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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{E 000}	Initial Comments	{E 000}		
{F 000}	INITIAL COMMENTS An unannounced Medicare/Medicaid revisit survey was conducted 1/2/2020 through 1/3/2020. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The census in this 142 certified bed facility was 114 at the time of the survey. The survey sample consisted of 19 current Resident reviews (Residents #101 through #119).	{F 000}		
{F 580} SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)	{F 580}		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 01/30/2020

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{F 580}	Continued From page 1	{F 580}		

(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician.
(iii) The facility must also promptly notify the resident and the resident representative, if any, when there is-
(A) A change in room or roommate assignment as specified in §483.10(e)(6); or
(B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section.
(iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s).

§483.10(g)(15)
Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9).
This REQUIREMENT is not met as evidenced by:
Based on staff interview and clinical record review, the facility staff failed to notify the change in condition for 1 of 19 residents in the survey sample for Resident #104 as evidenced by Resident #104 experienced a blood sugar that was 403 and the physician was not notified of this blood sugar.

The findings included:

The facility staff failed to notify the physician of an

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elevated blood sugar of 403 for Resident #104.

Resident #104 was a resident in the nursing facility at the time of this survey which occurred on 1/2 through 1/3/2020. The quarterly MDS (Minimum Data Set) with an ARD (Assessment reference Date) 10/18/19 coded the resident as requiring extensive assistance from 1-2 staff members for dressing and personal hygiene and also be totally dependent on 1 staff member for bathing. Resident 104 had the following diagnoses of, but not limited to anemia, diabetes, heart failure and high blood pressure.

During the clinical record review on 1/2 and 1/3/2020, the surveyor noted that on 12/20/19 at 4:30 pm, Resident #104's blood sugar was documented as being 403 on the MAR (Medication Administration Record).

The surveyor also reviewed the physician orders sheets which read in part, " ...Notify MD (medical doctor) if BS (blood sugar) < (less than) 60 or > (greater than) 400 ..." This order was written on 5/31/19.

The surveyor reviewed the nursing notes for the date of 12/20/19 and did not note any documentation that the physician was notified on this date at 4:30 pm for a blood sugar being 403.

The surveyor interviewed the DON (director of nursing) on 1/3/2020 at 11 am. The surveyor asked what her expectations of the nursing staff were when a BS of 403 was obtained. The DON stated, "I would expect them to notify the doctor and this resident had orders to notify the doctor if the BS was greater than 400." The surveyor asked if the nursing staff notify the physician for

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{F 580}	Continued From page 3 this BS. The DON stated, "I would have to look into it." The surveyor asked the DON if any information concerning the reporting of this BS was done, could she bring me a copy of that nurse' note. The DON verbalized understanding of this request. The surveyor notified the administration team which consisted of the administrator, DON and regional nurse of the above documented findings on 1/3/2020 at 3:25 pm. The surveyor asked the DON if any additional information had been found concerning this BS. The DON stated, "I didn't find any." No further information was provided to the surveyor prior to the exit conference on 1/3/2020 at 6:30 pm.	{F 580}		
{F 684} SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review, and facility document review, the facility staff failed to ensure that residents receive treatment and care for the highest practicable well-being for 2 of 19 residents (#113, and #110). The facility staff	{F 684}		

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failed to administer medications and a tube feeing as ordered by the physician.

The findings included:

1. When Resident #113 was readmitted to the facility the nursing staff failed to enter the residents new orders into the electronic record. This resulted in Resident #113 receiving medications that were not ordered by the physician, not receiving new medications, and receiving the wrong tube feeding. The resident did not have any adverse reactions.

The clinical record was reviewed on 01/02-01/03/2020.

The Residents face sheet included the diagnoses of methicillin resistant staph aureus, chronic pain, chronic obstructive pulmonary disease, schizoaffective disorder depressive type, generalized anxiety, major depressive disorder, delusional disorder, and other specified mental disorders due to known physiological condition.

This face sheet included information to indicate Resident #113 was their own responsible party.

