STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495233	A. BUILDING _____ B. WING _____	01/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAUQUIER HEALTH REHABILITATION & NURSING CENTER	360 HOSPITAL DRIVE WARRENTON, VA 20186

(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 An unannounced Emergency Preparedness survey was conducted 01/25/2022 through 01/27/2022. The facility was in substantial compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities.	E 000		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 01/25/2022 through 01/27/2022. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care Requirements. The Life Safety Code survey/report will follow. The census in this 113 certified bed facility was 54 at the time of the survey. The survey sample consisted of 27 current resident reviews and four closed record reviews.	F 000		
F 623 SS=D	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section.	F 623		2/22/22

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

Electronically Signed | 02/11/2022

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F 623	Continued From page 1 §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;	F 623		

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F 623	Continued From page 2	F 623		

(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;
(vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and
(vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act.

§483.15(c)(6) Changes to the notice.
If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available.

§483.15(c)(8) Notice in advance of facility closure
In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l).
This REQUIREMENT is not met as evidenced by:

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F 623	Continued From page 3 Based on staff interview, facility document review, and clinical record review, it was determined that the facility staff failed to provide written notice of hospital transfer for one of 31 residents in the survey sample, Resident #45. Resident #45 transferred to the hospital on 10/11/21. The facility staff failed to provide written notice of the transfer to the resident representative or ombudsman. The findings include: Resident #45 was admitted to the facility on 9/13/16. Resident #45's diagnoses included but were not limited to high blood pressure, heart disease and major depressive disorder. Resident #45's quarterly minimum data set assessment with an assessment reference date of 11/22/21 coded the resident's cognition as severely impaired. Review of Resident #45's clinical record revealed a nurse's note that documented the resident was transferred to the hospital on 10/11/21 for a left knee wound. Further review of Resident #45's clinical record failed to reveal evidence that written notice of the transfer was provided to Resident #45's representative or the ombudsman. On 1/26/22 at 2:11 p.m., an interview was conducted with RN (registered nurse) #1. RN #1 stated the nurses notify residents' representatives of hospital transfers via phone but not via written notice. On 1/26/22 at 2:03 p.m., an interview was conducted with OSM (other staff member) #3 (the	F 623	F623 Notice Requirements Before Transfer/Discharge Criterion #1 □ Resident #45 returned to facility. Criterion #2 □ The facility will review transfer/discharge information for residents who are currently in the hospital; if the resident was not provided with written notice of transfer, it will be provided to the resident/resident representative. Criterion #3 □ Social work and licensed nursing staff will be re-educated by QA Coordinator/designee on the protocol of providing written notice of transfer when the resident is transferred to the hospital or has an unplanned discharge. Criterion #4 □ a 100% notice of transfer audit x3 months for unplanned transfers from our facility or tertiary facility will be completed by social services/designee. Findings from the monthly audits will be reported to the QAPI Committee for additional oversight. Criterion #5 □ Date of compliance 2/22/22	

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F 623	Continued From page 4 social services director) in regards to providing written notice of transfer to the ombudsman. OSM #3 stated she populates the facility discharge list and faxes it to the ombudsman each month. OSM #3 stated that Resident #45's 10/11/21 transfer was not classified as a discharge because the resident returned on 10/12/21 so the resident's name was not on the list faxed to the ombudsman. In regards to written notice to the representative, OSM #3 stated she provides written notice of transfer to the representative via certified mail but she only started this process in November 2021. On 1/26/22 at 5:33 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern. The facility policy titled, "Facility Initiated Transfer and Discharge" documented, "H. Before a facility transfers or discharges a resident, the facility will notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand...8. The facility will send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman..." No further information was presented prior to exit.	F 623		
F 625 SS=D	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or	F 625		2/22/22

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F 625	Continued From page 5 the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on clinical record review, facility document review and staff interviews it was determined that the facility staff failed to evidence a bed hold notice was provided to 1 of 31 residents in the survey sample, Resident #254. Written bed hold notice was not provided to Resident #254 or their responsible party after admission to the hospital on 11/9/2021. The findings include: Resident #254 was admitted to the facility on 10/18/2021 with a readmission on 11/11/2021	F 625	F625 Notice of Bed Hold Policy Before/Upon Transfer Criterion #1 □ Resident #254 had returned to the facility and passed away on January 27, 2022. Criterion #2 □ The facility will review bed-hold notices for residents who are currently in the hospital; if the resident was not provided with written notice of bed hold policy, it will be provided to the resident/resident representative. Criterion #3 □ Social Services and licensed nursing staff will be re-educated	

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F 625	Continued From page 6	F 625		

with diagnoses that included but were not limited to malignant neoplasm of bladder (1) and end stage renal disease (2).

