STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495300	A. BUILDING _____ B. WING _____	C 04/05/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HALL KING GEORGE	10051 FOXES WAY KING GEORGE, VA 22485

(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 684	Continued From page 76 twice daily)" and part (3) "weight monitor weekly." On 04/04/2019 at 11:10 AM, an interview with CNA L was conducted. When asked about the process for weighing residents, CNA L stated there is one scale in the facility and 2 she is one of two CNA's that weigh most of the residents. CNA L stated that weights are recorded "in the weight book." CNA L stated she writes weekly weights on a form that is kept in the back office. CNA L and this surveyor went to that office and CNA L retrieved a clipboard from the shelf with documents on it entitled "Weekly Weight Tracking System." It contained the weekly weights for residents in the month of March 2019. Resident #45 was not listed. CNA L stated since Resident #45 was scheduled for weekly weights every Monday instead of Wednesdays, it would be completed by the CNA assigned to care for him that day. CNA L stated that the CNA would report to the nurse what the value was and the nurse would enter it into the computer. When asked about weight changes, CNA L stated they compare weights and if there is a 5 pound weight change, more or less, they tell the nurse and the QA nurse who is responsible for monitoring weights. On 04/04/2019 at 11:30 AM, an interview with LPN F was conducted. When asked about the expectation of the nurse if there was a significant weight change, LPN F stated it would "depend on the parameters." LPN F went on to say if it exceeded parameters, she would notify the physician, the responsible party, and the QA nurse." When asked specifically about Resident #45 being on Lasix and losing 27 pounds in 6 days, she stated, "That's desirable weight loss to get rid of extra fluid."	F 684		

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F 684	Continued From page 77 On 04/04/2019 at 12:25 PM, an interview with the QA nurse was conducted. She confirmed that she monitors weights on all residents. When asked about the process for recording weights, she stated monthly weights go in the weight book and weekly weights go on the weight tracking sheet. She stated that "no one puts weekly weights in the computer" because weekly weight sheets in the weight book eventually go into the hard charts as part of the clinical record. The QA nurse stated that daily weights are done by the assigned CNA and reported to the assigned nurse. When asked about how she tracks residents' weights, she stated she gets a monthly weight tracking form from the electronic health record and also uses a Microsoft excel spreadsheet. When asked about the expectation for weight changes, the QA nurse stated that if there is a weight change 3 pounds, more or less, "we notify the doctor and investigate what we need to do." When asked if she checks for weight values in resident's electronic health record, she stated, "No." The QA nurse and this surveyor looked at Resident #45's weight values in the electronic health record. When the QA nurse saw the weight values for 03/25/2019 and 04/01/2019, she stated, "That weight (199.6 pounds) should've been rechecked." On 04/04/2019 at 3:40 PM, the QA nurse provided a copy of a clinical note entry dated 04/04/2019 at 3:31 PM: "weighed resident due to last weekly weight was incorrect; resident current weight 235.2#; resident has not lost weight but has gained 8.8#; nurse practitioner made aware and she stated just to monitor him and continue weekly weights at this time; call placed to [family member name]; and made aware; [family member name] stated "I guess I gotta quit	F 684		

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F 684	Continued From page 78 bringing him in all those snacks." In summary, Resident #45 had a potentially significant weight loss that was not identified or assessed by facility staff. On 04/05/2019 at approximately 2:30 PM, the Administrator and the DON were notified of findings and offered no further information or documentation.	F 684		
F 685 SS=D	Treatment/Devices to Maintain Hearing/Vision CFR(s): 483.25(a)(1)(2) §483.25(a) Vision and hearing To ensure that residents receive proper treatment and assistive devices to maintain vision and hearing abilities, the facility must, if necessary, assist the resident- §483.25(a)(1) In making appointments, and §483.25(a)(2) By arranging for transportation to and from the office of a practitioner specializing in the treatment of vision or hearing impairment or the office of a professional specializing in the provision of vision or hearing assistive devices. This REQUIREMENT is not met as evidenced by: Based on observation, Resident interview, staff interview, and clinical record review the facility staff failed to provide proper treatment and hearing assistive devices for 2 residents (Resident #57 and #35) in a sample size of 30 residents. 1. For Resident #57, the facility staff failed to provide proper treatment and assistive devices to maintain and/or enhance his hearing ability.	F 685	**F685** **Corrective Action(s):** Resident #57 has been reassessed by his attending physician for decreased hearing and an appointment has been scheduled for resident #57 to see the ENT physician for hearing loss and hearing aid consultation. A facility Incident & Accident form has been completed for this incident. Resident #35 has an appointment scheduled for an eye exam and for glasses fitting. A facility Incident & Accident form has been completed for this incident **Identification of Deficient Practice(s) & Corrective Action(s):** All other residents who have assistive devices may have potentially been affected. The Social Services director will complete a 100% audit of all residents with hearing aids and eye glasses to ensure they are available, functional, and being used the correct way. Any/all negative findings will be corrected at time of discovery. An Incident & Accident form will be completed for each negative finding.	

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F 685	Continued From page 79 2. For Resident #35, the facility staff failed to assist with procurement of eye glasses as prescribed by optometrist. The Findings included: Resident #57, an 89 year old male who was admitted to the facility on 05/21/12 with diagnoses to include but not limited to diabetes, right leg amputation, high blood pressure, peripheral vascular disease, and depression. Resident #57's most recent Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 02/01/2019 was coded as an Annual assessment. Resident #57 was coded with a Brief Interview of Mental Status (BIMS) score of "14" out of possible 15 indicating no cognitive impairment. He was also coded as having moderate hearing difficulty with no hearing aids used. On 04/02/2019 at approximately 2:00 PM an interview was conducted with Resident #57. He stated "if I had hearing aids, I would use them...I had to choose between teeth or hearing aids and I chose teeth....I have had two sets of hearing aids and they don't last long...I don't know what else to do". During the course of the interview, Resident #57 appeared to have difficulty hearing by cupping his right hand around his right ear and asking for questions to be repeated frequently. He was able to comprehend the questions and was apologetic for not being able to hear better. On 04/02/2019 a review was conducted of Resident #57's clinical record. A copy of Resident	F 685	**Systemic Change(s):** The Social Service Director and the nursing departments have established a list of all residents utilizing Assistive hearing and vision devices which is kept at each nurse's station. Instruction for the use of each device are kept inside the resident's closet door. The Social Services director and/or the DON will inservice all nursing staff on the usage, care, and storage of assistive devices and the process to follow when one is missing, broken or the resident refuses to wear the assistive hearing and vision devices. **Monitoring:** The Social Services director and the DON is responsible for maintaining compliance. The Social Services Director and /or Unit managers will monitor all residents with assistive hearing and vision devices daily to ensure they are in use. Any/all negative findings will be reported to the administrator for immediate correction and disciplinary action will be taken as warranted. All negative findings will be reported to the Quality Assurance Committee for review, analysis, and recommendations for change in facility policy, procedure, and/or practice. **Completion Date: May 20, 2019**	

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F 685	Continued From page 80 #57's current Care Plan was requested and received (Care Plan was undated). On page 9 it read, "Wears glasses and is HOH [hard of hearing]....ENT [ear, nose, throat] consult". No evidence of ENT consultation was provided. On 04/03/2019 at approximately 4:00 PM, an interview was conducted with the Social Worker (Employee G). When asked about Resident #57's remark with regard to having to choose between teeth or hearing aids, she replied, "It has not been brought to my attention...I never knew he had hearing aids, I know he is hard of hearing". When asked if she had professionally assessed him, she replied "Nobody has ever told me that he needed anything...I do review the MDS quarterly but he only has a moderate hearing loss...Nursing needs to tell me if he needs anything...I have resources available to me to get him hearing aids". On 04/04/2019 at approximately 5:30 PM, the Administrator (Employee A) and Director of Nursing (DON, Employee B) were notified of the findings. No further information was received, including a policy on Assistive Devices. 2. For Resident #35, the facility staff failed to assist with procurement of eye glasses as prescribed by optometrist. Resident #35, 70-year female, was admitted to the facility on 10/22/2011. Diagnoses include but not limited to heart failure, hypertension, morbid obesity, and muscle weakness.	F 685		

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F 685	Continued From page 81 Resident #35's most recent Minimum Data Set had an Assessment Reference Date (ARD) of 01/02/2019 and was coded as a significant change in status assessment. Resident #35 was coded with a Brief Interview of Mental Status (BIMS) score of 15 out of possible 15 indicative of intact cognition. Functional status for bed mobility, dressing, and personal hygiene were all coded as requiring extensive assistance from staff. Vision was coded as adequate - sees fine detail, including regular print in newspapers/books. On 04/02/2019 at 12:51 PM, an interview with Resident #35 was conducted. When asked if she had any concerns, Resident #35 stated she had an eye exam last year but never received glasses. Resident #35 stated she spoke with LPN B about it. Resident #35 also stated she loves to read but is unable to do so without her reading glasses. Resident #35 was not wearing glasses at the time of the interview. On 04/03/2019 at 9:10 AM, Resident #35 was observed in her bed sleeping with the head of the bed elevated approximately 30 degrees. On 04/04/2019 at 9:00 AM, Resident #35 was observed in bed, awake, with the head of her bed elevated approximately 45 degrees. The TV was on. Resident #35 was not wearing glasses. Resident #35 stated, "my left eye is my good eye." She went on to say that if she closes her left eye, everything is blurry. On 04/04/2019 at 4:05 PM, LPN B was asked if she was aware Resident #35 needed glasses and LPN B stated, "Yes." When asked about the process of getting glasses for Resident #35, LPN	F 685		