Section C (cognitive patterns) of the residents quarterly MDS (minimum data set) assessment with an ARD (assessment reference date) of 09/05/19 included a BIMS (brief interview for mental status) summary score of 10 out of a possible 15 points.

The facility provided the surveyor with a copy of the residents CCP (comprehensive care plan). This CCP included the intervention "Give medications as ordered."

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The Residents clinical record included readmission orders from a local hospital dated December 31, 2019. These readmission orders included orders for apixaban 5 mg every 12 hours, lansoprazole 30 mg every 12 hours, phenol spray every 6 hours, gabapentin 300 mg every 12 hours, cholecalciferol 2,000 units 1X a week, quetiapine fumarate 50 mg daily, terazosin 2 mg daily, sertraline 100 mg daily, levothyroxine 125 mcg daily, diclofenac gel 2 grams every 6 hours, clonazepam 1 mg every 6 hours, benztropine 0.5 mg every 12 hours, senna/docusate 1 tab every 12 hours, lactulose 10 grams at bedtime, and the enteral feed order isosource 1.5.

A review of the Residents MAR (medication administration records) for December 31, 2019 revealed that the facility nursing staff had administered benztropine at 9:00 p.m., ferrous sulfate at 5:00 p.m. and 9:00 p.m. (no order), fluphenazine at 9:00 p.m. (no order), terazosin at 9:00 p.m., chlorhexidine at 5:00 p.m. (no order), senna at 5:00 p.m., trazadone at 5:00 p.m. (no order), clonazepam 1 mg at 5:00 p.m. and 9:00 p.m., (order was for every 6 hours), and the enteral feed twocal HN (high nitrogen) (no order). No other medications were documented as being administered.

For January 1, 2020 Resident #113 did not receive their physician ordered benztropine at 9:00 p.m., senna at 9:00 p.m., lactulose at bedtime, quetiapine 50 mg at 9:00 a.m. or quetiapine 100 mg at bedtime, apixaban at 9:00 p.m., lansoprazole suspension at 9:00 p.m., phenol at 6:00 a.m., 6:00 p.m., or 12:00 a.m., gabapentin at 9:00 a.m. or 9:00 p.m.,

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cholecalciferol was ordered 1x week and was signed for as being administered on 01/01/2020 and again on 01/03/2020, diclofenac gel at 6:00 a.m., 6:00 p.m., or 12:00 a.m., and clonazepam at 6:00 a.m., 6:00 p.m. or 12:00 a.m.

For January 2, 2020 the nursing staff had signed they had administered the residents 9:00 a.m. gabapentin. At 9:00 p.m. the facility nursing staff documented this medication was not given and an order was obtained on 01/02/2020 at 11:50 a.m. to hold this medication as a "...hard script for medication" was needed by the pharmacy.

On 01/03/2020 at 9:20 a.m., the surveyor interviewed pharmacy tech #1 via phone. During this interview the pharmacy tech verbalized to the surveyor that Resident #113's gabapentin was sent to the facility yesterday 01/02/2020 and signed for the facility staff at 5:44 p.m. Indicating it would have been available for administration at 9:00 p.m.

On 01/03/2020 at 9:30 a.m., the executive director provided the survey team with a copy of the facility control box list. A review of this document revealed that the medication gabapentin was available in this box for administration.

On 01/03/2020 at 9:30 a.m., Resident #113 verbalized to the surveyor that they were receiving their medications.

On 01/03/2020 at 9:35 a.m., the surveyor and LPN (licensed practical nurse) #2 checked the medication cart for the gabapentin. The control box on the medication cart contained 60 capsules of this medication.

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The policy regarding medication unavailability was requested by the survey team but was not received.

On 01/03/2020 at 1:25 p.m., during a meeting with the administrator, DON (director of nursing), and regional director of clinical services, these staff were asked if there had been medication errors made on Resident #113. The DON replied yes and that the nurse(s) had been reeducated.