Resident #254's most recent MDS (minimum data set), an admission five-day assessment with an ARD (assessment reference date) of 10/22/2022, coded Resident #254 as scoring a 12 on the brief interview for mental status (BIMS) assessment, 12- being moderately impaired for making daily decisions.

The progress notes for Resident #254 documented in part,

- "11/9/2021 07:52 (7:52 a.m.) Note Text: resident appears shaky this morning. Vital signs normal. Blood sugar 100. Lips and tongue appear dry. Resident barely interacting with staff. Low output from Foley last night. Per report, resident did not drink or sleep well. Juice given. Resident became more alert as he drank. Resident left for dialysis as scheduled."
- "11/9/2021 08:36 (8:36 a.m.) Note Text: This writer was transporting resident to the front of the building to take resident to his transport van for Dialysis. This writer noticed that the resident was not responding well to voice or touch as well as shaking. Called on the overhead for the charge nurse and floor nurse to come assist. Pulse and BS (blood sugar) taken. Resident still was not responding well, thicken apple juice was given and resident started to perk up more. Before leaving the facility, he was asked again if anything was hurting and he stated his stomach, appropriate staff notified. 0750 (7:50 a.m.)"
- "11/9/2021 11:31 (11:31 a.m.) Note Text: This nurse informed that resident was transferred from dialysis to ER (emergency room) via EMS (emergency medical services) for altered mental

by QA Coordinator/designee on the protocol of providing written notice of bed hold policy when the resident is transferred to the hospital or has an unplanned discharge.
Criterion #4 □ a 100% audit of notice of bed-hold policy x3 months for all transfers/discharges to be completed by Social Services/designee. Findings from the monthly audits will be reported to the QAPI Committee for additional oversight.
Criterion #5 □ Date of compliance 2/22/22.

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status and low oxygen saturation. RP (responsible party) already aware."

- "11/9/2021 13:11 (1:11 p.m.) Note Text: This nurse informed that resident will be admitted to [Name of hospital]. Resident ADT out."

- "11/11/2021 23:30 (11:30 p.m.) Note Text: Patient re-admitted to facility at approx. (approximately) 2230 (10:30 p.m.) via stretcher from [Name of hospital] ..."

The clinical record failed to evidence documentation of a bed hold notice being provided to Resident #254's responsible party for the admission to the hospital on 11/9/2021.

On 1/27/2022 at 11:05 a.m., an interview was conducted with OSM (other staff member) #1, the social services director. When asked about resident transfers, OSM #1 stated that when residents were transferred from the facility a packet was sent with the resident which included a transfer notice, a bed hold notice and other required documents. OSM #1 stated that when a resident was transferred from the doctor's office or dialysis center to the hospital they did not receive the packet because they were not aware the resident was going to the hospital. OSM #1 stated that they had not been enforcing the bed hold policy because of the abundance of beds in the facility and the pandemic but did not have documentation of this practice being in place. OSM #1 stated that they would check with the finance staff to see if the previous finance person had sent a bed hold notice or contacted the family.

On 1/27/2022 at 12:45 p.m., an interview was conducted with ASM (administrative staff member) #2, the director of nursing. ASM #2

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stated that the social worker handled bed hold notices. ASM #2 stated that since the facility did not transfer Resident #254 to the hospital the bed hold notice would be sent by certified mail the day after admission to the hospital.

On 1/27/2022 at approximately 1:35 p.m., a request was made to ASM #1, the administrator for the facility policy for bed hold notice.