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F 685	Continued From page 82 B stated, "The social worker takes care of that." On 04/04/2019 at approximately 4:40 PM, Employee G, a social worker, was asked about the process for vision services and Employee G stated she visits with residents and asks them if they want to see the eye doctor and if so, their name is put on a list. Employee G then provided a list to show that Resident #35 was scheduled for vision services on 04/17/2019. On 04/05/2019 at 9:25 AM, Resident #35 was observed in her room, in bed, awake. When asked if a social worker had talked with her about getting glasses and she stated, "No." She went on to say "I miss being able to read." On 04/05/2019 at approximately 10:05 AM, Employee G was interviewed. When asked about the process if a resident has concerns pertaining to their glasses, she stated if the glasses are broken, she will try to fix them herself and used the example of applying superglue to the hinge. She also stated that if a resident needs reading glasses, she has a whole box of them in her office and will give them to the residents that need them. When asked if she knew why Resident #35 wanted to see the eye doctor, she stated she didn't know. The social service notes ranging from 06/15/2018 through 03/18/2019. Of the 15 social services entries by Employee G, there were no entries addressing vision services. The facility provided "Summary Ocular Progress Notes" dated 07/13/2018 for Resident #35. An optometrist documented the chief complaint, "Blurred vision, hard to see at distance and near."	F 685		

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F 685	Continued From page 83 Under "Diagnosis and Treatments", it was documented, "Age-related nuclear cataract, bilateral - cataracts - OU-Mild/stable - not visually significant - monitor 6 mos (months)." The progress notes also included a glasses prescription that expires 7/13/19. The prescription documented, "OD (right eye) -2.75 sph x ...add +2.50 OS (left eye) -1.25 sph x ...Add +2.50." The care plan was reviewed. A problem/need onset dated 04/11/2016 documented, "[Resident #35] prefers to structure her own day, and stays in bed per her choice, enjoys reading Bible, listening to gospel music, keeping up with news, and participating with religious programs in her room. Enjoys reading and writing and getting to know new people. In past, loved to sing. Has dx (diagnosis) of DM2 (type 2 diabetes) and severe morbid obesity." Approaches associated with this focus included but not limited to "offer and provide writing materials and other materials to promote continued independence; provide Bible for resident to use as requested." Resident #35's vision deficit and her need for glasses was not addressed on the care plan. The policy entitled, "Social Services" the facility staff provided was reviewed. In Section 4, it is documented, "The social worker, or social services designee, will pursue the provision of any identified need for medically-related social services of the resident. Attempts to meet the needs of the resident will be handled by the appropriate discipline(s). Services to meet the resident's needs may include:" Under part (d) of Section 4, it is documented, "Making arrangement for obtaining items, such as adaptive equipment, clothing, and personal items."	F 685		

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F 685	Continued From page 84 In summary, Resident #35 was examined by an optometrist in July 2018 which included a prescription for glasses. Resident #35 loves to read but is unable to do so because she did not have glasses and did not receive glasses following the exam by the optometrist nearly 9 months ago. On 04/05/2019 at approximately 2:30 PM, the DON and Administrator were notified of findings and they offered no further information or documentation.	F 685		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility documentation review and clinical record review, the facility staff failed to provide adequate supervision to prevent accidents for one resident (Resident #55) in a survey sample of 30 residents . For Resident #55 the facility staff failed to implement interventions and provide supervision to reduce fall risks and hazards following falls on 2/6/19 and 3/28/19. The findings included:	F 689	**F689** **Corrective Action(s):** Resident #55 has been reassessed for fall prevention by Physical/Occupational Therapy to determine the appropriate assistive device to be used to prevent accidents/injuries related to falls. The residents comprehensive care plan has been revised to reflect their current fall prevention approaches and interventions. A Risk Management I&A form was completed for this incident. **Identification of Deficient Practices/Corrective Action(s):** All other residents at risk for falls may have been potentially affected. The facility will conduct a 100% audit of all resident fall risk assessments to identify residents at risk for falls and the need for safety/assistive devices and supervision. Residents identified at risk will be screened by therapy for fall prevention needs and have appropriate interventions incorporated into their plan of care.	

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F 689	Continued From page 85 Resident #55, was admitted to the facility on 2/1/19. The resident's diagnoses included, but were not limited to: hypertension, Type 2 diabetes, and neuromuscular dysfunction of bladder. Resident #55's most recent MDS with an ARD (assessment reference date) of 2/8/19 was coded as an admission assessment. The resident was coded as having a BIMS (Brief Interview for Memory Status) score of 15, indicating the resident was cognitively intact. Functional status for transfers, dressing, toilet use and personal hygiene, was coded as Resident #55 required extensive assistance of staff. Clinical record review of nursing notes dated 2/1/19-4/3/19, revealed that Resident #55 sustained falls on 2/6/19, 2/11/19, and twice on 3/28/19. During an interview with the Director of Nursing on 4/5/19 at approximately 9am when asked how they define a fall, she stated, "any change in elevation." When asked if a resident was assisted or lowered to the floor by staff, is this a fall? She stated, "yes." When asked how often Fall Risk Assessments are completed, she said, "on admission, quarterly and with each fall." Review of nursing notes, physician progress notes, physical therapy notes, occupational therapy notes, nursing assessments and careplan, all with dates of 2/1/19-4/3/19, reveal that no action or supervision was provided to Resident #55 following his fall on 2/6/19 or 3/28/19. In the nursing notes dated 3/28/19 at 2:38pm the nurse wrote, "Resident stated that it was in his room and while trying to reach over to	F 689	**Systemic Change(s):** The facility policy & procedure has been reviewed and no revisions are warranted at this time. Licensed staff will be inserviced by the DON, ADON and/or Regional Nurse consultant on the policy and procedure regarding fall prevention, the use of assistive devices, adaptive equipment and supervision for preventing accidents and falls. The Risk Management Committee review all of falls weekly and provide recommendations for fall and accident prevention. These recommendations will be forwarded to the interdisciplinary team to be incorporated in the comprehensive care plan. **Monitoring:** The DON is responsible for maintaining compliance. The Risk Management Program includes a review of all falls weekly for maintaining compliance. The DON, ADON and/or QA nurse will complete the falls tracking audit weekly to monitor for appropriate safety/assistive device usage. All negative findings will be corrected at time of discovery, reported to the Risk Management Committee weekly for review and recommendations and disciplinary action will be taken as needed. Aggregate findings will be reported to the QA Committee for review, analysis, and recommendations of change in facility policy, procedure, or practice. **Completion Date: May 20, 2019**	

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F 689	Continued From page 86 turn on his light causing to slip r/t (related to) regular socks with out grips."[sic] The DON provided a "post-incident actions" form with an incident date of 3/28/19 at 1pm that "grippy socks" were provided to the resident. The nursing notes dated 3/28/19 at 11:36pm following his second fall, the nurse wrote, "This writer went down to assess the resident and resident again stated that while attempting to turn on the light switch he slid to the floor because his socks were slippery." Review of the "Fall Risk Assessment" dated 2/1/19 indicated that Resident #55 was "alert (oriented x 3)" and had "no falls in the past 3 months." Repeat Fall Risk Assessments completed on 2/7/19, 2/15/19 and 2/22/19 all indicated that Resident #55 had "no falls in the past 3 months" and as a result gave a score of less than 10, indicating he was not at high risk for falls. Review of the facility policy titled "Falls and Fall Risk, Managing" with a revision date of March 2018 was reviewed and read: "Resident-Centered Approaches to Managing Falls and Fall Risk: The staff, with the input of the attending physician, will implement a resident-centered fall prevention plan to reduce the specific risk factor(s) of falls for each resident at risk or with a history of falls. If falling recurs despite initial interventions, staff will implement additional or different interventions, or indicate why the current approach remains relevant." The administrator and DON were made aware of the failure of the facility staff to provide supervision to a resident to prevent accidents during the end of day meeting on 4/4/19 at	F 689		

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F 689	Continued From page 87 5:30pm. No further information was provided.	F 689		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to	F 690	**F690** **Corrective Action(s):** Resident #55's Bowel and Bladder status has been reassessed by the nursing department. A restorative bowel program has been established to reestablish bowel continence and the use of the commode for all bowel movements. His comprehensive care plan has been revised to reflect his current bowel program. **Identification of Deficient Practices & Corrective Action(s):** All other residents requiring toileting assistance may have potentially been affected. The DON, ADON and/or Unit Managers will review each resident's current bowel and Bladder status to include appropriate interventions to meet their resident specific needs. The residents comprehensive care plans will be revised to reflect their current needs to promote or maintain their current bowel and bladder function to promote continence of bowel and bladder. **Systemic Change(s):** The facility policy and procedure has been reviewed and no changes are warranted at this time. The DON and/or designee will provide ongoing inservice training to the licensed staff and CNA staff to address the importance of providing assistance to residents during bowel and bladder care and accurately following and maintaining a Bowel and Bladder continence program.	