On 01/03/2020 at 2:05 p.m., LPN #1 provided the surveyor with a copy of an "MD/Nursing Communications" form addressed to the facility physician. This form read in part, Nursing Concerns: Admitted ____ and was given Iron 220/44, Fluphenazine 5 mg, Terazosin 2 mg, Chlorhexidine Gluconate 0.12% 15 ml X2, Trazodone 50 mg, and 2 cal 1 can X2 from his old orders. No adverse reactions. Not given Seroquel 100 mg, Zoloft 100 mg, Apixaban 5 mg, Lactulose 10 grams, Osmolite @ 95 CC/H (hour), Gabapentin 300 mg, Clonazepam 1 mg X2, Diclofenac gel 1% X2, Phenol Liquid 1.4%. This form had a time date stamp of January 2, 2020 at 3:33 p.m. On January 3, 2020, the physician had transcribed "Ok" onto this form.

On 01/03/2020 at 2:06 p.m., during an interview with LPN #1, LPN #1 verbalized to the surveyor that when Resident #113 was readmitted to the facility an agency nurse was working. LPN #1 stated that they had went over the medications with this agency nurse and told them to discontinue the resident's previous medications and start from scratch with the new orders. LPN #1 stated the agency nurse did not do that and when they returned on January 1, 2020 the

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residents old orders had popped up in the computer. LPN #1 stated the agency nurse had assumed someone had put the residents orders in even though I had told them they had to put all of the residents new orders into the computer. When LPN #2 came in, I told them to discontinue what was in the computer and get the new orders in there ASAP (as soon as possible).

On 01/03/2020 at 2:20 p.m., during an interview with LPN #2, LPN #2 verbalized to the surveyor that when they came into work on January 1, 2020 they relieved the agency nurse who was on duty when the resident was admitted. (This agency nurse had worked a double shift). LPN #2 stated they were told all the orders were in. However, the admission had not been done and when they tried to put the new orders into the computer system something was wrong. The agency nurse had completed a paper MAR. LPN #2 stated they had administered the residents medications using the paper MAR and checked this against the admission orders. LPN #2 stated they were also made aware that the resident did not have a hard script for their gabapentin.

No further information regarding this issue was provided to the survey team prior to the exit conference on 01/03/2020.

2. The facility staff failed to administer Ativan (Lorazepam: an antianxiety medication) per physician orders to resident #110.

Resident #110's "TRANSFER/DISCHARGE REPORT" noted the resident's diagnoses included, but were not limited to, anxiety disorder, catatonic schizophrenia, dysphagia (difficulty swallowing), epilepsy (seizure disorder), Parkinson's disease, brief psychotic disorder,

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functional quadriplegia, and major depressive disorder.

The clinical record for Resident #110 was reviewed on 01/02/2020 and 01/03/2020. The most recent MDS (minimum data set) was an annual assessment with an ARD (assessment reference date) of 11/22/19. Section C of the MDS assessed cognitive levels and Resident #110 had a BIMS (brief interview for mental status) score of 13 out of 15.

The current care plan for Resident #110 documented one of the focus areas as, "I get nervous and anxious Around[sic] large crowds, In[sic] noisy areas." The interventions included but were not limited to, "Please give me my medications that help me with my anxiety."

Resident #110's physician orders included but were not limited to, "Lorazepam Tablet 1 MG Give 1 tablet via G-Tube four times a day for agitation." The resident's MAR (medication administration record) noted Resident #110 received the medication as ordered during December 2019 except the dose due at 9:00 p.m. on 12/19/19. That dose had a documented "7" on the MAR which referred to seeing a subsequent nurse's progress note. A nurse's progress note dated 12/19/19 at 11:01 p.m. referenced the evening dose of Lorazepam and read, "medication not currently available, pharmacy is aware and will bringing [sic] it on the next run." Resident #110's clinical record contained a handwritten "MD/Nursing Communications" form that read under Nursing Concerns: "Ativan dose 12-19-19 @ 2100 (9:00 p.m.) not given. Pharmacy sending." The communication form was signed by the physician as having "noted" this

