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	495370	A. BUILDING _____ B. WING _____	C 01/13/2022

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E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 1/11/2022 through 1/13/2022. The facility's Emergency Preparedness Plan was reviewed and found to be in compliance with CFR 483.73, the Federal requirements for Emergency Preparedness in Long Term Care facilities.	E 000		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 01/11/2022 through 01/13/2022. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. One complaint was investigated during the survey. Complaint VA00053883 was substantiated with a related deficiencies. The Life Safety Code survey will follow. The census in this 127 certified bed facility was 120 at the time of the survey. The survey sample consisted of 24 current resident reviews and two closed record reviews.	F 000		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following -	F 656		2/15/22

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

Electronically Signed | 02/01/2022

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F 656	Continued From page 1 (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review, and in the course of a complaint investigation, the facility staff failed to develop a comprehensive plan of care for two of 26 residents in the survey sample. Resident #37 had no care plan developed regarding hydration and behaviors. Resident #60 had no care plan about behaviors.	F 656	F656. Development/Implement Comprehensive Care Plan. 1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice. The care plan for resident #37 has been	

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F 656	Continued From page 2 The findings include: 1. Resident #37 was admitted to the facility on 7/29/21 with diagnoses that included Alzheimer's, dementia with behaviors, insomnia, urinary tract infection, atrial fibrillation with pacemaker, hypertension, gastroesophageal reflux disease, hypothyroidism, history of kidney cancer, history of colon cancer and major depressive disorder. The minimum data set (MDS) dated 11/2/21 assessed Resident #37 with short and long-term memory problems and severely impaired cognitive skills. This MDS documented the resident demonstrated physical behaviors directed toward others (hitting, kicking, grabbing), verbal behaviors (screaming, yelling) and other behaviors such as hitting, rummaging and throwing food/items. a) Resident #37's clinical record from October 2021 through 1/10/22 documented the following behaviors. 10/8/21 - "...attempting to climb out of chair...got verbally aggressive with the aide and nurses. when the nurse attempted to give him medication he kicked her and attempt to grab her wrists and pull her close to him. he remained verbally aggressive..." 10/12/21 - "...today tearing up papers, books, boxes..." 10/21/21 - "...continuing to spit all over med cart and on floor. took his drink cup and dumped it all over the table and floor in dining room..." 10/27/21 - "...spit his meds out, and spit on the floor. Pouring water on the floor..." 10/31/21 - "...was opening and slamming his cabinet doors shut, hitting on dresser...threw his mug on the floor, which then broke...spitting on	F 656	updated on 1/17/22 to reflect the problem, goals, and interventions regarding both hydration and behaviors regarding this resident. The care plan for resident #60 has been updated on 1/17/22 to reflect the problem, goals, interventions regarding this resident. 2. Address how the facility will identify other resident's having the potential to be affected by the same deficient practice. The clinical leadership will conduct thorough reviews of all resident's EMR for their respective household, including a thorough review of each resident's care plan to ensure that all resident problems, goals, interventions are documented in the resident's care plan. 3. Address what measures will be put in place, or what systemic changes will be made to ensure the deficient practice will not occur. A mandatory meeting will be held on February 8th, 2022 to discuss the deficient practice and new systemic changes. The clinical leadership will conduct thorough reviews on all resident EMR's for their respective household monthly as part of BRC's QAPI process to ensure that all diagnoses, as well as any areas of concern regarding each resident are properly care planned, to include the problem, goals, and interventions specific to the resident. 4. Indicate how the facility plans to	

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F 656	Continued From page 3 the floor and in his plate..." 11/9/21 - "...began to spit on the floor and after eating his ice cream he threw the empty container across the dining room floor..." 11/19/21 - "...has been yelling at other residents and arguing with the aids [aides]. He attempted to punch one of the aids...threw his water at the nurse and his beer at another aid..." (sic) 12/1/21 - "...Resident became physically aggressive when aides attempted to wash and dress him. Resident grabbed aide...by throat and would not let go...released aide, but was yelling..." 12/1/21 - "...noted resident grabbing wife's arm...small bruise to wife's wrist..." 12/1/21 - "...in dining room...knocked the plant off the window sill...arch his back in attempt to break the window...climbed up onto the table...scooting across the table...continues to spit..." (sic) 12/8/21 - "...spitting on the recliner and the floor..." 12/17/21 - "...was noted to be tearing up newspaper and moving things around in his room..." 12/17/21 - "...resident started to hit another resident with a brush and then began spitting on the floor..." The clinical record documented redirection, diversion activities, family visits, psychiatric evaluations and multiple medication changes to address the ongoing behaviors. Resident #37's plan of care (revised 1/11/22) included no problems, goals and/or interventions regarding the aggressive physical and verbal behaviors. The plan of care documented the resident had "...a behavior problem of touching/talking to team members, and a resident in a sexually inappropriate manner..." The	F 656	monitor its performance to make sure that solutions are sustained. As part of BRC's QAPI process, the clinical leadership will conduct monthly chart reviews on all residents of their respective households to ensure that thorough reviews of each resident's EMR for all residents in their respective households are being completed. 5. Corrective action will be completed by February 15, 2022	

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problem was initiated on the plan on 9/10/21. The care plan made no mention of the resident's hitting, kicking, grabbing, rummaging, tearing books, spitting or throwing items.

On 1/13/22 at 8:08 a.m., the licensed practical nurse (LPN #1) unit manager responsible for care plans was interviewed about Resident #37. LPN #1 stated not all of the resident's behaviors were listed on the care plan and the plan did not include interventions implemented to address the resident's aggressive behaviors.

This finding was reviewed with the administrator and director of nursing on 1/13/22 at 1:50 p.m.

b) Resident #37's clinical record documented the resident had ongoing physical and verbal behaviors that included hitting, grabbing, kicking, sexual comments, yelling and screaming and an ongoing issue with falls. Intake records documented the resident had decreased fluid and meal intake on 10/3/21, 10/4/21 and 10/5/21 with the resident refusing food and drink.

The nurse practitioner (NP) progress note dated 10/5/21 documented the resident had experienced a fall on 10/4/21, hit his head and the responsible party refused for the resident to go to the emergency room. This progress note dated 10/5/21 documented, "Nursing call this afternoon around 1245 stating that resident has become increasingly lethargic throughout the day, now lying in bed most of the late morning...he is not eating and drinking...POA [power of attorney] is now agreeable to have him sent in [to emergency room]."

The emergency room report dated 10/5/21

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documented, "...Incidentally found to have evidence of acute kidney injury and admitted...Concerning patient's mild acute kidney injury this was likely secondary to his recent worsening nutritional status and diminished p.o. [oral] intake in his nursing facility...Metabolic encephalopathy likely due to dehydration due to poor oral intake likely due to worsening advanced dementia..." The resident received intravenous fluids and discharged back to the nursing facility on 10/7/21 with instructions to maintain adequate nutritional status and intake after discharge to the nursing facility.