On 1/27/2022 at 2:46 p.m., ASM #1 provided via email the policy "Bed Hold Policy" dated 5/2019. It documented in part, "Whenever a resident leaves the facility overnight or is discharged to the hospital, the resident's bed may be reserved. The following procedures are to be followed upon the discharge of any resident form this facility ...During normal business hours, the Admissions staff or designee will be responsible for contacting the responsible party to determine if the bed will be held ..."

On 1/27/2022 at approximately 1:30 p.m., ASM #1, the administrator and ASM #2, the director of nursing were made aware of the findings.

No further information was provided prior to exit.

References:

1. malignant neoplasm
The term "malignancy" refers to the presence of cancerous cells that have the ability to spread to other sites in the body (metastasize) or to invade nearby (locally) and destroy tissues. Malignant cells tend to have fast, uncontrolled growth and DO NOT die normally due to changes in their genetic makeup. Malignant cells that are resistant to treatment may return after all

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F 625	Continued From page 9 detectable traces of them have been removed or destroyed. . This information was obtained from the website: https://medlineplus.gov/ency/article/002253.htm. 2. end-stage kidney disease The last stage of chronic kidney disease. This is when your kidneys can no longer support your body's needs. This information was obtained from the website: https://medlineplus.gov/ency/article/000500.htm.	F 625		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on clinical record review and staff interview, it was determined that the facility staff failed to accurately code a Resident's MDS (minimum data set) assessment for 1 of 31 residents in the survey sample, Resident #8. For Resident #8, the facility staff failed to accurately code the 11/01/2021 MDS for hospice care. The findings include: Resident # 8 was admitted to the facility with diagnoses that included but were not limited to: high blood pressure, low iron and breast cancer. Resident # 8's most recent MDS (minimum data set) assessment, a quarterly assessment with an ARD (assessment reference date) of 11/01/2021, coded Resident # 8 as scoring a 0 (zero) out of 15 on the brief interview for mental status (BIMS),	F 641	F641 Accuracy of Assessments Criterion #1 □ Resident #8□s MDS was corrected and transmitted to CMS on 2/9/22. Criterion #2 - a 100% MDS audit for those residents who are on hospice services from date of survey to be completed by 2/22/22. If variances are found, the MDS will be corrected and transmitted to the federal database. Criterion #3 □ MDS Coordinator and social services staff will be re-educated by QA Coordinator/designee regarding accuracy coding for the MDS per the RAI manual. Criterion #4 □ QA/designee will audit MDS accuracy weekly x 8 weeks to ensure that MDS assessments completed for residents who are receiving hospice	2/22/22

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with 0 indicating the resident is severely impaired of cognition for making daily decisions. Section O "Special Treatments, Procedures and Programs" failed to code Resident # 8 as receiving hospice.

The POS (physician's order sheet) for Resident # 8 documented in part, "Admit to LTC (long term care) for hospice service - [Name of Hospice Organization]. Date Order: 07/29/2021."

The comprehensive care plan for Resident # 8 dated 08/03/2021 documented. "FOCUS: [Resident # 8] has chosen [Name of Hospice Organization] services for end of life care. Date Initiated: 07/29/2021." Under "Interventions" it documented in part, "Work with nursing staff to provide maximum comfort for the resident. Date Initiated: 07/29/2021."

On 01/326/2022 at approximately 4:03 p.m., an interview was conducted with LPN (licensed practical nurse) # 3, MDS coordinator. After reviewing Resident # 8's MDS assessment with an ARD of 11/01/2021 and the comprehensive care plan dated 07/29/2021, and the physician's order for Resident # 8's hospice, LPN # 3 stated, stated, "The MDS should have been coded for hospice. It wasn't put in." When asked what she uses as guidance for completing the MDS LPN # 3 stated she uses the RAI (Resident Assessment Instrument) manual.

CMS's (Centers for Medicare/Medicaid Services) Long-Term Care RAI (Resident Assessment Instrument) Version 3.0 Manual documented, "O0100: Special Treatments, Procedures, and Programs (cont.) O0100C, Oxygen therapy. Code continuous or intermittent oxygen administered via mask, cannula, etc., delivered to a resident to

services are accurately coded. Variances will be investigated and corrected.
Findings from the monthly audits will be reported to the QAPI Committee for additional oversight.
Criterion #5- Date of compliance 2/22/22.