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{F 684}	Continued From page 10 information. One surveyor spoke with the facility's pharmacy and the pharmacy staff member acknowledged a lorazepam prescription was sent for Resident #110 on 12/19/19 at 7:57 p.m. The pharmacy staff member stated that due to travel times, the prescription was not signed for by a facility's employee until 12/20/19 at 12:40 a.m. The facility's executive director provided a list of medications the facility's "control box" contained. One locked and secured control box was kept in the facility to be accessed when a resident was in need of an ordered medication not available in the medication cart. The control box list included the medication "Lorazepam 0.5 mg (Ativan)" and showed a total of 6 (six) pills. At 9:57 a.m. on 01/03/2020, the facility's director of nursing (DON) was interviewed related to Resident #110's lorazepam not being given on 12/19/19 at 9:00 p.m. The DON acknowledged the medication was available in the control box and should have been given when it was scheduled to be given. The DON informed the surveyor that the nurse who signed the MAR noting that the medication had not been given and was being sent from the pharmacy was an agency nurse and not working at the facility at the time. No further information was provided to the survey team prior to the exit conference.	{F 684}		
{F 755} SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency	{F 755}		

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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

§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, facility document review and clinical record review, the facility staff failed to provide a physician ordered medication available for administration for 1 of 19 residents in the survey sample as evidenced by not having Clonazepam available to be administrated to Resident #104 on 12/8/19 as ordered by the physician.

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{F 755}	Continued From page 12	{F 755}		

The findings included:

Resident #104 was a resident in the nursing facility at the time of this survey which occurred on 1/2 through 1/3/2020. The quarterly MDS (Minimum Data Set) with an ARD (Assessment reference Date) 10/18/19 coded the resident as requiring extensive assistance from 1-2 staff members for dressing and personal hygiene and also be totally dependent on 1 staff member for bathing. Resident 104 had the following diagnoses of, but not limited to anemia, diabetes, heart failure and high blood pressure.

During the clinical record review on 1/2 and 1/3/2020, the surveyor noted documentation on the December 2018 MAR in which the nursing staff had coded the physician ordered medication with a "3" for Clonazepam 0.5 mg (milligram)to be given three times a day for anxiety. This occurred on 12/8/19 at 9 am and 1 pm. According to the chart codes at the bottom of the MAR, a "3" represents "Hold/See Nurse Note".

The surveyor reviewed the nursing notes for 12/8/19 and a nursing note timed for 13:24 (1:34 pm) which read, "Notified pharmacy to obtain medication. Held this shift. MD (medical doctor) aware. Okay to hold until arrives from pharmacy. Pharmacy states it was ordered and is on the way to the facility at this time."

On 1/3/2020 at 10 am, the surveyor notified the DON (director of nursing) and regional nurse of the above documented findings. The surveyor requested a copy of the "STAT Box" contents that is on the nursing unit for Resident #104.

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{F 755}	Continued From page 13 At 10:15 am, the surveyor received the copy of the contents in the "STAT Box". The content page did list Clonazepam 0.5 mg as being available to be given to the resident. At 3:25 pm, the administrator, DON and regional nurse were notified of the above documented findings concerning the availability of Clonazepam. No further information was provided to the surveyor prior to the exit conference on 1/3/2020 at 6:30 pm.	{F 755}		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and	F 758		

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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 document review, the facility staff failed to ensure that
psychotropic medications necessary to treat a specific condition as diagnosed and documented in the clinical record
followed physician orders in regards to administering antipsychotic and psychotropic medications for 1 of 3 residents (Resident #113) and failed to monitor side effects of medications for 2 of 3 residents (Residents #106 and #110).

The findings included:

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1. For Resident #113, when the resident was re-admitted to the facility the nursing staff failed to enter the residents new orders into the computer system resulting in the resident receiving fluphenazine (anti-psychotic) and trazodone (anti-depressant) without a physicians order and being administered clonazepam at 5:00 and 9:00 p.m. when the order read every 6 hours. The resident had no adverse reactions to the medications.

The clinical record was reviewed on 01/02-01/03/2020.

The Residents face sheet included the diagnoses schizoaffective disorder depressive type, generalized anxiety, major depressive disorder, delusional disorder, and other specified mental disorders due to known physiological condition.