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F 690	Continued From page 88 restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview,facility record review, and clinical record review, the facility staff failed to provide necessary care and services to ensure that a resident who was continent of bowel on admission receives services to maintain continence for one resident (Resident #55) in a survey sample of 30 residents. The facility staff were not assisting Resident #55 to have bowel movements in the toilet. The findings included: Resident #55, a 55 year old, was admitted to the facility on 2/1/19. The resident's diagnoses included, but were not limited to: hypertension, Type 2 diabetes, and neuromuscular dysfunction of bladder. Resident #55's most recent MDS with an ARD (assessment reference date) of 2/8/19 was coded as an admission assessment. The resident was coded as having a BIMS (Brief Interview for Memory Status) score of 15, indicating the resident was cognitively intact. Functional status for transfers, dressing, toilet use and personal hygiene, was coded as Resident #55 required extensive assistance of staff. Review of the Nursing Admission Assessment dated 2/1/19 is coded that the resident is continent of bowel movements. Interview with Resident #55 on 4/5/19 at 9:34am the resident	F 690	**Monitoring:** The DON is responsible for maintaining compliance. The DON and/or designee will perform weekly audits to ensure that their bowel and bladder needs are being addressed. Any/all negative findings will be reported to the DON for immediate correction. Detail findings of these audits will be reported to the Quality Assurance Committee for review, analysis, and recommendations for changes in facility policy, procedure, and/or practice. **Completion Date: May 20, 2019**	

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F 690	Continued From page 89 stated, "I know when I need to go but it makes it easier for everyone if I use this diaper and let them know when it needs changing. I can get in my chair and go to the bathroom." Baseline careplan indicates resident requires assistance of one staff person for transfers and toileting and is continent of bowel. CNA careplan dated 2/1/19 indicates resident needs "assisted toileting." Review of the "Bowel & Bladder Report" from 2/2/19-4/4/19 indicates Resident #55 had a bowel movement on 70 days. Of the 70 occurrences 66 of those were incontinent, using an adult brief. Surveyor A conducted an interview with CNA M on 4/3/19 at approximately 2pm. During the interview, CNA M stated, "[Resident #55's name] is continent, he has a foley, he will let me know when he needs changed, he just uses his brief." The Administrator and Director of Nursing were made aware of the findings of staff failing to provide ADL assistance to maintain bowel continence for Resident #55 during end of the day meeting on 4/4/19. No further information was provided.	F 690	**F730** **Corrective Action(s)** The facility Administrator and HR director have reviewed the requirement for providing CNA staff with at least 12 hours of inservice training per year. An incident & accident form was completed for this incident.	
F 730 SS=D	Nurse Aide Peform Review-12 hr/yr In-Service CFR(s): 483.35(d)(7) §483.35(d)(7) Regular in-service education. The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. In-service training must comply with the requirements of §483.95(g). This REQUIREMENT is not met as evidenced	F 730	**Identification of Deficient Practice & Corrective Action(s):** All CNA staff to include new hires may have potentially been affected. All CNA files will be reviewed to establish the current number of inservice hours that have been completed. The findings of this review will be reviewed with the Administrator and DON to aid in setting up the appropriate inservice training.	

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F 730	Continued From page 90 by: Based on staff interview and facility documentation review the facility failed to ensure certified nurse aides (CNA's) receive regular in-service education for 2 of 5 employees. (CNA F and CNA H) The facility staff failed to ensure CNA's receive 12 hours of in-service training annually for CNA F and CNA H. The findings included. On 4/4/19 a review of employee records was conducted and revealed that CNA F and CNA H had no recorded in-service training for 2018. An interview with Employee F on 4/4/19 at 10:14am she stated, "they have no training on file." The Administrator and Director of Nursing were made aware of the findings on 4/4/19 at 5:30pm. No further information was provided.	F 730	**Systemic Change(s):** The administrator and DON have reviewed the inservice schedule for the nursing department to ensure all CNA staff receive at least 12 hours of insevice training yearly. An inservice training calendar has been developed to maintain competence and meet state/federal requirements for nursing and CNA staff. The business office assistant will file the inservice schedule and dates in the personnel file. **Monitoring:** The Administrator is responsible for maintaining compliance. The administrator and/or designee will review CNA personnel files quarterly to ensure that each CNA is receiving inservices routinely per the inservice training calendar. All files will be reviewed annually. Aggregate findings of theses audits will be forwarded to the Quality Assurance Committee for review, analysis, and recommendations for change in facility policy, procedure, and/or practice. **Completion Date: May 20, 2019**	
F 740 SS=D	Behavioral Health Services CFR(s): 483.40 §483.40 Behavioral health services. Each resident must receive and the facility must provide the necessary behavioral health care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Behavioral health encompasses a resident's whole emotional and mental well-being, which includes, but is not limited to, the prevention and treatment of mental and substance use disorders.	F 740	**F740** **Corrective Action(s):** Resident #6 has been assessed by their attending physician and a referral to Brighter Day Behavioral Health Services has been made to assess their current psychological and behavioral needs to establish an appropriate plan of treatment to meet his behavioral and psychosocial needs. The comprehensive care plan has been revised to reflect the current approaches and interventions in place.	

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F 740	Continued From page 91 This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, clinical record review, and facility document review, the facility staff failed to provide behavioral health services for 1 resident (Resident #6) of the 30 residents in the survey sample. Resident 6's clinical record documented that the Resident had anxiety and depression on admission. Continued behavioral health services assessment, care planning, physician evaluation, and non-pharmacologic nursing interventions, were not performed by facility staff. The findings included: Resident #6, was admitted to the facility on 12-18-18. Diagnoses included; depression, anxiety, heart disease, diabetes, high blood pressure, and chronic obstructive pulmonary disease (COPD). The most recent Minimum Data Set assessment was a quarterly assessment with an assessment reference date (ARD) of 3-26-19. Resident #6 was coded with a Brief Interview of Mental Status (BIMS) score of 13 indicating little to no cognitive impairment and requiring assistance with physical activities of daily living. The full admission MDS assessment was also reviewed with an ARD date of 12-25-18 which revealed a BIMS score of 13, and both documents did not code depression nor anxiety as diagnoses to be treated or care planned for this Resident. An interview was conducted with Resident #6 on	F 740	**Identification of Deficient Practice(s) & Corrective Action(s):** All other residents who display psychosocial and/or behavioral needs/difficulties may have been potentially affected. The Social Service director will conduct 100% review of all resident's records for the last 30 days to check residents displaying any behavioral health needs or difficulties. Residents identified at risk will have their current needs and behaviors assessed by their attending physician and/or Behavioral Health services to establish appropriate treatment interventions. **Systemic Change(s):** The facility policy and procedure has been reviewed and no changes are warranted at this time. The DON, Unit Managers and/or Social Services director will review the 24-hour report daily to ensure that each resident's current medical needs including their behavioral health and psychosocial needs are being addressed in a timely manner to ensure that appropriate medical and psychological interventions are being obtained as ordered. All negative findings will be reported to administrator for immediate corrective action.	