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F 641	Continued From page 11 relieve hypoxia in this item. Code oxygen used in Bi-level Positive Airway Pressure/Continuous Positive Airway Pressure (BiPAP/CPAP) here. Do not code hyperbaric oxygen for wound therapy in this item. This item may be coded if the resident places or removes his/her own oxygen mask, cannula." On 01/27/2022 at approximately 1:30 p.m., ASM (administrative staff member) # 1, the administrator and ASM # 2, director of nursing, were made aware of the findings. No further information was provided prior to exit.	F 641		
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable.	F 655		2/22/22

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F 655	Continued From page 12 §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on clinical record review, staff interviews and facility document review, it was determined that the facility staff failed to provide a written summary of the baseline care plan after a readmission to the facility for 1 of 31 residents in the survey sample, Resident #254. There is no evidence to support that Resident #254 and/or the responsible party were provided a written summary of the care plan after the readmission to the facility on 11/11/2021. The findings include: Resident #254 was admitted to the facility on 10/18/2021 with a readmission on 11/11/2021 with diagnoses that included but were not limited	F 655	F655 Baseline Care Plan Criterion #1 □ Resident #254 was discharged on 1/27/22 upon his passing. Criterion #2 □ The facility will review current admission/re-admissions to ensure that the resident or the resident's representative has received a copy of the base line care plan. If variances are found, the resident/resident representative will be provided a written summary. Criterion #3 □ Social worker or designee will re-educate the interdisciplinary team on procedure for providing base line care plan to residents/families. Criterion #4 □ a 100% audit of new admissions/re-admissions to ensure base	

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F 655	Continued From page 13 to malignant neoplasm of bladder (1) and end stage renal disease (2). Resident #254's most recent MDS (minimum data set), an admission five-day assessment with an ARD (assessment reference date) of 10/22/2021, coded Resident #254 as scoring a 12 on the brief interview for mental status (BIMS) assessment, 12- being moderately impaired for making daily decisions. The progress notes for Resident #254 documented in part, - "11/9/2021 07:52 (7:52 a.m.) Note Text: resident appears shaky this morning. Vital signs normal. Blood sugar 100. Lips and tongue appear dry. Resident barely interacting with staff. Low output from Foley last night. Per report, resident did not drink or sleep well. Juice given. Resident became more alert as he drank. Resident left for dialysis as scheduled." - "11/9/2021 08:36 (8:36 a.m.) Note Text: This writer was transporting resident to the front of the building to take resident to his transport van for Dialysis. This writer noticed that the resident was not responding well to voice or touch as well as shaking. Called on the overhead for the charge nurse and floor nurse to come assist. Pulse and BS (blood sugar) taken. Resident still was not responding well, thicken apple juice was given and resident started to perk up more. Before leaving the facility, he was asked again if anything was hurting and he stated his stomach, appropriate staff notified. 0750 (7:50 a.m.)" - "11/9/2021 11:31 (11:31 a.m.) Note Text: This nurse informed that resident was transferred from dialysis to ER (emergency room) via EMS (emergency medical services) for altered mental status and low oxygen saturation. RP	F 655	line care plan has been provided to residents/families will be completed weekly x 8 weeks to be completed by Social Services or designee. Findings from the monthly audits will be reported to the QAPI Committee for additional oversight. Criterion #5 □ Date of compliance 2/22/22	

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(responsible party) already aware."

- "11/9/2021 13:11 (1:11 p.m.) Note Text: This nurse informed that resident will be admitted to [Name of hospital]. Resident ADT out."
- "11/11/2021 23:30 (11:30 p.m.) Note Text: Patient re-admitted to facility at approx. (approximately) 2230 (10:30 p.m.) via stretcher from [Name of hospital] ..."
- "11/12/2021 13:04 (1:04 p.m.) Note Text: Care Plan meeting: Resident, Spouse, Son-in-law, NP (nurse practitioner), Therapy, Care Manager, and this SW (social worker) present for this meeting... Medications and care plan were discussed..."