This face sheet included information to indicate Resident #113 was their own responsible party.

Section C (cognitive patterns) of the residents quarterly MDS (minimum data set) assessment with an ARD (assessment reference date) of 09/05/19 included a BIMS (brief interview for mental status) summary score of 10 out of a possible 15 points.

The facility provided the surveyor with a copy of the residents CCP (comprehensive care plan). This CCP included the intervention "Give medications as ordered."

When Resident #113 was readmitted to the facility, the physician did not reorder the medications fluphenazine and trazodone and the

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medication clonazepam was ordered every 6 hours.

A review of the residents MAR's (medication administration records) for December 31, 2019 revealed that the nursing staff had administered fluphenazine at 9:00 p.m. and trazadone at 5:00 p.m. without a physicians order. The nursing staff also administered clonazepam at 5:00 p.m. and 9:00 p.m. when the order was for every 6 hours.

On 01/03/2020 at 9:30 a.m., Resident #113 verbalized to the surveyor that they were receiving their medications.

On 01/03/2020 at 1:25 p.m., during a meeting with the administrator, DON (director of nursing), and regional director of clinical services, these staff were asked if there had been medication errors made on Resident #113. The DON replied yes and that the nurse(s) had been reeducated.

On 01/03/2020 at 2:05 p.m., LPN (licensed practical nurse) #1 provided the surveyor with a copy of an "MD/Nursing Communications" form addressed to the facility physician. This form read in part, Nursing Concerns: Admitted ____ and was given...Fluphenazine 5 mg...Trazodone 50 mg...Not given...Clonazepam 1 mg X2..." This form had a time date stamp of January 2, 2020 at 3:33 p.m. On January 3, 2020, the physician had transcribed "Ok" onto this form.

On 01/03/2020 at 2:06 p.m., during an interview with LPN #1, LPN #1 verbalized to the surveyor that when Resident #113 was readmitted to the facility an agency nurse was working. LPN #1 stated they had went over the medications with this agency nurse and told this nurse to

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discontinue the resident's previous medications and start from scratch with the new orders. LPN #1 stated the agency nurse did not do that and when they returned on January 1, 2020 the resident's old orders had popped up in the computer. LPN #1 stated the agency nurse had assumed someone had put the residents orders in even though I had told them that they had to put all of the residents new orders into the computer. When LPN #2 came in, I told them to discontinue what was in the computer and get the new orders in there ASAP (as soon as possible).

On 01/03/2020 at 2:20 p.m., during an interview with LPN #2, LPN #2 verbalized to the surveyor that when they came into work on January 1, 2020 they relieved the agency nurse who was on duty when the resident was admitted. (This agency nurse had worked a double shift). LPN #2 stated they were told all the orders were in. However, the admission had not been done and when they tried to put the new orders into the computer system something was wrong. The agency nurse had completed a paper MAR. LPN #2 stated they had administered the residents medications using the paper MAR and checked this against the admission orders.

No further information regarding this issue was provided to the survey team prior to the exit conference on 01/03/2020.

2. The facility staff failed to monitor Resident #106 for side effects associated with the use of Effexor (an antidepressant) and failed to monitor Resident #110 for side effects associated with the use of Citalopram (an antidepressant), Haloperidol (an antipsychotic), Lorazepam (an antianxiety) and Risperdal (an antipsychotic).

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a. Resident #106's "ADMISSION RECORD" noted the resident had diagnoses that included, but were not limited to, hemiplegia (paralysis on one side of the body) and hemiparesis (muscle weakness or partial paralysis on one side of the body) following unspecified cerebrovascular disease (affecting blood supply to the brain, stroke) affecting left non-dominant side, chronic kidney disease stage 2, dysphagia (difficulty swallowing), altered mental status, aphasia (difficulty speaking and/or understanding speech), major depressive disorder, and hypertension.

The clinical record for Resident #106 was reviewed on 01/03/2020. The most recent MDS (minimum data set) was a modified quarterly assessment with an ARD (assessment reference date) of 10/23/19. Section C of the MDS assessed cognitive patterns and Resident #106 had a BIMS (brief interview for mental status) score of 14 out of 15.