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F 740	Continued From page 92 4-2-19, at 1:00 p.m., and on 4-3-19 at 12:00 p.m. During the interviews, Resident #6 was tearful. The Resident stated that she did not get to see her family often, and had just moved to Virginia from another state, and had no friends here other than family. The Resident went on to say the family members lived quite a distance from the facility, and were busy raising children, and working. The Resident was asked if she had ever talked with the social worker about her feelings, and she stated "no, I only saw her twice the first week I came here, and the day I had to move out of my room because my room mate was so disruptive." "I haven't seen her since." When asked if she was interested in talking with the social worker, Resident #6 stated "no, I would rather see a doctor." When asked if she meant a psychologist, or a psychiatrist, she stated "yes". Resident #6's clinical record was reviewed. The social services notes indicated that the social services director (SSD) did visit the Resident on 12-19-18, and ten days later on 12-29-18 for routine admission, and "14 day" follow up. The SSD did not document seeing the Resident again until 3-18-19 to prepare for the quarterly MDS submission. The SSD documented the following entry on 3-18-19; "There has been no change to the resident during this quarter in behaviors or mood. The resident appears anxious, nervous in conversation but is very pleasant and nice. Residents son visits often, but tends to complain about "little things" or things of unimportance in regards to residents overall care and treatment. The resident tends to stay in room and is socially withdrawn by nature."	F 740	**Monitoring:** The Director of Nursing and social services director is responsible for maintaining compliance. The DON, ADON and/or Unit Managers will perform chart audits weekly coinciding with the Care Plan calendar to monitor for compliance. Detailed findings of the 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: May 20, 2019**	

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F 740	Continued From page 93 On 3-19-19, the Resident was moved to another room. A review of all discipline notes in the clinical record did not reveal any documentation of the reason for the move, or how the Resident responded to the move. All behavior documents were reviewed, to include social work notes, physician notes, nursing notes, medication administration notes, and MDS documents, which revealed that the Resident had no aberrant behaviors. All physician notes were reviewed from admission to the dates of survey. There were 4 visits, and the documents revealed the first visit as a "medical history", which was a 3 page form dated 12-20-18. This first visit document described the Resident as negative for psychiatric problems, and went on to document, alert and oriented to person/place/time. Depression and anxiety were not included in the diagnoses written on the form. On 2-7-19, 2-21-19, and 3-26-19 the doctor saw the Resident and documented the first 2 visits as "recert" visits for skilled care. The final visit on 3-26-19 was a sick visit, as the Resident had been diagnosed with pneumonia. None of these visits have any documentation under the "psyche" heading on the document, and they were left blank, as no assessment in this area was conducted. All other headings were assessed and documented as such. No psychiatric physician evaluation was ever conducted. Review of all nursing notes since admission, and to the time of survey revealed no assessment or interventions for depression or anxiety. Physician's orders, and Medication Administration	F 740		

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F 740	Continued From page 94 Records (MAR's) were reviewed and revealed the following (4) psychoactive medications were ordered and administered during Resident #6's stay; 1. Zoloft 125 milligrams (mg) every day at 9:00 a.m. for depression. Ordered 12-19-18, and continued through survey. 2. Buspar 15 mg three times per day at 10:00 a.m., 2:00 p.m., and 9:00 p.m. for anxiety. Ordered 12-19-18, and continued through survey. 3. Xanax 0.5 mg every 6 hours as needed for anxiety. Ordered 12-19-18, discontinued 12-23-18, reordered 12-25-18 to stop 2-15-19. 4. Xanax 0.5 mg every day at 9:00 a.m. for anxiety. ordered 2-16-19, and continued through survey. The Residents care plan in the computer, and the paper copy with revisions from the care plan book on the nursing unit were reviewed. The 2 care plans revealed, no baseline initial care plan, nor comprehensive care plan was ever devised for the Resident's depression, anxiety, and behavioral health care needs. At the end of day meeting on 4-3-19, the Director of Nursing (DON) and Administrator were notified that the facility staff were not providing for Resident #6's behavioral health needs. It was reviewed that Resident #6's depression and anxiety were not care planned, nor was there any formal psychiatric assessment, nor social work interventions. The administrative staff were asked to provide clarification in this matter, and they stated they would get back to the surveyors	F 740		

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F 740	Continued From page 95 with any information found. The Administrator and DON were notified of the concern again on 4-4-19 at 11:00 a.m. regarding Resident #6, and the DON stated "you have everything we have." No further information was able to be provided.	F 740		
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 sufficient detail to enable an accurate reconciliation; and	F 755	**F755** **Corrective Action(s):** Resident 7's attending physician has been notified that the facility failed to provide 2 doses of the physician ordered Alprazolam (Xanax) medication because it was not available from the pharmacy. 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 regimes has been conducted by the DON, ADON, QA nurse and/or Unit managers to 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 96 §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 documentation the facility failed to provide 2 doses of medication ordered daily for 1 Resident (Resident #7) in a survey sample of 30 Residents. The findings included: Resident # 7 is a 78 year old woman admitted to the facility on 5/2/13 with diagnoses of but not limited to Bipolar Disorder, Acute Kidney Failure, Repeated Falls, Pacemaker implant, Major Depressive Disorder, and Seizure Disorder On 4/3/19 during a clinical record review it was discovered that Resident #7 had missed 2 doses of a scheduled anti-anxiety medication Alprazolam (Generic Xanax) 0.25 MG daily. The medication was scheduled for 9:00 AM On 3/30/19 the (Medication Administration Record) MAR was marked N which indicates it has not been given. Under the comments it states "Awaiting Pharmacy". On 3/31/19 the MAR was marked again with N indicating not given and under comments it states "Received new script from Doctors Office." On 4/4/19 the DON was asked why the Resident missed 2 doses of the Alprazolam. The DON stated that they needed a new prescription to get it from the pharmacy on March 30th. On March 31st they had obtained the script but the	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, ADON or Unit manager 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: May 20, 2019**	

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F 755	Continued From page 97 pharmacy was in the process of filling it. They received the medication on the night of the 31st and were able to give it on April 1st. On 4/4/19 at the end of day meeting the Administrator was made aware and no further information was provided.	F 755		
F 757 SS=D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on clinical record review and facility documentation the facility failed to ensure Resident is free from unnecessary meds for 1 Resident (#97) in a survey sample of 30	F 757	F757 **Corrective Action(s):** Resident #97's attending physician was notified that resident #97 received a Heparin flush 3 times a day instead of the physician ordered daily Heparin flush for their Midline Catheter. Resident #97's Heparin Flush order has been clarified and corrected. A facility Incident & Accident form and a medication error form was completed for this incident. **Identification of Deficient Practice(s) and Corrective Action(s):** All other residents with Heparin Flush orders may have been potentially affected. The DON, ADON and/or QA nurse will review the medication orders of all residents to ensure that no unnecessary administration of Heparin Flushes have been ordered or administered. 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 757	Continued From page 98 Residents. For Resident #97 the facility staff failed to follow Physicians Order for Heparin (an anti-coagulant) Flush to be administered daily, but instead, administered the Heparin Flush three times per day thus administering unnecessary amount of Heparin. The findings include Resident #97 is an 84 year old woman admitted to the facility on 6/22/17 with diagnoses of but not limited to Anemia, Hypertension, Dementia (Alzheimer's Type) History of Stroke, Anxiety and Depression. On 4/5/19 during clinical record review it was noted that Resident #97 had orders for Flushing Midline Catheter (Intravenous Line for medication administration.). The orders began on 3/17/18 at 2:30 PM. The orders read: Heparin flush 10 Units/ML [10 Units per Milliliter] Flush midline with Heparin [an Anti-Coagulant] & Normal Saline QD [Every Day] The order appears on the (Medication Administration Record) MAR signed off and timed for 6:30 AM, 2:30 PM and 10:30 PM (3 times daily) The first dose was signed off at 2:30 PM on 3/17/19 and continued to be signed off as administered three (3) times a day for the duration of the month of March.	F 757	**Systemic Change(s):** The facility Policy and Procedure has been reviewed. No revisions are warranted at this time. All nursing staff will 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 of all medications. This includes the administration of Heparin Flushes per physician order. **Monitoring:** The DON is responsible for maintaining compliance. The DON, Unit Manager and/or designee will complete weekly physician orders and MAR audits coinciding with the Care plan calendar 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: May 20, 2019**	

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F 757	Continued From page 99 A second order was initiated on 3/17/19 in addition to the original Heparin Flush order. The order stated: Normal Saline Flush Syringe Flush Midline with saline & Heparin QD [Every Day] Discontinue Date 3/18/19 - That order was timed for 2:00 PM (daily) and signed off on 3/17/19 and 3/18/19 at 2:00 PM then it was discontinued. A third order was initiated on 3/18/19 in addition to the Heparin Flush order. That order stated: Clarification order: Normal Saline Flush Syringe 10 ML Flush Midline with 10 ML NS [normal saline] Q 12hours [Every 12 hours] This order was written on the 18th but not imitated until the 19th and timed for 9:00 AM and 9:00 PM. This order was signed off as administered twice daily for the duration of the month of March. The Physicians order sheet for April read: Heparin flush 10 Units/ML Flush midline with Heparin [an Anti-Coagulant] & Normal Saline QD [Every Day] [Once again the Heparin order was timed and signed off at 6:30 AM 2:30 PM and 10:30 PM for	F 757		

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F 757	Continued From page 100 April 1st-5th] Also on April Physicians Orders was: Clarification order: Normal Saline Flush Syringe 10 ML Flush Midline with 10 ML NS [normal saline] Q 12hours [Every 12 hours] The Normal Saline order was signed off at 9:00 AM and 9:00 PM. On 4/5/19 at 1:45 PM LPN E was asked how many times a day does the Residents Midline get flushed and stated that it was done every shift. She then elaborated that "Night shift does it at 6:30 AM, Day shift at 2:30 PM and Evening shift does it at 10:30 PM." No further information was provided.	F 757		
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	F 758	**F758** **Corrective Action(s):** Resident #24's attending physician was notified that resident #24 received PRN Ativan without an appropriate clinical indication to support its use and no non-pharmacological interventions were tried prior to medication administration. A facility Incident & Accident form was completed for this incident. Resident 86's attending physician was notified that resident #86 received Seroquel without an appropriate medical diagnosis or clinical indication to support its use. Resident #86's physician reviewed resident #86's medication regime and adjusted their psychotropic medications. A facility Incident & Accident form and a medication error form was completed for this incident.	