The clinical record documented the resident at times refused meals/drinks. Fluid intake records documented the resident routinely accepted daily fluid amounts less than those recommended by the registered dietitian.

Resident #37's plan of care (revised 1/11/22) included no problems, goals and/or interventions regarding fluid intake or dehydration prevention following the diagnosis of dehydration. The plan listed the resident was at risk of weight loss but made no mention of fluid intake to prevent dehydration.

On 1/13/22 at 8:08 a.m., the licensed practical nurse (LPN #1) unit manager responsible for care plans was interviewed. LPN #1 stated the staff members encouraged fluids with Resident #37. LPN #1 stated the resident at times accepted all fluids and other days refused due to advanced dementia and behaviors. LPN #1 stated alternate supplements had been attempted with the resident preferring med-pass. LPN #1 stated hydration was typically included in the care plan for residents with impaired intake. LPN #1 stated

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F 656	Continued From page 6	F 656		

the last care plan meeting for Resident #37 was held in November 2021 and the plan was focused on family concerns and nothing had been added to the care plan specifically about fluid intake and dehydration prevention.

This finding was reviewed with the administrator and director of nursing on 1/13/22 at 1:50 p.m.

2. Resident #60 was admitted to the facility on 8/17/13 with diagnoses that included Alzheimer's, hypothyroidism, diabetes, coronary artery disease, atherosclerotic heart disease, obstructive uropathy due to benign prostatic hypertrophy (BPH), hypertension, depression and venous thrombosis. The minimum data set (MDS) dated 11/16/21 documented Resident #60 had short and long-term memory problems and moderately impaired cognitive skills.

Resident #60's clinical record documented the following nursing notes regarding ongoing behaviors.

12/29/21 - "...Resident had some sexual behaviors directed to this nurse...Resident grabbed penis and stated, 'I have some medication here for you some of my penis, do you want it.' ...Resident kept grabbing himself and stating to this nurse vulgar things..."
12/30/21 - "...Resident displaying inappropriate sexual advances toward staff..."
1/1/22 - "...Resident sexually inappropriate x 1 with team..."
1/4/22 - "...resident displayed short outburst of inappropriate behavior earlier in the shift..."
1/9/22 - "...Res [resident] observed pulling down pants and pullup while reclined in chair..."

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F 656	Continued From page 7 A nurse practitioner (NP) progress note dated 1/4/22 documented, "...seen for abnormal urine and urine culture along with continued inappropriate sexual behavior. He is exhibiting confusion and behaviors...He has been sexually inappropriate with staff and around the other residents...Pleasant but does make some sexual comments today..." Resident #60's plan of care (revised 12/27/21) included no problems, goals and/or interventions regarding sexually behaviors. The plan listed the resident had a history of being irritable due to dementia but made no mention of the ongoing sexual related behaviors/comments. On 1/13/22 at 9:04 a.m., the licensed practical nurse (LPN #1) unit manager responsible for care plans was interviewed about Resident #60. LPN #1 stated the resident started with sexual behaviors about 3 to 4 weeks ago. LPN #1 stated the resident was treated for a urinary tract infection and she initially thought the behaviors were related to the infection. LPN #1 stated the behaviors were ongoing after treatment for the infection and had not been added to the care plan. This finding was reviewed with the administrator and director of nursing on 1/13/22 at 1:50 p.m.	F 656		
F 680 SS=E	Qualifications of Activity Professional CFR(s): 483.24(c)(2)(i)(ii)(A)-(D) §483.24(c)(2) The activities program must be directed by a qualified professional who is a qualified therapeutic recreation specialist or an activities professional who- (i) Is licensed or registered, if applicable, by the	F 680		2/2/22

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F 680	Continued From page 8 State in which practicing; and (ii) Is: (A) Eligible for certification as a therapeutic recreation specialist or as an activities professional by a recognized accrediting body on or after October 1, 1990; or (B) Has 2 years of experience in a social or recreational program within the last 5 years, one of which was full-time in a therapeutic activities program; or (C) Is a qualified occupational therapist or occupational therapy assistant; or (D) Has completed a training course approved by the State. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review and complaint investigation, the facility staff failed to employ a qualified activity professional for the facility. For two years, the facility had no qualified therapeutic recreation specialist or activities professional providing direction/supervision of the activity programs for residents. The findings include: During a complaint investigation regarding Resident #37's activities, the household coordinator (CNA #1) was identified as the staff person responsible for providing recreational activities on the resident's living unit. On 1/12/22 at 2:37 p.m., certified nurses' aide (CNA) #1 was interviewed about Resident#37's activities program. During this interview, CNA #1 stated she was responsible for completing activity assessments and implementing the activity programs for residents on her assigned unit. When asked what training and/or qualifications	F 680	F680 – ACTIVITIES PROFESSIONAL 1. Address how corrective action will be accomplished for those residents found to have been affected by deficient practice. Bridgewater Home has adopted a culture change model to resident engagement, and has six Household Coordinators who oversee the activities programming in each respective household. Bridgewater Home will sponsor those individuals in getting certified as licensed Activities Professionals to ensure the regulation is met. Immediately, Pam Arbogast, ADC (License # ADC880550) will be made available to oversee the activities program. 2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice.	

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F 680	Continued From page 9 she had regarding recreational activities, CNA #1 stated the previous CNA household coordinator provided her training. CNA #1 stated she had received training about dementia care but had no formal education or training regarding recreational activity programming. CNA #1 stated she worked together with the other household coordinators. When asked who provided supervision and direction of the facility's recreation activities, CNA #1 stated she reported to the administrator. CNA #1 was not aware of a qualified recreation specialist or activity professional in the facility. On 1/12/22 at 4:08 p.m., the administrator was interviewed about a qualified recreation specialist for the facility. The administrator stated there was a certified therapeutic recreation specialist working in the retirement community but that person was not involved with assessment, planning or implementing of the long-term care activity programs. The administrator stated they did not currently have a qualified activity professional and had not had one employed at the facility for approximately two years. This finding was reviewed with the administrator and director of nursing on 1/13/22 at 1:50 p.m.	F 680	All residents will have oversight from a licensed Activities Professional once certification has been met by the Household Coordinators. Immediately, Bridgewater Home will provide oversight to the activities program with Pam Arbogast, ADC. 3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur. Bridgewater Home will continue to sponsor Household Coordinators in getting licensed as Activities Professionals when transitions occur to ensure that there is professional oversight of resident engagement at any given time. Otherwise, Bridgewater Home will provide oversight of the activities program by another actively licensed professional. 4. Indicate how the facility plans to monitor its performance to make sure the solutions are sustained. Bridgewater Home will review qualifications annually to ensure that at least one Household Coordinator is licensed as an Activities Professional at any given time. 5. Include dates when corrective action will be completed. Bridgewater Home has begun the process of identifying accredited licensed Activities	