The current plan of care for Resident #106 documented one of the focus areas as "Potential for drug related complications associated with use of psychotropic medications related to: Anti-Depressant medication." The care plan's interventions included but were not limited to, "Observe for side effects and report to physician: Antidepressant-Sedation, drowsiness, dry mouth, blurred vision, urinary retention, tachycardia, muscle tremor, agitation headache, skin rash, photo sensitivity and excess weight gain."

Resident #106's physician orders included but were not limited to, "Venlafaxine HCl 75 MG (milligram) Give 1 tablet by mouth two times a day for major depressive disorder." The resident's MAR (medication administration

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record) included documentation that Venlafaxine had been administered twice a day during the month of December 2019 and January 1st and 2nd, 2020. The MAR did not include evidence of monitoring for side effects of Venlafaxine.

3. Resident #110's "TRANSFER/DISCHARGE REPORT" noted the resident's diagnoses included, but were not limited to, anxiety disorder, catatonic schizophrenia, dysphagia (difficulty swallowing), epilepsy (seizure disorder), Parkinson's disease, brief psychotic disorder, functional quadriplegia, and major depressive disorder.

The clinical record for Resident #110 was reviewed on 01/02/2020 and 01/03/2020. The most recent MDS (minimum data set) was an annual assessment with an ARD (assessment reference date) of 11/22/19. Section C of the MDS assessed cognitive levels and Resident #110 had a BIMS (brief interview for mental status) score of 13 out of 15.

The current care plan for Resident #110 documented one of the focus areas as "Potential for drug related complication with use of psychotropic medications related to: Anti-Anxiety medication, Anti-psychotic medication, Anti-depressant medication, Hypnotic." The care plan interventions included but were not limited to, "Observe for side effects and report to physician: Anti-anxiety/Hypnotic medications-drowsiness, morning, hang over, ataxia, dry mouth, constipation, blurred vision, urinary retention, headache, vertigo, nausea, hypotension, tachycardia, weakness, sedation, lethargy, confusion, memory loss and dependence." And "Observe for side effects and

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report to physician: Antidepressant-Sedation, drowsiness, dry mouth, blurred vision, urinary retention, tachycardia, muscle tremor, agitation, headache, skin rash, photo sensitivity and excess weight gain." And "Observe for side effects and report to physician: Antipsychotic medication-sedation, drowsiness, dry mouth, constipation, blurred vision, EPS (Extrapyramidal Side Effects), weight gain, edema, postural hypotension, sweating, loss of appetite, urinary retention."

Resident #110's physician orders included but were not limited to, "Citalopram Hydrobromide Tablet 20 MG Give 1 tablet via G-Tube one time a day for depression, Haloperidol Lactate Concentrate 2 MG/ML Give 1.5 ml via J-Tube at bedtime for schizophernia[sic]/agitation, Haloperidol Lactate Concentrate 2 MG/ML Give 2 ml via J-Tube one time a day for schizophernia[sic]/agitation, Lorazepam Tablet 1 MG Give 1 tablet via G-Tube four times a day for agitation, Risperdal Tablet 0.5 MG (risperidone) Give 0.5 tablet via G-Tube two times a day for RLS (restless leg syndrome) to be given with 1mg to equal 1.25mg dose, risperidone Tablet 1 MG Give 1 tablet via G-Tube two times a day for RLS to be given with 0.25[sic] to equal 1.25mg dose." The resident's MAR (medication administration record) included documentation that the medications listed had been administered as ordered during the month of December 2019 and January 1st and 2nd, 2020. The MAR did not include evidence of monitoring for side effects of any of these medications.