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F 758	Continued From page 101 psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review and facility documentation the facility staff failed to ensure freedom from unnecessary psychotropic medications for 4 Residents (Resident #24, Resident # 86, #69, and #39) in a survey sample of 30 Residents.	F 758	Resident 69's attending physician was notified that resident #69 received Seroquel without an appropriate medical diagnosis or clinical indication to support its use. Resident #69's physician reviewed resident #69's medication regime and adjusted their psychotropic medications. A facility Incident & Accident form and a medication error form was completed for this incident. Resident 39's attending physician was notified that resident #39 received Seroquel without an appropriate medical diagnosis or clinical indication to support its use. Resident #39's physician reviewed resident #39's medication regime and adjusted their psychotropic medications. A facility Incident & Accident form and a medication error form was completed for this incident. **Identification of Deficient Practice(s) and Corrective Action(s):** All other residents receiving antipsychotic medications may have been potentially affected. The DON, ADON, and/or Pharmacy consultant will review the medication orders of all residents receiving psychotropic/antipsychotic medications to ensure that no unnecessary medications have been ordered and that all antipsychotic medications have an appropriate medical diagnosis and/or clinical indication for their use. 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 102 1. For Resident #24 the facility doctor gave orders for Ativan 0.5 (Milligrams) MG every 6 hours (as needed) PRN for 90 days at a time. 2. For Resident #86 the facility staff gave anti-psychotic medication to a Dementia Resident without a proper diagnosis for use. 3. For Resident #69, the facility staff failed to ensure he was free from Seroquel (an antipsychotic) which is not indicated for use in residents with dementia. 4. For Resident #39, the facility staff failed to ensure she was free from Seroquel, an antipsychotic which is not indicated for use in residents with dementia. The findings include: 1. For Resident #24 the facility doctor gave orders for Ativan 0.5 (Milligrams) MG every 6 hours (as needed) PRN for 90 days at a time. Resident # 24 is an 81 year old woman admitted to facility on 8/1/16 with diagnoses of but not limited to Major Depressive Disorder, Dementia without Behavioral Disturbance, Anxiety Disorder, Diabetes Type II, Congestive Heart Failure, History of Aortocoronary Bypass Graft and Chronic Obstructive Pulmonary Disease. Her most recent (Minimum Data Set) MDS coded as a Quarterly with an (Assessment Reference Date) ARD of 1/10/19 codes Resident as having a (Brief Interview of Mental Status) BIMS score of 15 indicating no cognitive impairment. She is	F 758	**Systemic Change(s):** The facility Policy and Procedure has been reviewed. No revisions are warranted at this time. All nursing staff will be inserviced by the DON and/or regional nurse consultant on the facility policy and procedure for proper administration and monitoring of psychotropic medication to include antipsychotic medications. This includes having an appropriate medical diagnosis or clinical indication for its use, addressing required gradual dosage reductions and the use of non-pharmacological interventions prior to using medication. **Monitoring:** The DON is responsible for maintaining compliance. The DON, Unit Manager and/or designee will complete monthly chart audits coinciding with the Care plan calendar 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: May 20, 2019**	

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F 758	Continued From page 103 also coded as needing 1 person physical assistance with most of her (Activities of Daily Living) ADL's and she uses a wheelchair for locomotion on unit. On 4/3/19 during a clinical record review, it was noted that Resident #24 was receiving 2 psychotropic medications concomitantly including a PRN anti-anxiety medication. The Physician Order Sheets are as follows: Sertraline (generic Zoloft) 150 MG [Anti-Depressant] Lorazepam (generic Ativan) 0, 5 MG [Anti-Anxiety] X 30 days Review of care plan indicated Psych consult PRN. Review of Physicians Orders state Psych Consult PRN. On 4/4/19 at 2:40 PM any Psychiatry or Psychology notes for the Resident was requested. The DON stated she doesn't see a psychiatrist or psychologist she went on to say the facility Physician and/or Nurse Practitioner prescribes the Resident's psychotropic medications. According to the Pharmacy Consult dated Jan 1st - Jan 11th 2019- [Resident Name Redacted] has a PRN order for an anxiolytic, which has been in place for greater than 14 days without a stop date: Lorazepam Recommendation: If the medication cannot be discontinued at this time, current regulations require that the	F 758		

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F 758	Continued From page 104 prescriber document the indication for use, the intended duration of therapy, and the rationale for the extended time period. Thank You Response Required [Box marked with X] I decline the recommendations above and do not wish to implement any changes due to the reason below Rationale: Pt is very anxious. DON provided the last Physician note dated 3/25/19 under Assessment & Plan the NP wrote: 1. Chronic Anxiety- Patient with a history of Dementia, however does contribute to exam. Patient with occasional episodes where she becomes anxious and staff are unable to calm patient or redirect. Patient requires the use of Ativan for chronic anxiety. Will continue the current dose of Ativan 0.5 MG 1 tablet (by mouth) PO (Every) Q6 hours PRN X 90 DAYS. MD/NP to re-evaluate for continued need in 90 days. It should be noted that on the (Medication Administration Record) MAR the Resident received the PRN dose 34 times in the month of March and out of those 34 times, 19 were documented on the MAR under behavior as 0 indicating no behaviors. In addition, the care plan did not address Non-pharmacological interventions. The Administrator was made aware of this on 4/4/19 at the end of day conference. No further information was provided.	F 758		

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F 758	Continued From page 105 2. For Resident #86 the facility staff gave anti-psychotic medication to a Dementia Resident without a proper diagnosis for use. Resident # 86 is an 89 year old woman admitted to the facility on 12/29/17 with diagnoses of but not limited to Cardiac Arrhythmia, Hypertension, Myocardial Infarction (heart attack), and Dementia with behavioral disturbance, and Dysphasia. Resident's most recent (Minimum Data Set) MDS coded as a significant change coded Resident as having a BIMS of 3 indicating severe cognitive impairment. Resident was also coded as needing physical assist of 1 for ADL activities and is uses a wheelchair for locomotion on unit. On 4/4/19, a clinical record review was conducted and it was noted that Resident # 86 had a diagnosis of Dementia and received anti-psychotic medications. The Physicians Orders read: Quetiapine Fumarate [generic Seroquel] 100 MG by mouth every morning for Dementia with Behaviors. Quetiapine Fumarate 25 MG Give 3 tabs PO [by mouth] to equal 75 MG Q [every] Evening for Dementia with Behaviors. On 4/4/19 at 3:00 PM, an interview was conducted with the DON who stated that Resident # 89 has been on Seroquel for a while because of her behaviors. When asked about Pharmacy Reviews and recommendations she	F 758		

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F 758	Continued From page 106 provided some from 2018 through 2019. The Pharmacy Review addressing Seroquel from a year ago (dated 4/1/2018) showed the attending physician agreed with Gradual Dose Reduction The Pharmacist Recommendation was as follows: [Resident name redacted] has dementia and receives Quetiapine Fumarate 100 MG by mouth twice daily for dementia with Behavioral Disturbances. Recommendation: If clinically appropriate please attempt a Gradual Dose Reduction of Quetiapine Fumarate perhaps 100 MG q am[100 MG every morning] and 75 q pm [75 MG every Evening] with the eventual goal of discontinuation, while concurrently monitoring for re-emergence of target behaviors and or withdrawal symptoms. Thank You Rationale for Recommendation: The FDA has issued a black box warning for anti-psychotics posing and increased risk of mortality in elderly individuals with dementia retaliated psychosis. The Beers criteria recommends avoiding anti-psychotics for the behavioral or psychological symptoms of dementia due to increased risk for stroke and mortality unless non-pharma logical options have failed and the residents behaviors are documented as a threat to self or others. For Antipsychotic therapy, it is recommended that a) The prescriber document an assessment of risk verses benefit indicating that it continues to be a valid therapeutic intervention. and b) The	F 758		

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F 758	Continued From page 107 facility Interdisciplinary Team ensures ongoing monitoring of specific target behaviors documentation of 1) a danger to self or others including indications of resident distress 2) desired outcome 3) the efficacy of individualized, non-pharmacological approaches 4) potential adverse consequences and 5) History and outcome of previous attempts. [The box was checked] I accept the recommendations above please implement with the following modifications [Physician wrote] Reduce from 100 MG BID [twice a day] to 50 MG BID [twice daily] No GDR has been attempted since April 2018 According to the (Medication Administration Record) MAR for February 2019 under the nurses initials there is a line for Behaviors they are marked 0 indicating no behaviors for the entire month. According to the (Medication Administration Record) MAR for March 2019 under the nurses initials there is a line for Behaviors they are marked 0 indicating no behaviors for the entire month. According to the (Medication Administration Record) MAR for April 2019 under the nurses initials there is a line for Behaviors they are marked 0 indicating no behaviors thus far this month. The MDS dated 3/8/19 reads: Section E Behavioral Symptoms:	F 758		