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F 680	Continued From page 10	F 680	Professional programs for the Household Coordinators to participate in. Bridgewater Home has immediately made Pam Arbogast, ADC available for oversight to Household Coordinators and activities programming until they have had time to complete an accredited program.	
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 observation, staff interview, and facility document review, the facility staff failed to perform quality control checks for a glucometer (a device to measure blood sugar) on one of 6 units, Joy unit. A glucometer located in the medication cart had not had a quality control check since October 2021. Findings include: On 1/12/22 at 9:45 an inspection of the medication cart was conducted with LPN (licensed practical nurse) #4. A glucometer was located in the first drawer, and LPN #4 was asked when the most recent quality control had been performed. LPN #4 stated she did not know, as that was done on second or third shift. LPN #4	F 684	F684. Quality of Care. 1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice. Each resident with scheduled blood glucose monitoring orders will have an individual glucometer placed in their named section of the medication cart. Quality Control checks will be performed weekly, and results documented on the resident's EMAR. A glucometer for PRN use will be placed in the medication room and quality control checks will be conducted weekly for this glucometer on	2/15/22

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F 684	Continued From page 11 was then asked if there was a log for the quality control checks. She stated there was, and retrieved the book. The review revealed that the checks had been performed monthly, and the last documented quality control check was 10/21. LPN #4 stated "Ill get the clinical coordinator; I'm not sure why that's the last time it was performed, but I don't know why...." LPN #4 then went and got LPN #3, who was the clinical coordinator. LPN #3 stated there were no residents on the unit getting blood sugar monitoring, and therefore the quality control check had not been done. LPN #3 stated the only resident with diabetes currently on the unit had a system that was checked with an application on their cell phone, but did not have routine blood sugar monitoring ordered. On 1/12/22 at 10:15 a.m. the DON (director of nursing) was informed of the above findings. The DON stated "There should not even be a glucometer in the medication cart. If a resident is ordered blood sugar monitoring, they are assigned their own glucometer and quality control checks are performed and documented on their MAR (medication administration record). I have no idea why that is in the cart. Let me see what I can find out." The administrator and the DON (director of nursing) were informed of the above findings during a meeting with facility staff 1/12/22 beginning at 3:50 p.m. The DON stated "After talking to staff, it seems the glucometer was in the cart in case the resident with the self-check system would need to have a blood sugar check...." The DON was asked if, in that case, the quality control check should be performed and up-to-date in case of an emergency, she stated "Yes."	F 684	Saturday's. Results will be documented on a paper log, which will be located in the medication room in a notebook. BRC's Policy & Procedure for Blood Glucose Monitoring (Hyperglycemia and Hypoglycemia) have been updated to reflect this practice. 2. Address how the facility will identify other resident's having the potential to be affected by the same deficient practice. The clinical leadership will conduct a thorough check of each resident's EMR to ensure that quality control check orders are in the EMAR for any resident with orders for scheduled blood glucose monitoring. A log for the PRN glucometer will be placed in the Medication room in a notebook. These weekly control checks for the PRN glucometer will be performed every Saturday by the charge nurse on duty. 3. Address what measures will be put in place, or what systemic changes will be made to ensure that the deficient practice will not occur. A mandatory clinical leadership meeting will be held on February 8th, 2022 to discuss the deficient practice and corrective action. As part of BRC's QAPI process, the clinical leadership will conduct monthly chart reviews on all residents of their respective households to address any order changes to their resident's blood glucose monitoring	

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F 684	Continued From page 12 No further information was provided prior to the exit conference	F 684	orders to ensure that quality control checks orders are on the resident's EMAR. Weekly checks of the PRN glucometer log will be conducted by the clinical leadership to ensure that these checks are being performed accurately and results are being documented. 4. Indicate how the facility plan to monitor its performance to make sure that solutions are sustained. As part of BRC's QAPI process, the clinical leadership will conduct monthly chart reviews on all residents of their respective households to address any order changes to their resident's blood glucose monitoring orders to ensure that quality control checks orders are on the resident's EMAR. Weekly checks of the PRN glucometer log will be conducted by the clinical leadership to ensure that these checks are being performed accurately and results are being documented. 5. Corrective Action will be completed on February 15, 2022.	
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition	F 686		2/15/22

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F 686	Continued From page 13 demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on family interview, staff interview and clinical record review, the facility staff failed to perform routine skin assessments prior to development of a pressure ulcer for one of 26 residents in the survey sample, Resident #79. Resident #79 developed a stage 2 pressure ulcer on her sacrum after going over four months without a documented skin assessment for pressure ulcer prevention. The findings include: Resident #79 was admitted to the facility on 11/8/17 with a re-admission on 4/23/20. Diagnoses for Resident #79 included Alzheimer's dementia, heart failure, protein-calorie malnutrition, cerebrovascular disease, dysphasia, hypertension, cerebral infarction, osteoporosis, anemia, depression, atherosclerotic heart disease, hyperlipidemia, irritable bowel syndrome, glaucoma and osteoarthritis. The minimum data set (MDS) dated 11/30/21 documented Resident #79 with short and long-term memory problems and severely impaired cognitive skills. This MDS listed the resident required the extensive assistance of one person for transfers and bed mobility. On 1/11/22 at 11:45 a.m., Resident #79's family member was interviewed about quality of care in the facility. The family member stated the	F 686	F686 Treatment/Services to Prevent/Heal Pressure Ulcer 1. Address how corrective active will be accomplished for those residents found to have been affected by the deficient practice. Resident # 79's clinical chart has been reviewed and skin assessments have been scheduled to show up weekly for the charge nurse to complete. 2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice. The clinical leadership team will conduct a thorough review of all resident's EMR in their respective household to ensure that every resident has a weekly skin assessment scheduled in their EMR, to completed by the charge nurses. 3. Address what measures will be put in place, or what systemic changes will be made to ensure the deficient practice will not occur. A mandatory clinical leadership meeting will be held on February 8th, 2022 to	