The clinical record failed to evidence a written summary of the baseline care plan for the readmission on 11/11/2021 being offered and/or provided to the resident and/or responsible party.

On 1/27/2022 at 11:05 a.m., an interview was conducted with OSM (other staff member) #1, the social services director. OSM #1 stated that the MDS (minimum data set) staff managed the care plans and each department documented their specific areas on the care plan. OSM #1 stated that they did not create baseline care plans for readmissions because the comprehensive care plan was reactivated when they were readmitted. OSM #1 stated that they offered a copy of the care plan to the resident or responsible party when they had the comprehensive care plan meetings.

On 1/27/2022 at 11:15 a.m., an interview was conducted with LPN (licensed practical nurse) #3, MDS coordinator. LPN #3 stated that the comprehensive care plan was updated for readmissions to include any new needs identified

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from the hospitalization. LPN #3 stated that Resident #254 was sent to the hospital from the dialysis center and his readmission was anticipated so they did not discontinue the comprehensive care plan. LPN #3 stated that they reviewed the care plan on readmission and used that as the baseline care plan. At this time, a request was made for evidence of a written summary of the care plan being offered and/or provided to the resident and/or responsible party.

On 1/27/2022 at 12:00 p.m., LPN #3 provided a copy of the care plan meeting note dated 11/12/2021 and stated that it documented the care plan being discussed with the family. When asked if the note evidenced a written summary being offered and/or provided to the resident and/or responsible party, LPN #3 stated, "No."

On 1/27/2022 at 12:50 p.m., an interview was conducted with LPN #1, unit manager. LPN #1 stated that residents readmitted to the facility had their existing comprehensive care plan reviewed on admission. LPN #1 stated that a written copy of the care plan was offered and provided on request to the resident and/or responsible party during the care plan meetings. LPN #1 stated that the social worker documented the meetings and the evidence would be in the note.

On 1/27/2022 at approximately 1:35 p.m., a request was made to ASM #1, the administrator for the facility policy for baseline care planning.

On 1/27/2022 at 2:46 p.m., ASM #1 provided via email the policy "Baseline Care Assessment and Comprehensive Care Plan" dated 7/2019. It documented in part, "All residents admitted to [Name of facility] are required to have a baseline

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F 655	Continued From page 16 care plan assessment completed within 48 hours of admission...Review of baseline care plan and medication list, with a printed summary is provided to the resident and/or residentts [sic] responsible party prior to completion of the comprehensive care plan. Documentation of this conversation/review is completed is in the EMR (electronic medical record)..." On 1/27/2022 at approximately 1:30 p.m., ASM #1, the administrator and ASM #2, the director of nursing were made aware of the findings. No further information was provided prior to exit. References: 1. malignant neoplasm The term "malignancy" refers to the presence of cancerous cells that have the ability to spread to other sites in the body (metastasize) or to invade nearby (locally) and destroy tissues. Malignant cells tend to have fast, uncontrolled growth and DO NOT die normally due to changes in their genetic makeup. Malignant cells that are resistant to treatment may return after all detectable traces of them have been removed or destroyed. . This information was obtained from the website: https://medlineplus.gov/ency/article/002253.htm. 2. end-stage kidney disease The last stage of chronic kidney disease. This is when your kidneys can no longer support your body's needs. This information was obtained from the website: https://medlineplus.gov/ency/article/000500.htm.	F 655		
F 656 SS=E	Develop/Implement Comprehensive Care Plan	F 656		2/22/22

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F 656	Continued From page 17 CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (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.	F 656		