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F 758	Continued From page 108 E 0200- A Physical Behavioral symptoms directed toward others (e.g. hitting kicking, pushing, scratching grabbing abusing others sexually) coded O Behavior was not exhibited E 0200 - B Verbal behavioral symptoms directed toward others (threatening others, screaming at others, cursing at others) E 0200- C other behavioral symptoms not directed toward others E 0500 - Impact on Resident Did any identified behaviors put resident at risk for physical illness or injury? Coded No E 0800 Rejection of care Did the resident reject evaluation or care (e.g. bloodwork, taking medicine, ADL assistance) that is necessary to achieve the resident's goals for health and well-being? Do not include behaviors that have already Been addressed 0- Behavior not exhibited E 0900 Wandering Presence and Frequency Has the Resident Wandered? 2- Behavior of this type occurred 4-6 days a week but less than daily. E 1000 does the wandering place the Resident at significant risk of getting into a potentially dangerous place? 1- Yes E 1100 - Does the wandering significantly intrude on the privacy and activities of others? 0- No	F 758		

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F 758	Continued From page 109 It should be noted that wandering was the only behavior listed for this Resident on the MDS. The Administrator was made aware of this on 4/4/19 at the end of day conference. No further information was provided.. 3. For Resident #69, the facility staff failed to ensure he was free from Seroquel (an antipsychotic) which is not indicated for use in residents with dementia. Resident #69, a 59-year old male, was admitted to the facility on 08/30/2013. Diagnoses listed on Resident #69's facility face sheet included but not limited to cerebral infarction, major depressive disorder (recurrent, severe with psych symptoms), unspecified psychosis not due to a substance or known physical condition, and vascular dementia. Resident #69's most recent MDS assessment with an ARD date of 02/22/2019 was coded as a quarterly review. The Brief Interview for Mental Status was coded as 15 out of possible 15 indicative of intact cognition. The Mood Severity Score was 00 and there were no behaviors documented in MDS Section E - Behaviors. On 04/02/2019 at 12:25 PM, Resident #69 was observed in his room, fully dressed, seated in wheelchair watching TV. Resident #69 appeared calm and neat in appearance. On 04/03/2019 at 9:00 AM, Resident #69 was observed resting in bed with the head of the bed up approximately 60 degrees.	F 758		

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F 758	Continued From page 110 The current physician's orders were reviewed. An active entry dated 04/19/2018 documented, "Quetiapine (Seroquel, an antipsychotic) 25 mg by mouth at bedtime, dx (diagnosis) psychosis." According to the National Institute of Mental Health, "The word psychosis is used to describe conditions that affect the mind, where there has been some loss of contact with reality. " The Medication Administration Record for February 2019 was reviewed. Quetiapine 25 mg was signed off as administered each evening in February. Pre-administration behavior count, behavior types, and pre-and-post admin of antipsychotic side effects all documented, "None." The Medication Administration Record for March 2019 was reviewed. Quetiapine 25 mg was signed off as administered at 8:00 PM each evening. Pre-administration behavior types and pre-and-post antipsychotic side effects were documented as "none" for March 2019 with the exception of March 3, 21, and 28. For each of those days, pre-administration behavior count documented "1" but no further information was documented. On 04/03/2019 at 1:55 PM, an interview with a CNA familiar with Resident #69, CNA D, was conducted. When asked if Resident #69 had any behaviors, she stated, "No, he's a nice guy." She then went on to say "but he can be cranky sometimes." On 04/04/2019 at 9:00 AM, Resident #69 was observed eating breakfast in his room. He appeared calm.	F 758		

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F 758	Continued From page 111 The nurse's notes ranging from 01/31/2019 through 03/21/2019 were reviewed. An entry dated 01/21/2019 at 10:14 PM documented, "Resident was cussing at aides and refusing shower. He stated that he had a shower on 7-3(shift), this was not true. His shower is 3-11 (shift). Resident continued to yell and cuss at staff and insist on being put to bed. Resident was put to bed and shower was refused." There were no entries associated with psychotic behaviors. The care plan was reviewed. An undated problem area documented, "[Resident #69] has a diagnosis of psychosis, insomnia and depression and is currently receiving psychotropic meds and is at risk for complications." The goal associated with this problem documented "[Resident #69] will be on therapeutic dose through next review." Approaches associated with this problem included but not limited to "Meds as ordered. Monitor for adverse reactions. Notify MD/NP as needed. Labs as ordered. Results to MD/NP. Allow [Resident #69] to verbalize thoughts/feelings. Monitor for behaviors during med pass and PRN (as needed) for types of behaviors, frequency, response to interventions and notify MD/NP if occur. Non-pharmacologic interventions will be attempted by staff with resident to attempt to alleviate any negative behaviors/emotions. Diversion, right direction, validation, toileting, outside consultation, calm approach, allow to vent feeling." A problem area (undated) documented, "[Resident # 69] will be receiving long-term care services. He has the diagnosis of major depressive disorder recurrent, severe with psych symptoms and psychosis. He can state his own	F 758		

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F 758	Continued From page 112 goals and structures his own days. Prefers to have an unrestricted diet." Approaches associated with this problem included but not limited to "Mental health referrals as needed, redirect from unsafe practices as needed, educate on possible consequences for non-compliance behaviors when dealing with personal care/hygiene issues as needed, redirect and help identify triggers from periods of agitation as needed." "Directly engage with [Resident #69] and seek positive resolutions during periods of emotional distress as needed." There were no psychotic symptoms or triggers listed on the care plan. Social Services notes ranging from 9/04/2018 through 1/10/2019 were reviewed. An entry dated 9-4-2018 at 11:54 a.m. documented "Quarterly: There has been no change to the resident during this quarter in behaviors or mood the resident continues to participate in selected activities and socialize with others at times. The residents family is actively involved in visits the residence on a regular basis. Social Services will continue to provide 1:1 visits and complete referrals as needed for the resident. SSD (Social Services Department) will continue to monitor the resident for changes in behaviors or mood on a daily basis and will make staff aware to notify Social Services if any should occur. An entry dated 12-3-2018 at 10:46 a.m. documented "Annual: There has been no change to the resident during this quarter in behaviors or mood during a look back over the past year. The resident has remained consistent/stable for behaviors and mood. The resident continues to participate and selected activities and socialize with others at times. The resident's family is actively involved and visits the resident on a regular basis. The	F 758		

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F 758	Continued From page 113 resident is pleasant with SSD in interaction. Resident is very close with his sister [name]. Social Services will continue to provide one to one visits and complete referrals as needed for the resident. Social Services will continue to monitor the resident for changes in behaviors are mood on a daily basis and will make staff aware to notify Social Services if any should occur." An entry dated 1/10/2019 4:43 PM documented, "SSD and unit manager met with resident and discussed his alcohol orders. Resident can have alcohol per orders but SSD will monitor his behavior on alcohol from staff reporting/feedback. SSD explained to resident the policies and rights of patients and staff. Resident stated that he will try to not get angry at CNAs and staff and work on his anger control in a more healthy way." A pharmacy consultation report dated 9-19-2018 documented in the "Comments" section "[Resident 69] has received Seroquel 50 mg qd (daily), Sertraline 50 mg qd (daily), Temazepam 30 mg at bedtime, and trazodone 100 milligrams for depression insomnia. CMS regulations require periodic antipsychotic evaluation for clinical appropriateness of a gradual dose reduction." Under the section entitled, "Recommendation", it was documented," if appropriate, please consider a gradual dose reduction (perhaps Seroquel 37.5 mg at bedtime, and/or Temazepam 15 mg at bedtime, and/or Sertraline 25 mg daily and/or trazodone 75 mg at bedtime), while monitoring for a re-emergence of target and/or withdrawal symptoms. Thank you. For antipsychotic therapy, it is recommended that a) the prescriber document and assessment of risk vs benefit, indicating that it continues to be a	F 758		