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F 686	Continued From page 14 resident had recently developed an open area on her bottom and nurses were providing daily treatment to the wound. The family member stated the resident had declined and was now entering hospice. Resident #79's clinical record documented a physician's order dated 1/4/22 to cleanse the stage 2 pressure injury with wound cleanser, apply skin prep to surrounding skin and cover with foam dressing every day and as needed. Resident #79's treatment administration record documented daily treatments as ordered to the stage 2 pressure injury starting on 1/5/22. Nursing notes failed to evidence an assessment of a pressure ulcer on 1/4/22 by nursing. A nurse practitioner (NP) progress note dated 1/4/22 documented, "...98-year-old resident being seen for open skin area on her sacral region. There is intermittent pain noted to the area...Stage 2 sacral wound...Noted to her buttocks over the sacral region is a open skin area, discolored. The area is approximately nickel size with a central darkening of the skin noted. There is some surrounding erythema that is blanchable. The area is mildly tender to palpation. There is no active drainage noted but the dressing does have some serosanguineous drainage present...there is no slough notable, only epithelial tissue which is no longer intact..." (Sic) The clinical record documented no measurements of the pressure injury until 1/6/22. A nursing note dated 1/6/22 documented the resident had an open area on the sacrum measuring 0.5 centimeters (cm) in width, 1.5 cm	F 686	discuss this deficient practice and measures to be put in place for the clinical leadership team to conduct weekly chart reviews on the residents of their respective households in ensure that weekly skin assessments are showing up correctly in the resident's EMR and that they are being completed in a timely manner. 4. Indicate how the facility plan to monitor its performance to make sure that solutions are sustained. As part of BRC's QAPI process, the clinical leadership will conduct weekly chart reviews on all residents of their respective households to ensure that weekly skin assessments are scheduled weekly and are being completed weekly in the resident's EMR by the charge nurse. 5. Corrective Action will be completed on February 15, 2022.	

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F 686	Continued From page 15	F 686		

in length with no depth measurement listed.

The most recent assessment of the pressure injury dated 1/10/22 listed the pressure ulcer as a "Kennedy Terminal Ulcer" with measurements of 2.7 cm length, 2.0 cm width and area of 3.5 cm. The assessment documented slough present on the wound bed with serosanguineous exudate and dark-reddish brown skin color surrounding the wound.

Resident #79 had no documented skin assessments and/or body audits in the weeks and months prior to the pressure injury noted on 1/4/22. The clinical record documented the most recent skin assessment prior to the pressure injury was on 8/14/21.

Resident #79's most recent pressure ulcer risk assessment was completed on 11/26/21. The Braden Scale for Predicting Pressure Sore Risk listed the resident with moderate risk for pressure ulcer development with a score of 14. Risk factors listed on this assessment included bedfast status, very limited mobility, probable inadequate nutrition and potential for friction/shear.

Resident #79's plan of care (revised 3/1/21) listed the resident required the extensive assistance of one staff person for turning and repositioning in bed and had potential for pressure ulcer development due to immobility. Interventions to maintain intact skin included, "Inform the resident/family/caregivers of any new area of skin breakdown...Monitor nutritional status. Serve diet as ordered...Monitor/document/report PRN [as needed] any changes in skin status: appearance, color, wound healing...infection wound size (length x width x depth), stage."

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F 686	Continued From page 16 On 1/12/22 at 7:30 a.m., the registered nurse (RN #1) caring for Resident #79 was interviewed about skin assessments. RN #1 stated she thought skin assessments were required every week or every other week. RN #1 stated required skin assessments "popped up" on the computer screen from the electronic health record when they were due so nurses knew when to complete the assessments. Resident #79's sacral pressure injury was not observed during the survey as the family representative declined permission for the surveyor to see the wound or observe wound care. On 1/13/22 at 8:30 a.m., the unit manager (LPN #1) was interviewed about the lack of skin assessments prior to the 1/4/22 pressure ulcer. LPN #1 stated skin assessments were supposed to be completed weekly on all residents by the floor nurses. LPN #1 reviewed Resident #79's clinical record and stated she did not see a routine skin assessment prior to the pressure injury since August 2021. LPN #1 stated the electronic health record was supposed to prompt nurses each week for completion and documentation of the assessments. LPN #1 stated Resident #79's skin assessment schedule had been altered and/or rescheduled and no prompts were being initiated by the computer system. The National Pressure Injury Advisory Panel (NPIAP) defines a pressure injury as, "...localized damage to the skin and underlying soft tissue usually over a bony prominence or related to a medical or other device. The injury can present	F 686		

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F 686	Continued From page 17 as intact skin or an open ulcer and may be painful. The injury occurs as a result of intense and/or prolonged pressure or pressure in combination with shear..." The NPIAP defines a stage 2 pressure injury as, "Partial-thickness loss of skin with exposed dermis. The wound bed in viable, pink or red, moist, and may also present as an intact or ruptured serum-filled blister..." (1) The NPIAP Pressure Injury Prevention Points documents concerning skin care to prevent pressure ulcers, "...Inspect all of the skin upon admission as soon as possible (but within 8 hours)...Inspect the skin at least daily for signs of pressure injury, especially nonblanchable erythema...Assess pressure points, such as the sacrum, coccyx, buttocks, heels, ischium, trochanters, elbows and beneath medical devices..." (2) This finding was reviewed with the administrator and director of nursing on 1/13/22 at 1:50 p.m. (1) NPIAP Pressure Ulcer Stages/Categories. National Pressure Ulcer Advisory Panel. 1/15/22. www.npiap.com (2) Pressure Injury Prevention Points. 2020 National Pressure Injury Advisory Panel. 1/15/22. www.nipiap.com	F 686		
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	F 690		2/15/22

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F 690	Continued From page 18 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 restore as much normal bowel function as possible. 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 appropriate catheter care for one of 26 residents in the survey sample, Resident #60. Resident #60 had a urinary catheter in use without the tubing secured to prevent pulling/tugging at the insertion site.	F 690	F690. Bowel/Bladder Incontinence, Catheter, UTI. 1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice.	

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F 690	Continued From page 19 The findings include: Resident #60 was admitted to the facility on 8/17/13 with diagnoses that included Alzheimer's, hypothyroidism, diabetes, coronary artery disease, atherosclerotic heart disease, obstructive uropathy due to benign prostatic hypertrophy (BPH), hypertension, depression and venous thrombosis. The minimum data set (MDS) dated 11/16/21 documented Resident #60 had short and long-term memory problems and moderately impaired cognitive skills. Resident #60's clinical record documented a physician's order dated 3/16/20 for an indwelling Foley catheter due to obstructive uropathy. On 1/12/22 at 2:13 p.m., certified nurses' aide (CNA) #2 was interviewed about Resident #60's catheter. CNA #2 stated she did not think the resident's catheter tubing was attached with an anchor or stabilizing device. On 1/12/22 at 2:15 p.m., accompanied by CNA #2 and with the resident's permission, the resident's catheter and tubing were observed. There was no anchor or stabilizing device attached to the catheter tubing. CNA #2 was interviewed at this time about an anchor device. CNA #2 stated the resident was supposed to have an anchor. CNA #2 stated she bathed the resident earlier in the morning and no device was in place. On 1/12/22 at 2:16 p.m., the registered nurse (RN #1) caring for Resident #60 was interviewed. RN #1 stated, "He [Resident #60] usually has one [anchor] attached to the upper leg." RN #1 stated she did not know why the tubing was not secured.	F 690	A foley catheter tubing securement device was placed on Resident #60 on 1/12/22, after the deficient practice was discovered. 2. Address how the facility will identify other resident's having the potential to be affected by the deficient practice. A thorough check on all residents with foley catheters was conducted on 1/12/22 to ensure that they had a proper foley catheter tubing securement device to stabilize their foley catheter tubing. 3. Address what measures will be put in place, or what systemic changes will be made to ensure the deficient practice will not occur. For residents with foley catheters, a task will be added to the CNA's point of care charting to check that the resident has a catheter tubing securement device anchored to their tubing. If the resident does not have this device, they will be instructed in their point of care charting to alert the charge nurse, so that this device can be placed on the resident for tubing securement. A mandatory clinical leadership meeting will be held February 8th, 2022 to discuss this deficient practice and the POC charting intervention that will be put in place. The clinical leadership will then be holding charge nurse and CNA meetings within their respective household during the week of February 8th through the 15th to educate the nursing team on the deficient practice and	