During a meeting with the facility's director of nursing (DON), executive administrator, and regional director of clinical services at 01/03/2020

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F 758	Continued From page 21 at approximately 1:25 p.m., the concern related to the lack of documentation for medication side effects was discussed. The DON stated the facility's process was for staff to document medication side effects within the residents' MARs. At 3:58 p.m. the same day, the DON acknowledged there was no documention of medication side effects found for Resident #106 or Resident #110. No further information was provided to the survey team prior to the exit conference.	F 758		
{F 842} SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the	{F 842}		

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records, except when release is-
(i) To the individual, or their resident representative where permitted by applicable law;
(ii) Required by Law;
(iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;
(iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.

§483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.

§483.70(i)(4) Medical records must be retained for-
(i) The period of time required by State law; or
(ii) Five years from the date of discharge when there is no requirement in State law; or
(iii) For a minor, 3 years after a resident reaches legal age under State law.

§483.70(i)(5) The medical record must contain-
(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

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(vi) Laboratory, radiology and other diagnostic services reports as required under §483.50.
This REQUIREMENT is not met as evidenced by:
Based on staff interview and clinical record review, the facility staff failed to maintain a complete and accurate clinical record for 1 of 19 residents in the survey sample as evidenced by the incorrect documentation of a blood sugar on the MAR (Medication Administration Record) for Resident #104.

The findings included:

The facility staff failed to correctly document the blood sugar on Resident #104's MAR that was obtained on 12/6/19.

Resident #104 was a resident in the nursing facility at the time of this survey which occurred on 1/2 through 1/3/2020. The quarterly MDS (Minimum Data Set) with an ARD (Assessment reference Date) 10/18/19 coded the resident as requiring extensive assistance from 1-2 staff members for dressing and personal hygiene and also be totally dependent on 1 staff member for bathing. Resident 104 had the following diagnoses of, but not limited to anemia, diabetes, heart failure and high blood pressure.

During the clinical record review on 1/2 and 1/3/2020, the surveyor noted that Resident #104's blood sugar was documented on the December 2018 MAR as being "3" at 4:30 pm on 12/6/19.

On 1/3/2020 at 8:00 am, the surveyor notified the regional nurse of the above documented findings concerning the resident's blood sugar.

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{F 842}	Continued From page 24 AT 8:30 am, the regional nurse came back to the surveyor and stated, "I spoke to the nurse that documented on 12/6/19 and she stated it was a documentation error and not a blood sugar of "3"." The surveyor interviewed RN (registered nurse) #1 at 10:10 am in the conference room. RN #1 stated, "I know that the blood sugar was not 3. I just feel I documented that number by mistake." At 3:25 pm, the administrator, director of nursing and regional nurse were notified of the above documented findings concerning the incorrect documentation blood sugar for Resident #104. No further information was provided to the surveyor prior to the exit conference on 1/3/2020 at 6:30 pm.	{F 842}		
F 925 SS=D	Maintains Effective Pest Control Program CFR(s): 483.90(i)(4) §483.90(i)(4) Maintain an effective pest control program so that the facility is free of pests and rodents. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility staff failed to maintain a pest free environment in the dining room as evidenced by two surveyors walked into dining room and observed a roach crawling across the floor. The findings included: On 1/3/2020 at approximately 12:15 pm, 2 surveyors walked into the dining room to speak to	F 925		

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3 un sampled residents. While the surveyors were walking in, 1 surveyor looked down and a brown colored roach was noted to be running from out of the bottom of the wall and going toward the center of the dining room. The three unsampled residents stated to the two surveyors, "We are so glad that you got that roach. He comes out every day and tries to have lunch with us." The surveyors asked if they have only observed one roach in the dining room. The three residents stated, "No there are usually three of them."

The maintenance director was notified of the above documented findings at 12:25 pm by the 2 surveyors. The maintenance director stated, "I didn't know the residents had been seeing them in here (referring to dining room)."

At 2 pm, the maintenance director came into the conference room and stated to the surveyor that they do have a pest control company that comes every month and sprays for them. He was last here the middle of December. But I went ahead and called him to come this afternoon due to having these sightings of the roach."

At 3:25 pm, the surveyor notified the administrator, director of nursing and regional nurse of the above documented findings.

No further information was provided to the surveyor prior to the exit conference at 6:30 pm on 1/3/2020.