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F 656	Continued From page 18 (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, facility document review and clinical record review, it was determined the facility staff failed to implement the comprehensive care plan for four of 31 residents in the survey sample, Residents #51, #8, #5, and #6. The findings include: 1. The facility staff failed to offer non-pharmacological interventions and document the location of pain prior to the administration of pain medications per the comprehensive care plan for Resident #51. Resident #51 was admitted to the facility on 6/6/2017 with diagnoses that included but not limited to: stroke (abnormal condition in which hemorrhage or blockage of the blood vessels of the brain leads to oxygen lack and resulting symptoms - sudden loss of ability to move a body part [as an arm or parts of the face], or to speak, paralysis weakness or if severe, death) (1), hemiplegia (paralysis affecting only one side of the body (2), Bipolar Disorder (a mental disorder characterized by episodes of mania and depression) (3), and chronic pain syndrome. The most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 1/5/2022, coded the resident as scoring a "13" on the BIMS (brief interview for mental status) score, indicating the	F 656	F656 Develop/Implement Comprehensive Care Plan □ Criterion #1 □ Resident #□s 51□s care plan has been reviewed and staff and staff are documenting physical monitors for pain and non-pharmacological interventions related to the administration of pain medication. Resident #8□s care plan has been reviewed and use of wander guard is being documented in the resident□s medical record. Resident #5□s care plan has been reviewed and weights are being obtained and documented in the medical record in accordance with physician order. Resident #6□s care plan has been reviewed and behavior monitoring is being documented in the resident□s medical record. These residents remain in the facility. Criterion #2 □ The facility will review orders and care plans for current residents to ensure that the care plans are complete, and to address the unique needs of the resident. Identified variances will be investigated and corrected. Criterion #3 - The DON/designee will re-educate all licensed nursing staff on proper documentation of non-pharmacological interventions;	

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resident is capable of making daily cognitive decisions. The resident was coded as requiring extensive assistance for most of her activities of daily living such as bathing, eating, transfers and dressing. In Section J - Health Conditions, the resident was coded as having pain in the past five days. The resident was coded as having almost constant pain and the pain was coded as being severe in nature.

The comprehensive care plan dated, 6/9/2017 and revised on 8/24/2021, documented in part, "Focus: (Resident #51) has potential for pain related to S/P (status post) left hip fx (fracture), left hemi (hemiplegia) S/P CVA (stroke), depression, and other generalized discomforts such as neuropathic pain S/P CVA, c/o (complaint of) muscle spasms." The "Interventions" documented in part, "Anticipate (Resident #51)'s need for pain relief and respond immediately to any complaint of pain. Monitor/document for probable cause for each pain episode. Remove/limit cases where possible. Monitor/record pain characteristics as patient complains of pain and PRN (as needed), Quality (e.g. sharp, burning); Severity (1 to 10 scale); Anatomical location; Onset, Duration (e.g., continuous, intermittent); Aggravating factors; Relieving factors. Provide non-pharmacological interventions for pain relief prior to administering PRN medications such as change in position, cool compress or heat, diversional activities such as tv, snack, drink, others as desired."

The November 2021 MAR (medication administration record) documented the above physician orders. On 11/21/2021 at 1:25 a.m., 11/23/2021 at 12:00 a.m. and 11/29/2021 at 10:00 p.m. the Morphine was administered. The

wander guard use; recording of weights; recording of behaviors.
Criterion #4 - The DON/designee will conduct weekly audits x8 weeks, on 25% of residents, to compare care plan interventions to medical record documentation demonstrating implementation of the care plan. Variances will be investigated; staff education or correction will be completed based on the weekly audits and summary of the audits will be provided to QAPI Committee for additional oversight.
Criterion #5 □ Date of compliance 2/22/22.

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location of the pain was documented as "3." There was no chart code for "3" for location. On 11/23/2021 at 2:07 p.m. the Morphine was administered, documented for non-pharmacological interventions was "y." A "y" was documented also at that time for the location of pain.

The December 2021 MAR documented the above physician orders. The Morphine was administered on 12/10/2021 at 3:08 a.m., 12/30/2021 at 1:51 a.m. and 12/31/2021 at 6:10 a.m., the location of the pain was documented as a "3." On 12/16/2021 at 11:40 p.m., the Morphine was administered. It was documented, a "0" in the box for the non-pharmacological interventions.