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F 690	Continued From page 20 On 1/13/22 at 9:06 a.m., the licensed practical nurse (LPN #1) unit manager was interviewed about Resident #60's unsecured catheter tubing. LPN #1 stated the tubing should be secured. LPN #1 stated anchor devices were available in the supply room. Resident #60's plan of care (revised 12/27/21) documented the resident had a Foley catheter. Interventions to prevent catheter related trauma included checking tubing for kinks every shift and monitoring for signs of urinary tract infection. The Lippincott Manual of Nursing Practice 11th edition documents on page 602 concerning tubing placement with male catheterization, "Make sure catheter is secured to patient's thigh and tubing is not creating traction on catheter, which will cause pain..." (1) This finding was reviewed with the administrator and director of nursing on 1/13/22 at 1:50 p.m. (1) Nettina, Sandra M. Lippincott Manual of Nursing Practice. Philadelphia: Wolters Kluwer Health/Lippincott Williams & Wilkins, 2019.	F 690	the new intervention in POC that will be going into place. 4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. As part of BRC's QAPI process, the clinical leadership will conduct monthly chart reviews on all residents of their respective households to assess that proper foley catheter care tasks are in the resident's EMR. 5. Corrective Action will be completed by February 15, 2022.	
F 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters	F 692		2/15/22

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F 692	Continued From page 21 of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on clinical record review, staff interview, and review of facility documents, the facility failed to maintain acceptable parameters of nutrition for one of 26 residents in the survey sample, Resident # 81. Upon the identification of a significant weight loss of 19.2 pounds (13.8% loss) in 30 days, the facility failed to initiate measures to prevent further unplanned weight loss. No interventions were implemented until a month after the initial significant weight loss occurred and the resident continued to lose weight. The findings were: Resident # 81 in the survey sample was admitted to the facility on 3/15/2021 with diagnoses that included dementia without behavioral disturbance, hypertension, stage 3 chronic kidney disease, anxiety disorder, depression, age related physical debility, malaise, slow transit constipation, polyosteoarthritis, gastroesophageal reflux disease, and hyperlipidemia. According to the Admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 3/22/2021,	F 692	F692. Nutrition/Hydration Status Maintenance. 1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice. Resident #81 will continue to be closely monitored by the dietician in conjunction with the clinical and household leadership team to ensure that weight monitoring and appropriate interventions are in place for weight loss. 2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice. BRC now has a dedicated full -time dietician who is highly involved in the nutritional plan of care for every resident at BRC. She will be present during our weekly continuous monitoring meeting to address any concerns or issues related to	

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F 692	Continued From page 22 the resident was assessed under Section C (Cognitive Patterns) as being severely cognitively impaired, with a Summary Score of 5 out of 15. Under Section G (Functional Status), the resident was assessed as being independent with set-up help only for eating. Review of the weight records in the resident's Electronic Health Record (EHR) noted the following weights: 7/2/2021 - 139.2 pounds 8/13/2021 - 120.0 pounds 9/13/2021 - 116.0 pounds 10/2/2021 - 115.6 pounds Resident # 81's weight loss between 7/2/201 (139.2 pounds) and 8/13/2021 (120.0 pounds) was 19.2 pounds, or a 13.8% weight loss in 30 days. The resident's weight loss between 7/2/2021 (139.2 pounds) and 9/13/2021 (116.0 pounds) was 23.2 pounds, or a 16.6% weight loss in two months. Review of the Nutrition Progress Assessment, dated 7/1/2021, noted the following: "Tolerating regular diet regular texture thin liquids without problems. PO (Oral) intake varies 12-100% at meals. Fair to good fluid intake. Occasional snacks. Weights discontinued for comfort. No diet changes indicated at this time. Continue to encourage increased food/fluid intake. (NOTE: There was no documentation that the resident's weights were "...discontinued for comfort.") A Nutrition Dietary Note contained in the Progress Notes, dated 9/3/2021, noted the following: "Weight change note: RT (Resident) with a weight change -5% in 30 (days), BMI 24.2 WNL (within normal limits). On regular diet with thin liquids;	F 692	weight loss. The RD will be required to attend Care Plan Meetings when weight loss is addressed within each household. 3. Address what measures will be put in place or what systemic changes will be made to ensure the deficient practice will not recur. The RD runs weekly weight reports on every resident. Any resident showing weight changes will be addressed in the weekly continuous monitoring meeting. The RD will follow up with the clinical leadership team for the respective resident with noted weight changes to ensure that appropriate interventions are put in place to correct and monitor significant weight loss. 4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. BRC's RD will conduct oversight and monitoring for all resident's nutritional needs. 5. This practice will be completed by February 15th, 2022.	

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PO intake fluctuates 25% to 50%. No dietary changes needed at this time; will continue to monitor."

Review of the Nutrition Progress Assessment, dated 9/15/2021, noted the following: "RT on regular diet with thin liquids. Her PO intake varies from < (less than) 50% to 75%; Her fluid intake also fluctuates. BMI (Body Mass Index) 23.4 WNL (Within Normal Limits); however her wt (weight) is trending downwards with a noted change of -10% X 108 days. At times she is depressed and states she does not like the food here per Dr. (name) notes. May recommend Med Pass bid (two times a day). Will continue to monitor."

Review of the Medication Administration Record (MAR) for the month of September 2021 in the resident's EHR revealed Med Pass (a nutritional supplement) was started on 9/17/2021 and discontinued on 9/23/2021. The addition of Med Pass came approximately one month after the resident's weight loss of 19.2 pounds, or a 13.8%, was identified.

A Progress Note, dated 9/23/2021, noted the following, "...Dietician recommended Medpass protein shake but resident doesn't care for it. Staff attempted Thrive (frozen ice cream-caloric equivalent of Medpass) and resident enjoyed it..."