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F 758	Continued From page 114 valid therapeutic intervention for this individual, and b) the facility dinner disciplinary team ensure that the care plan includes ongoing monitor of specific target behaviors; documentation of 1) a danger to self or others 2) desired outcome 3) the efficacy of individualized non-pharmacologic approaches for potential adverse consequences. Update and adapt the care plan as needed to provide person centered care." Under the section "Physicians response", the following response was selected: "I decline the recommendation above because GDR (gradual dose reduction) is clinically contraindicated for this individual as indicated below." Part two was selected which documented, "The residents target symptoms returned or worsened after the most recent GDR attempt within the facility and a GDR attempt at this time is likely to impair this individual's function or cause psychiatric instability by exacerbating an underlying medical condition or psychiatric disorder as documented below." In the space provided, it was handwritten, "Pt (patient) got Sig (significantly) worse." A time line was requested pertaining to the use of Seroquel and Resident #69's behaviors. The DON provided a timeline on 04/04/2019 at approximately 5:00 PM. The time line indicated that on 04/18/2018, Seroquel was reduced from 50 mg to 25 mg at bedtime. A GDR was declined on 09/2018 due to behaviors. The time line also documented a statement at the bottom of the page: "Behaviors: yells, curses, hits staff, insomnia. Dx (diagnosis): Psychosis." In summary, Resident #69 does not have a diagnosis or behaviors to support the use of an antipsychotic.	F 758		

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F 758	Continued From page 115 On 04/05/2019 at approximately 2:30 PM, the Administrator and DON were notified of findings and they offered no further information or documentation. 4. For Resident #39, the facility staff failed to ensure she was free from Seroquel, an antipsychotic, which is not indicated in residents with the diagnosis of dementia. Resident #39, an 80-year old female, was admitted to the facility on 12/12/2014. Diagnoses listed on the face sheet were silent myocardial ischemia, adult failure to thrive, unspecified dementia with behavioral disturbance, and hypokalemia. Resident #39's most recent MDS (Minimum Data Set) with an ARD (assessment reference date) of 01/21/2019 was coded as a quarterly review. The Brief Interview for Mental Status was not coded but cognitive skills for daily decision-making was coded as severely impaired. Mood Severity score was coded as 00 indicative of no depressive symptoms. Psychosis and other behavioral symptoms were coded as not exhibited. The current physician's orders were reviewed. An entry dated 04/30/2018 documented, "Quetiapine fumarate 12.5 mg by mouth every other day at bedtime for dementia/psychosis." The Medication Administration Record for March 2019 was reviewed. Quetiapine 12.5 mg by mouth every other day at bedtime was signed off administered as ordered. Pre-administration behavior counts and types were documented at	F 758		

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F 758	Continued From page 116 "0" meaning none. A pharmacy consultation report dated 2/11/2019 documented in the Comments section, "[Resident #39 has dementia and receives an anti-psychotic, Quetiapine 12.5 mg QOD (very other day)." Under the header "Recommendation", it was documented, "If clinically appropriate, please consider a trial discontinuation, while concurrently monitoring for re-emergence of target and/or withdrawal symptoms. Thank you." Under the header "Rationale for recommendation", it was documented, "An FDA box warning identifies an increased risk of mortality and elderly individuals receiving an anti-psychotic for behavior or psychiatric symptoms of dementia (BPSD). The 2012 Beers Criteria recommend avoiding antipsychotics for BPSD due to an increase risk for stroke and mortality unless non-pharmacological options have failed and the patient's behaviors are documented as a threat to self or others." Under the header "Physician's Response", it was documented, "I decline the recommendation above and do not wish to implement any changes due to the reasons below." In the space provided, a handwritten note documented, "Pt stable at present dose" signed by physician dated 02/12/2019. On 04/04/2019 at 10:35 AM, Resident #39 was observed in activity room seated in her Broda chair. Resident #39's eyes were closed and head was slightly tipped to one side. An interview with Employee J in Activities was conducted. When asked about activities for Resident #39,	F 758		

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F 758	Continued From page 117 Employee J stated Resident #39 does small group activities, listens to music, sensory stimulation, and "one-on-ones." She also stated it is usual that Resident #39 would sleep during activity time like she is sleeping now. CNA J entered the Activity room joined the conversation and stated she was familiar with Resident #39. When asked if she usually sleeps like this, CNA J stated, "No, not really. Her eyes are bright and she will talk to you." When asked if Resident #39 had any behaviors, she stated Resident #39 had "no acting out." Employee J added "[Resident #39] is funny." CNA J attempted to talk with Resident #39, held her hand, and attempted to wake her up but was unable to do so. Employee J told CNA J to "take her back to her room so she can rest." On 04/04/2019 at approximately 10:40 AM, CNA J returned Resident #39 to her room. An interview in the hall near Resident #39's room with LPN E was conducted. LPN E stated she was familiar with Resident #39. When asked about behaviors, she stated Resident #39 does not have behaviors and stated, "She sleeps a lot." LPN E also stated that years ago, Resident #39 had to wear a helmet because she would "bang her head on things" but "not deliberately." LPN E stated Resident #39 no longer does that. When asked what medications Resident #39 had recently, LPN E and this surveyor looked at the Medication Administration Record. Resident #39 had received two anti-hypertensives, a supplement, a proton pump inhibitor, and a laxative this A.M. and Resident #39 received Seroquel 12.5 mg by mouth at bedtime last evening. On 04/04/2019 at 10:50 AM, CNA J exited Resident #39's room and stated that Resident	F 758		

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F 758	Continued From page 118	F 758		

#39 woke up a bit when she transferred her back to bed and went back to sleep again. LPN E and this surveyor entered Resident #39's room. Resident #39 was sleeping supine with head of bed elevated approximately 30 degrees. LPN E was unable to wake Resident #39 up. LPN E stated, "I'll check her vital signs." LPN E took Resident #39's blood pressure and pulse (123/75, 50, respectively). When asked if Resident #39 is sometimes difficult to wake up like this, she stated, "Yes."

On 04/04/2019 at 3:30 PM, an interview with the DON was conducted. When asked if Resident #39 exhibited any behaviors, she stated that in the past, Resident #39 had to wear a helmet because she would hit her head on the wall. She also wore elbow pads and knee pads. When asked about current behaviors, she stated that Resident #39 can be "combative" and "refuses care."

A medical management note completed by a nurse practitioner dated 3/30/2019 documented under "Mental status exam", "Upon arrival, patient sitting upright in wheelchair upon arrival. Patient has eyes closed but appears awake with body movements. Patient dressed appropriately and appears hygienically clean. Has flat appearing mood demeanor. Patient engaged in conversation with soft irrelevant mumbling that is mostly not understandable. Patient did provide a few one word answers. Oriented to self only. Insight limited judgment is impaired thought process he's a logical rambling unable to focus or follow interview effect flat no evidence of abnormal or psychotic thinking, perceptual disturbances, suicidal, violent or homicidal thoughts" Under the header "Plan of care", it was

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F 758	Continued From page 119 documented, "Please see GDR recommendation. Please continue to monitor patient. Suggest assisting patient with good sleep hygiene practices. For example, try to keep patient mentally occupied during the day, it here to a structured daily schedule, and provide opportunities for physical exercise. Also suggest assisting patient and physical needs, addressing pain, constipation, and other physical discomfort is crucial in preventing agitation, confusion, and other behavioral disturbances." Under the header "GDR Rationale", it was documented, "Pt history of psychotic symptoms that are difficulty to control. Pt seem stable at this time. GDR are not recommended. Under the header "Threat Statement", it was documented, "Patient currently NOT a danger to self or others." On 04/05/2019 at approximately 2:30 PM, the Administrator and DON were notified of concerns and offered no further information or documentation.	F 758		
F 812 SS=D	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices.	F 812	**F812** **Corrective Action(s):** C.N.A. A & C.N.A. B involved with the lunch pass and handling prepared food without gloves have received one-on-one inservice training from the DON on proper infection control practices and the proper handling of prepared food when assisting residents with their meals. A Facility Incident & Accident form has been completed for this incident. **Identification of Deficient Practices & Corrective Action(s):** The DON and/or ADON will monitor the lunch meal pass for 3 days to identify any negative findings with the tray pass or meal set up. All negative findings will be corrected at time of discovery. A facility Incident and Accident form will be completed for each negative finding identified.	