The January 2022 MAR documented the above physician orders. The Acetaminophen was administered on 1/10/2022 at 6:25 a.m. In the box for the administration of non-pharmacological interventions and the location of the pain, documented, "N/A." The Morphine was administered on 1/5/2021 at 2:33 p.m. A "N/A" was documented in the box for non-pharmacological interventions and for the location of the pain. On 1/8/2022 at 12:05 p.m., 1/9/2022 at 10:32 a.m., 1/10/2022 at 12:02 a.m. and 11:18 a.m., 1/16/2022 at 9:55 a.m., there was a "y" documented in the box for non-pharmacological interventions. On 1/17/2022 at 6:15 a.m. the box for non-pharmacological interventions was blank.

Review of the nurse's notes from 11/1/2021 through 1/127/2022 failed to reveal further explanation of the MAR documentation.

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An interview was conducted with RN (registered nurse) #1, the unit manager, on 1/27/2022 at 9:20 a.m. When asked the purpose of the care plan, RN #1 stated it was the plan of care for the resident, how to care for the resident. When asked should the care plan be implemented and followed, RN #1 stated, yes.

An interview was conducted with LPN (licensed practical nurse) #1, the unit manager, on 1/27/2022 at 9:41 a.m. The above information was shared with LPN #1. When asked if that was following the comprehensive care plan, LPN #1 stated, no.

The facility policy, "Baseline Care Assessment and Comprehensive Care Plan" documented in part, "The care plan must describe the services that are furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well being in accordance with the comprehensive assessment...8. The care planning process must include the resident with information so that he/she can participate in goals and wishes regarding treatment. 9. When there appears to be a conflict between a resident's right and the residents health or safety, the facility must accommodate both the resident's rights and the residents health, including exploration of alternative care through the care planning process in which the resident participates. 10. The care plan must reflect current standards of professional practice. 11. The care plan includes treatment objectives that have measurable outcomes with time tables and specific approaches to meet the defined needs."

"A written care plan serves as a communication tool among health care team members that helps

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ensure continuity of care...The nursing care plan is a vital source of information about the patient's problems, needs, and goals. It contains detailed instructions for achieving the goals established for the patient and is used to direct care."(6)

ASM (administrative staff member) #1, the administrator, and ASM #2, the director of nursing, were made aware of the above concern on 1/27/2022 at 1:33 p.m.

No further information was provided prior to exit.

References:
(1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 114.
(2) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 266.
(3) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 72.
(4) This information was obtained from the following website: https://medlineplus.gov/druginfo/meds/a681004.html.
(5) This information was obtained from the following website: https://medlineplus.gov/druginfo/meds/a682133.html
(6) Fundamentals of Nursing Lippincott Williams & Wilkins 2007 Lippincott Company Philadelphia pages 65-77.

2. The facility staff failed to implement Resident # 8's comprehensive care plan for checking the placement of a wander guard.

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Resident # 8 was admitted to the facility with diagnoses that included but were not limited to: high blood pressure, low iron and breast cancer.

Resident # 8's most recent MDS (minimum data set) assessment, a quarterly assessment with an ARD (assessment reference date) of 11/01/2021, coded Resident # 8 as scoring a 0 (zero) out of 15 on the brief interview for mental status (BIMS). A score of 0 indicates the resident severely impaired of cognition for making daily decisions. Section P "Restraints and Alarms" coded Resident # 8 for a wander guard "Used daily."

The POS (physician's order sheet) for Resident # 8 documented in part, "Wanderguard to wheelchair check function & (and) placement every shift. Date Order: 08/06/2021. Start Date: 08/06/2021."

The comprehensive care plan for Resident # 8 dated 08/03/2021 documented. "FOCUS: [Resident # 8] is an elopement risk/wanderer AEB (as evidenced by) impaired safety awareness. Date Initiated: 11/08/2021." Under "Interventions" it documented in part, "WANDER ALERT: Wander guard to wheelchair. Check placement every shift. Date Initiated: 11/08/2021."

The eTAR (electronic treatment record) for Resident # 8 dated January 2022 documented in part, "Wanderguard to wheelchair check function & (and) placement every shift. Start Date: 08/06/2021." Further review of the eTAR revealed blanks on 01/17/2022 on the night shift and on 01/23/2022 on the evening shift.