Review of Resident # 81's Quarterly Review MDS, with an ARD of 9/9/2021, found that under Section K (Swallowing/Nutritional Status), the resident was assessed as having a weight loss of 5% or more in the last month or loss of 10% or more in last six months that was not part of a physician prescribed weight loss regimen.

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F 692	Continued From page 24 At approximately 1:00 p.m. on 1/13/2022, the facility's Registered Dietitian (RD), identified as Other Staff # 2, was interviewed regarding Resident # 81's weight loss and mitigation measures. The RD said she was not the RD at the time the resident's weight loss occurred. Asked about the lack of mitigating interventions, the RD said she would have been more aggressive and would have taken action when the weight loss was identified. Resident # 81's care plan, dated 3/16/2021, and updated on 3/18/2021, included the following problem: "The resident has an ADL (Activities of Daily Living) self-care performance deficit r/t (related to) Dementia, Limited Mobility, weakness and HX (history of) dizziness." The goal for the problem was: "...The resident will improve current level of function in ADLs and ambulation through the review date." The interventions for the stated problem include: "The resident is able to eat independently after set up; The resident prefers the following fluids: OJ and black coffee with breakfast. Likes cranberry juice with pineapple, water, root beef floats." Resident # 81's care plan also had the following problem, dated 7/1/2021 and updated on 10/5/2021: "The resident has nutritional problem or potential nutritional problem r/t CKD3 (stage 3 Chronic Kidney Disease), Alzheimer's dementia, constipation." The goal for the problem was: "The resident will have gradual weight gain to within 10% of IBW (Ideal Body Weight) for sex and height range by review date." The interventions for the stated problem, added on 10/5/2021, included: "Provide and serve diet as ordered. Offer finger foods, particular likes,	F 692		

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F 692	Continued From page 25 encourage to try food before declining meals. Family may assist with meals/snacks during routine weekly visits, to promote health; Provide and serve supplements as ordered: Thrive BID, after meals." The findings were discussed during a meeting at 2:00 p.m. on 1/13/2022 that included the Administrator, Director of Nursing, and the survey team.	F 692		
F 758 SS=E	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs;	F 758		2/15/22

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F 758	Continued From page 26 §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 clinical record review and staff interview, the facility staff failed to ensure 2 of 26 residents in the survey sample were free from unnecessary psychotropic medications, Resident #45 and Resident #37. Resident #45 had physician orders for as needed (PRN) antianxiety medication Xanax that extended more than 14 days without a stop date. Resident #37 had physician orders for as needed (PRN) antipsychotic medication Zyprexa and the antianxiety medication Lorazepam that extended for more than 14 days without a stop date; and an as needed (PRN) dose of Zyprexa was administered to Resident #37 without an indication for use or documented prior attempts of non-drug interventions.	F 758	F758 Free from Unnecessary Psychotropic Meds/PRN Use 1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice. The PRN Lorazepam order for resident #37 has been discontinued as of 1/17/22 as it was determined after a chart review that the resident had not been administered this medication for over 14 days. For the PRN Zyprexa order, a stop date of 14 days has been added to the order, along with a separate order for the	

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F 758	Continued From page 27 The findings include: 1. Resident #45 was originally admitted to the facility on 08/25/2020 and readmitted on 11/01/2021 with diagnoses that included dementia with behavioral disturbance, depression, dementia with lewy bodies, Parkinson's Disease, generalized anxiety disorder, type 2 diabetes, and delusional disorders. The most recent minimum data set (MDS) dated 11/08/2021 was a 5-day assessment and assessed Resident #45 as severely cognitively impaired for decision making with a score of 3 out of 15. The MDS assessed Resident #45 with periods of fluctuating inattention, consistent disorganized thinking and displaying physical, verbal and wandering behaviors. On 01/12/2021, Resident #45's clincial record was reviewed. Observed on the physician's order sheet was the following order: " Xanax Tablet 0.5 MG (ALPRAZolam) *Controlled Drug* Give 0.5 mg (milligrams) by mouth every 8 hours as needed for anxiety related to GENERALIZED ANXIETY DISORDER. Give 1 tablet by mouth every 8 hours as needed for Anxiety Medication must continue > (greater than) 14 days for PRN (as needed) use and > (greater than) 60 days due to resident requiring intermittent administration for dx (diagnosis) of dementia with behaviors. AND Give 0.5 mg (milligrams) by mouth one time a day for Anxiety. Order Start Date: 01/18/2021." There was no documented stop date for the PRN (as needed) Xanax order.	F 758	provider to assess the use of this PRN medication every 14 days to determine if the prn psychotropic order needs to be continued for another 14 days. Documentation of the behaviors present, as well as non-pharmacological interventions attempted prior to the administration of the prn psychotropic medication have been attached to the prn Zyprexa order. Resident #45's order has been revised to include a stop date of 14 days, along with a separate order for the provider to assess the use of this PRN medication every 14 days to determine if the prn psychotropic order needs to be continued for another 14 days. 2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice. The clinical leadership team will conduct a thorough chart review on all residents within their respective households that have an order for a prn psychotropic medication to ensure that these orders have a stop date of 14 days, as well as the order for the provider to assess the use of the PRN medication every 14 days to determine if the prn psychotropic order needs to be continued for another 14 days. If it is discovered during the review that a prn psychotropic medication has not been used for greater than 14 days, the clinical leadership will consult with the provider to have this medication discontinued. 3. Address what measures will be put in	

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F 758	Continued From page 28 A review of the medication administration records (MAR) for the months of October 2021 through January 2022 documented Resident #45 received her scheduled dose of Xanax and received the PRN (as needed) dose of Xanax. The MAR documented Resident #45 received the PRN (as needed) dose of Xanax as followed: October 1, 3, 5, 6, 7, 9, 12, 15, 16, 17, 19, and 21; November 4, 6, and 13; December 2, 4, 5, 7, 10, 13, 14, 15, 16, 18, 19, and 22; and January 1, 7 8, 9, 10, and 12. The clinical record included documentation for indication of use including moods and behaviors and attempts of non-pharmacological interventions including 1:1 activities, incontinent care, snacks, turn/reposition, and/or attention diversion. A review of the Consultant Pharmacist's Medication reviews did not document any recommendations regarding the PRN Xanax. On 01/13/2022 at 10:03 a.m., the Household Clinical Coordinator (LPN #6) was interviewed regarding the PRN (as needed) Xanax order not having an end date. LPN #6 stated she completed a quarterly review of medications on her unit and recently had a conversation with the nurse practitioner regarding the order since it was written for greater than 60 days. LPN #6 stated Resident #45 displayed moods/behavior mostly in the evening hours and was recently started on a new Parkinson's medication which seemed to reduce some of Resident #45's moods and behaviors. LPN #6 was asked if the pharmacy consultant had made any recommendations regarding the PRN Xanax (as needed) order.	F 758	place, or what systemic changes will be made to ensure the deficient practice will not occur. A mandatory clinical leadership meeting will be held on February 8th, 2022 to discuss the deficient practices and measures to be put in place for monitoring. As part of BRC's QAPI process, the clinical leadership will conduct monthly chart reviews on all residents within their respective households to assess for prn psychotropic medication orders. This will include assessing that a stop date of 14 days has been included, as well as the order for the provider to assess the use of the PRN medications every 14 days to determine if the prn psychotropic medication needs to be continued for another 14 days. 4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. BRC will utilize our QAPI process of performing monthly chart reviews of the use of prn psychotropic medications to ensure that 14 day stop dates, as well as 14 day assessments by the provider to review the use of the prn psychotropic medication are in place. 5. Corrective action will be completed by February 15, 2022.	

