to resolve concerns. They will monitor all aspects of resident care and services for continuous quality improvements. **Monitoring:** The administrator is responsible for maintaining compliance. The Regional V.P. of Operations and/or Regional Nurse Consultant will visit the facility weekly to provide management and operational oversight per corporate direction. The Regional Director of Operations will provide detail reports of negative findings to Corporate Office for immediate corrections. These findings will be forward to Corporate for review, analysis, and recommendations for change in facility policy, procedure, and/or practice. **Completion Date: 9/13/19**	