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F 812	Continued From page 120 (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on staff interview and observation, the facility staff failed to serve food in accordance with professional standards for food service safety, for two residents (Resident #63, Resident #98) in a survey sample of 30 residents. 1. For Resident #63, the facility staff failed to serve food in a sanitary manner. 2. For Resident #98, the facility staff failed to serve food in a sanitary manner. The findings included: 1. For Resident #63, the facility staff failed to serve food in a sanitary manner. Resident #63, a 68-year old, was admitted to the facility on 04/02/2015. Diagnoses included but were not limited to Non-ST elevation (NSTEMI) myocardial infarction, heart failure, cerebral infarction, hypertension, diabetes, and hemiplegia. Resident #63 ' s most recent Minimum Data Set had an Assessment Reference Date (ARD) of 02/18/2019 and was coded as a quarterly assessment. Resident #63 was coded with a Brief Interview of Mental Status (BIMS) score of 3 out of possible 15 indicative of severe cognitive	F 812	**Systemic Change(s):** Current facility policy & procedure has been reviewed and no changes are warranted at this time. All nursing staff will be inserviced on the policy and procedure for proper meal tray pass and assistance. To include proper hand hygiene and wearing gloves prior to touching resident food items. **Monitoring:** The DON, ADON or Unit Manager will monitor 3 random meal passes a week to monitor for compliance. Any negative findings will be corrected at time of discovery and disciplinary action will be taken as warranted. The results of these audits will be reported to the Quality Assurance Committee for review, analysis, & recommendations for change in facility policy, procedure, and/or practice. **Completion Date: May 20,2019**	

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F 812	Continued From page 121 impairment. Functional status for bed mobility, transfers, dressing, and personal hygiene were all coded as requiring extensive assistance from staff. Functional status for eating was coded as requiring supervision from staff. On 4/3/19 at 11:38pm during observation of lunch service in the dining room, CNA A removed Resident #63's sandwich from the bag with her ungloved hands. Employee C, Dietary Manager then walked over to CNA A and talked to her. When Employee C was asked what she told her, Employee C stated "I told her to dump the bread out, we don't touch their food." On 4/4/19 at 3:44pm, an interview was conducted with the Director of Nursing regarding meal service and she stated her expectation is that "staff wash their hands and put gloves on if they are going to touch food." The Administrator and DON were made aware of the facility staff failing to serve food in a sanitary manner during the end of day meeting held on 4/4/19 at 5:30pm. No further information was provided. 2. For Resident #98, the facility staff failed to serve food in a sanitary manner. Resident #98, was admitted to the facility on 2/15/19. The resident's diagnoses included but were not limited to: heart failure, diabetes, CVA (cardiovascular accident), dementia and depression. Resident #98's most recent MDS (minimum data	F 812		

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F 812	Continued From page 122 set) (an assessment tool) with an ARD (assessment reference date) of 2/22/19 was coded as an admission assessment. The resident was coded as requiring limited assistance with transfers and personal hygiene. Resident #98 was coded as requiring extensive assistance for toileting and totally dependent on staff for bathing. On 4/3/19 at 11:41am, during observation of lunch in the dining room, CNA B was observed to remove Resident #98's plate from the tray with her thumb on the top of the plate, where food was located. On 4/4/19 at 3:44pm an interview was conducted with the Director of Nursing regarding meal service and she stated her expectation is that "staff wash their hands and put gloves on if they are going to touch food." The Administrator and DON were made aware of the facility staff failing to serve food in a sanitary manner during the end of day meeting held on 4/4/19 at 5:30pm. No further information was provided.	F 812		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted	F 842	F842 Corrective Action(s): Resident #63's Code status has been clarified and her medical record, comprehensive care and closet care plan was corrected to reflect her DNR code status. A facility incident and accident form has been completed for this incident.	

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F 842	Continued From page 123 to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, 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	F 842	**Identification of Deficient Practices & Corrective Action(s):** All other residents may have potentially been affected. A 100% audit of all resident medical records will be conducted by the DON, ADON and/or Medical Records clerk to identify residents at risk for an inaccurate medical record filing and missing or inaccurate code status documentation. All negative findings will be clarified and/or corrected at time of discovery and the attending physician notified of the incident. A facility Incident & Accident form will be completed for each negative finding. **Systemic Change(s):** The facility policy and procedure has been reviewed and no changes are warranted at this time. All licensed nursing staff and Medical Records clerk will be inserviced by the DON or regional nurse consultant on the clinical documentation standards per facility policy and procedure. This training will include the standards for maintaining accurate medical records and clinical documentation to include accurate documentation of medical information in the appropriate medical record and maintaining DNR forms and advance directives in the resident medical record.	

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	495300	A. BUILDING _____ B. WING _____	C 04/05/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HALL KING GEORGE	10051 FOXES WAY KING GEORGE, VA 22485

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F 842	Continued From page 124 (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, clinical record review, and facility documentation, the facility staff failed to maintain an accurate clinical record for one resident (Resident #63) in a sample size of 30 residents. The Resident #63's DNR status was inaccurate. The findings included: Resident #63, a 68-year old female, was admitted to the facility on 04/02/2015. Diagnoses include but not limited to Non-ST elevation (NSTEMI) myocardial infarction, heart failure, cerebral infarction, hypertension, diabetes, and hemiplegia. Resident #63's most recent Minimum Data Set had an Assessment Reference Date (ARD) of 02/18/2019 and was coded as a quarterly	F 842	**Monitoring:** The DON is responsible for maintaining compliance. The DON, ADON and/or designee will perform weekly chart audits coinciding with the care plan calendar to monitor for compliance. Any/all negative findings will be clarified and corrected at time of discovery and disciplinary action will be taken as needed. The results of this audit will be provided to the Quality Assurance Committee for analysis and recommendations for change in facility policy, procedure, and/or practice. **Completion Date: May 20, 2019**	

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F 842	Continued From page 125 assessment. Resident #63 was coded with a Brief Interview of Mental Status (BIMS) score of 3 out of possible 15 indicative of severe cognitive impairment. Functional status for bed mobility, transfers, dressing, and personal hygiene were all coded as requiring extensive assistance from staff. Functional status for eating was coded as requiring supervision from staff. On 04/02/2019 at 4:15 PM, the current physician's orders in the electronic health record were reviewed. A physician's order dated 11/25/2018 documented, "Resident Hospice care as of 11/16/18 [hospice company name]." A physician's order dated 11/26/2018 documented, "DNR (do not resuscitate)." The care plan in the electronic health record was reviewed. A problem onset dated 04/02/2015 documented, "[Resident #63] has an inability to perform ADLs (Activities of Daily Living) independently secondary to muscle spasms, HTN (hypertension), CVA (cerebral vascular accident), hemiparesis, RAKA (right above-the-knee amputation), depression. Resident refuses meals & supplements at time." (sic) One "approach" documented for this problem documented, "Full code." On 04/02/2019 at 4:40 PM, an interview with CNA C was conducted. When asked where a CNA would find out information about how to care for Resident #63, she stated she looks at "the care plan" that is posted on the inside of Resident #63's closet door. CNA C and this surveyor then entered Resident#63's room and CNA C then opened Resident #63's closet door to show a document entitled, "CNA Care Plan" which included Resident #63's name and room number	F 842		

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F 842	Continued From page 126 (handwritten). It also included Resident #63's needs pertaining to ADLs. On the left hand side of the paper, it was documented, "Information is current as of this date: 10-31-18." On the top left side of the CNA Care Plan, it was documented "Full code." CNA C then closed the closet door. This surveyor then asked CNA C what Resident #63's code status was and she stated, "She's a full code." A copy of the CNA Care Plan was requested and CNA C stated she would have to ask the nurse. On 04/02/2019 at approximately 4:45 PM, this surveyor and CNA C walked to the nurse's station. After speaking with a nurse, CNA C went to Resident #63's room to retrieve the CNA Care Plan on the closet door. The staff nurse got Resident #63's hard chart and displayed the Durable Do Not Resuscitate Order and stated to this surveyor, "Do you realize this resident is on hospice and she's a DNR?" CNA C returned with the CNA Care Plan and handed it to LPN B. LPN B looked at the document and stated, "It (closet care plan) wasn't updated." A copy of the Durable Do Not Resuscitate order and the electronic care plan were requested. On 04/02/2019 at 4:55 PM, a Durable Do Not Resuscitate document was provided. It was dated 11/20/18 and signed by physician, responsible party, and a witness. A paper copy of the electronic care plan was provided. Under the problem entitled, "Resident #63] has an inability to perform ADLs (Activities of Daily Living) independently secondary to muscle spasms, HTN (hypertension), CVA (cerebral vascular accident), hemiparesis, RAKA (right above-the-knee amputation), depression: Resident refuses meals & supplements at time." ,"Full Code" was crossed	F 842		

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F 842	Continued From page 127 out and "DNR" was added (handwritten and not dated or initialed). Employee L stated the most updated version of the care plan is on paper kept on the unit. Employee L stated electronic care plans (what is seen on the computer) are updated quarterly. On 04/05/19 at 10:10 AM, an interview with Employee H, the MDS/Care Plan Coordinator was conducted. When asked about how to determine when an intervention on a care plan was implemented, Employee H stated, "We don't date interventions." She went on to say the intervention either continues or it would be resolved. When asked about a resolved intervention, Employee H stated, "I would delete it." Employee H stated the paper copy care plans are kept in a book on the unit, updated on the paper, and eventually entered into the computer. When asked about the CNA (closet) care plans, Employee H stated closet care plans are also updated as needed. The facility policy entitled, "Advanced Directives" was reviewed. Section 7 documented, "Information about whether or not the resident has executed an advanced directive shall be displayed prominently in the medical record." Section 10 documented, "The plan of care for each resident will be consistent with his or her documented treatment preferences and/or advanced directive." In summary, there was conflicting information regarding Advanced Directives on the electronic care plan, the paper copy care plan, and the CNA closet care plan for Resident #63. On 04/05/2019 at approximately 2:30 PM, the	F 842		

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F 842	Continued From page 128 DON and Administrator were notified of findings and they offered no further information or documentation.	F 842		