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LPN #6 stated, "The pharmacy does things a little different here compared to my experience in another facility. I know [Nurse Practitioner] is good about monitoring [Resident #45] medications and that is why the order was written for greater than 60 days. I will discuss with her the importance of the mediation review and placing a stop date on the PRN medication. Also, [Resident #45] is seen by psych services and [Psych Provider] has been instrumental in helping with medication changes as well."

The above findings were reviewed with the Administrator and the Director of Nursing during a meeting on 01/13/2021 at 1:48 p.m.

2. Resident #37 was admitted to the facility on 7/29/21 with diagnoses that included Alzheimer's, dementia with behaviors, insomnia, urinary tract infection, atrial fibrillation with pacemaker, hypertension, gastroesophageal reflux disease, hypothyroidism, history of kidney cancer, history of colon cancer and major depressive disorder. The minimum data set (MDS) dated 11/2/21 assessed Resident #37 with short and long-term memory problems and severely impaired cognitive skills.

Resident #37's clinical record documented a physician's order dated 12/8/21 for the medication lorazepam 2 mg/ml (milligrams per milliliter) intramuscularly every 4 hours as need (prn) for agitation. The record documented a physician's order dated 12/9/21 for olanzapine (Zyprexa) disintegrating tablet 5 mg by mouth every 6 hours as needed for restlessness and agitation. These prn orders for psychotropic medications had been in place for over 30 days with no stop or end dates.

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Resident #37's medication administration records (MARs) from 12/1/21 through 1/11/21 documented the resident was administered five doses of the as needed lorazepam. As needed lorazepam was administered on 12/8/21, 12/9/21, 12/10/21, 12/13/21 and 1/2/22. As needed doses of Zyprexa were administered on 12/10/21, 12/21/21, 12/26/21 and on 1/11/22.

Resident #37's clinical record included no documentation or assessment indicating the need for the 1/11/22 dose of Zyprexa. A nursing note dated 1/11/22 at 11:52 p.m. documented Zyprexa 5 mg was "given for increased agitation." There was no documentation of any non-drug interventions implemented prior to the 1/11/22 dose of Zyprexa. There was no other assessment and/or description of the resident on 1/11/22 describing any behaviors demonstrated by the resident or events requiring the need to the antipsychotic medication.

Resident #37's plan of care (revised 1/11/22) listed the resident had "behavior problem of touching/talking to team members, and a resident in a sexually inappropriate manner..." No other behaviors were included in the care plan. Interventions regarding sexual comments included "Assist the resident to develop more appropriate methods of coping...(distraction and redirection). Encourage resident to express feelings...Explain all procedures...30 minute checks due to history of wandering..." The plan listed the resident used psychotropic medication due to depression with interventions documented to administer medications as ordered and to monitor for adverse effects. The plan documented the resident had potential for psychosocial problems and anxiety due to health

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problems. Interventions to maintain psychosocial adjustment included pastoral care, communication with family, resident participation in care and monitoring by psychiatric services. The only intervention listed to minimize anxiety was, "Resident takes comfort in holding a baby doll."

A pharmacist's recommendation dated 12/21/21 documented, "This resident has a current PRN order for Zyprexa as needed for aggression/restlessness (start date 12/01/2021) with no stop date indicated in the MAR. 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 ...please be sure the proper documentation is made in the resident's medical record..."

On 1/13/22 at 8:08 a.m., the licensed practical nurse (LPN #1) unit manager was interviewed about Resident #37's prn psychotropic medications. Concerning the medication orders with no end date, LPN #1 stated the nurse practitioner reviewed the medications at least every two week. LPN #1 stated she thought the orders had been updated to include a stop date. LPN #1 reviewed the note on 1/11/22 and stated she did not see an assessment or description of why the medication was administered or any non-drug interventions attempted. LPN #1 stated the nurse should have documented a complete assessment and rationale for the Zyprexa dose administered on 1/11/22. LPN #1 stated the resident had a history of aggressive physical and verbal behaviors. LPN #1 stated she had added the baby doll to the care plan as a non-drug intervention but the care plan did not include the

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F 758	Continued From page 32 all of the physically aggressive behaviors. The Nursing 2022 Drug Handbook on page 909 describes lorazepam as an anxiolytic used for the treatment of anxiety and insomnia with adverse reactions that include drowsiness, sedation, agitation and respiratory depression. This reference on page 910 documents, "...Use cautiously in elderly, acutely ill, or debilitated patients..." (1) The Nursing 2022 Drug Handbook on 1084 describes Zyprexa (olanzapine) as an antipsychotic medication used for the treatment of schizophrenia, manic episode associated with bipolar disorder, agitation caused by schizophrenia and treatment-resistant depression and lists adverse reactions that include somnolence, insomnia and dizziness. This reference documents on page 1086, "...Black Box Warning Drug may increase risk of CV [cardiovascular] or infection -related death in elderly patients with dementia. Olanzapine isn't approved to treat patients with dementia-related psychosis..." (1) This finding was reviewed with the administrator and director of nursing on 1/13/22 at 1:50 p.m. (1) Woods, Anne Dabrow. Nursing 2022 Drug Handbook. Philadelphia: Wolters Kluwer, 2022.	F 758		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the	F 761		2/15/22

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F 761	Continued From page 33 appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and facility document review, the facility staff failed to ensure an open bottle of liquid Ativan (an anti-anxiety medication) was dated when opened, on one of 6 units, Joy unit. Findings include: On 1/12/22 at 9:30 a.m. an inspection of the Joy unit's medication room was conducted with LPN (licensed practical nurse) #4. Two bottles of liquid Ativan were located in the narcotic drawer of the refrigerator. One bottle was open, but did not have a date when opened on any of the packaging. LPN #4 stated "I'm not sure about what to do with that, let me get the clinical	F 761	F761. Label/Store Drugs and Biologicals. 1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice. The open bottle of liquid Ativan was discarded per facility protocol and a new bottle of liquid Ativan was obtained by the pharmacy. This new bottle has been labeled with the date that it was opened. Our Policy and Procedure for Medication Administration and Storage has been updated to reflect this change in practice.	

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F 761	Continued From page 34 coordinator." LPN # 4 left the medication room and returned with LPN #3, who was the clinical coordinator. LPN #3 was shown the box and vial of Ativan, and was asked if there should be an opened date. LPN #3 stated "Yes, and I don't see one either." She then turned the box upside down and stated "Well, there is smudged writing on here, I can't tell what it says, but I think that's maybe the date...looks like some condensation occurred and has smudged the writing." On 1/12/22 at 10:15 a.m. the DON (director of nursing) was asked for a policy on labeling and storage of medications. The DON stated there was no policy; and that perhaps she could contact the pharmacy. The DON left and returned with an email from the pharmacy about shortened expiration dates. The email, "meds with shortened expiration dates" documented "Lorazepam (Ativan) Intensol: Pharmacy opens it and transfers it to another bottle with markings on side to measure, then send it to us. This means it expires 90 days from the fill date, as it has a short shelf-life." The administrator and the DON (director of nursing) were informed of the above findings during a meeting with facility staff 1/12/22 beginning at 3:50 p.m. No further information was provided prior to the exit conference.	F 761	2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice. Labels have now been provided to all nursing households. The label has an “open on” statement, with an area next to it to provide that date that the bottle is opened. These labels are located in all medication rooms in each nursing household. 3. Address what measures will be put in place, or what systemic changes will be made to ensure the deficient practice will not occur. Weekly checks will be conducted by the clinical leadership team in their respective medication room to ensure that all medications in the medication refrigerator are properly labeled with the date that they are opened. Any medications without this date will be discarded per facility protocol. A mandatory clinical leadership meeting will be held on February 8th, 2022 to discuss the deficient practice and the plan for correction. 4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. Weekly Checks of the medication room will be conducted by the clinical leadership team of their respective households for compliance.	

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F 761	Continued From page 35	F 761	5. Corrective action will be completed by February 15th, 2022.	
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 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,	F 842		2/15/22

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F 842	Continued From page 36 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 (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on clinical record review and staff interview, the facility staff failed to maintain a complete and accurate clinical record for two of 26 residents, Resident #76 and #103. Resident #76's pharmacy review for December was altered. Resident #103's code status was not correctly identified in the clinical record.	F 842	F842. Resident Records- Identifiable Information. 1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice.	

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F 842	Continued From page 37 Findings were: 1. Resident #76 was added to the survey sample for review of unnecessary medications. The clinical record was reviewed on 01/12/2022. A pharmacy review for the month of December 2021 was not observed. On 01/13/2021 a pharmacy review was presented by the Director of Nursing (DON). The form provided was a "Medication Review Regimen Review-Note to Attending Physician". The MRR (Medication Review Date) was 12/21/2021. The form was recognized as the form that was observed the previous day that had been signed by the nurse practitioner and scanned into the computer system on 01/04/2022. The form presented had been altered and signed by the clinical coordinator, LPN (licensed practical nurse) #5. The original form had been in the system but the date of the review was mistaken for January, when it had occurred in December. The pharmacy recommendations on the form were: "Recommend review Resident's Current condition and consider tapering Desyrel 50 mg QHS [at hour of sleep] to evaluate if Resident is on the lowest possible does, or continues to need the medication...." The nurse practitioner responded to the request with: "Resident has good response to current treatment which maintains baseline function. Dose reduction is not indicated due to benefits outweigh risks..." The form was signed by the nurse practitioner and dated 01/04/2022. The form presented on 01/13/2022 marked through the nurse practitioner's response and error was written. A new response of "Other" was	F 842	Resident #76's original medication review for December was found in the system. The altered form was discarded. Resident #103's code status was added to the orders on 1/21/22. 2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice. The clinical leadership will conduct a thorough review of all resident EMR's within their respective household to ensure that all monthly pharmacy reviews have been received, and any recommendations from the pharmacy have been addressed by the provider and entered into the resident's EMR. Reviews will also include checking the code status of all residents of their respective household and ensuring that the correct order for code status is in place. 3. Address what measures will be put in place, or what systemic changes will be made to ensure the deficient practice will not occur. A mandatory clinical leadership meeting will be held on February 8th, 2022 to discuss the deficient practices and measures to be put in place to correct deficient practice. As part of BRC's QAPI process, the clinical leadership will conduct monthly chart reviews on all residents within their respective households to ensure that all monthly pharmacy reviews have been received	

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F 842	Continued From page 38 marked and the handwritten on the form was "12/22-Res [resident] verbalized request for increase in Desyrel for insomnia. See order & encounter. Family Aware." The form was signed by LPN #5 and dated 12/28/2021. LPN #5 was interviewed on 01/13/2022 at approximately 8:30 a.m. She was asked about the changes to the form and when they occurred. She stated, "Yesterday, I thought that's what they wanted me to do." During a meeting with the DON and the administrator on 01/13/2022 at approximately 1:30 p.m., the above information was discussed. Concerns were voiced that LPN #5 had altered the form, signed her name, and back dated her signature. The DON stated, "I looked at the record yesterday, I didn't see the December review either, I asked her to see if she could find it. I didn't ask her to do that." No further information was obtained prior to the exit conference on 01/13/2022. 2. Resident # 103 was admitted to the facility 12/9/21 with diagnoses including but not limited to: idiopathic neuropathy, anemia, atrial fib, major depressive disorder, high blood pressure. The most recent MDS (minimum data set) was an admission assessment dated 12/16/21. Resident # 103 was assessed as having severe impairment in cognition with a score of 7 out of 15. The clinical record was reviewed 1/12/22 beginning at 8:00 a.m. The resident did not have a code status documented in the record to indicate whether she wanted any life-saving	F 842	and any recommendations from the pharmacy have been addressed by the provider and entered into the resident's EMR. Reviews will also include checking the code status of all residents of their respective household and ensuring that the correct order for code status is in place. 4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. BRC will utilize our QAPI process of performing monthly chart reviews to ensure that all monthly pharmacy reviews have been received and any recommendations from the pharmacy have been addressed by the provider and entered into the resident's EMR. Reviews will also include checking the code status of all residents of their respective household and ensuring that the correct order for code status is in place. 5. Corrective action will be completed by February 15th, 2022.	

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F 842	Continued From page 39 measures performed. On 1/12/22 the clinical coordinator, LPN (licensed practical nurse) # 3 for Resident #103's unit was asked for assistance in locating the code status. She reviewed the record and stated "Well, I admitted her, so I know she is a 'DNR' [Do Not Resuscitate]. The code status should be here on the face sheet where her picture is right under 'allergies'. I don't know how that was missed; I should have put it in there. I will fix that right now." The administrator and the DON (director of nursing) were informed of the above findings during a meeting with facility staff 1/12/22 beginning at 3:50 p.m. No further information was provided prior to the exit conference.	F 842		