On 01/27/2022 at approximately 9:20 a.m., an interview was conducted with RN (registered

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nurse) # 1, unit manager. After reviewing Resident # 8's the comprehensive care plan dated 08/03/2021, the physician's order for Resident # 8's wander guard and the blanks on the eTAR dated January 2022 for the dates listed above, RN # 1 was asked what the blanks on the eTAR indicated. RN # 1 stated, "It wasn't done. If it's blank I can't say it was done." RN # 1 was asked if Resident # 8's comprehensive care plan was implemented. RN # 1 stated no.

On 01/27/2022 at approximately 1:30 p.m., ASM (administrative staff member) # 1, the administrator and ASM # 2, director of nursing, were made aware of the findings.

No further information was provided prior to exit.

3. The facility staff failed to implement Resident # 5's comprehensive care plan for obtaining physician ordered daily weights.

Resident # 5 was admitted to the facility with diagnoses that included but were not limited to: high blood pressure, heart failure and cancer of the liver.

Resident # 5's most recent MDS (minimum data set) assessment, a quarterly assessment with an ARD (assessment reference date) of 10/27/2021, coded Resident # 5 as scoring a four out of 15 on the brief interview for mental status (BIMS), with four indicating the resident is severely impaired of cognition for making daily decisions.

The POS (physician's order sheet) for Resident # 5 documented in part, "Daily weight every day for Heart Failure. If weight greater than 3LBS (three pounds) in 1 (one) day and/or greater than 5LBS

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(five pounds) in 1 (one) week - reweigh immediately notify MD (medical doctor) loos/gain. Date Order: 03/26/2021. Start Date: 03/27/2021."

The comprehensive care plan for Resident # 5 with a revision date of 05/07/2021 documented. "FOCUS: [Resident # 5] is at increased nutritional risk r/t requiring a therapeutic diet, PMH (past medical history) of T2DM (type two diabetes mellitus), diabetic foot wound, HF (heart failure), Alzheimer's disease, dementia, chronic pain syndrome. She chooses to follow own eating plan that may contradict physician-ordered plan. Current BMI is 47.4 (obese classification). Revision on: 05/07/202." Under "Interventions" it documented in part, "Monitor weight, notify MD/RP (medical doctor/responsible party) of weight change 5 % (five percent) x (times) 30 days, 7.5 (seven and a half) % x 90 days, 10% x 180 days, if indicated, anticipate variations and investigate causative factors upon occurrence. Date Initiated: 02/17/2021."

The eTAR (electronic treatment record) for Resident # 5 dated November 2021 through January 2022 documented in part, "Daily weight every day for Heart Failure. If weight greater than 3LBS (three pounds) in 1 (one) day and/or greater than 5LBS (five pounds) in 1 (one) week - reweigh immediately notify MD [medical doctor] loss/gain. Start Date: 03/27/2021." Further review of the eTARs revealed a blank on 11/24/2021, 12/17/2021, 12/23/2021, 12/25/2021, 12/29/2021, 12/30/2021, 01/08/2022 and on 01/14/2022.

The facility's "Weights and Vitals Summary" sheet for Resident # 5 dated November 2021 through January 2022 failed to evidence weights for the

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same dates as listed above.

The facility's progress notes for Resident # 5 dated November 2021 through January 2022 failed to evidence weights for the same dates as listed above.

On 01/27/2022 at approximately 9:20 a.m., an interview was conducted with RN (registered nurse) # 1, unit manager. After reviewing Resident # 5's the comprehensive care plan dated 05/07/2021, the physician's order for Resident # 5's weigh and the blanks on the eTARs for the dates listed above, RN # 1 was asked what the blanks on the eTAR indicated. RN # 1 stated, "It wasn't done. If it's blank I can't say it was done." RN # 1 was asked if Resident # 5's comprehensive care plan was implemented. RN # 1 stated no.

On 01/27/2022 at approximately 1:30 p.m., ASM (administrative staff member) # 1, the administrator and ASM # 2, director of nursing, were made aware of the findings.

No further information was provided prior to exit.

4. The facility staff failed to implement Resident # 6's comprehensive care plan for behavior monitoring.

Resident#16 was admitted to the facility with diagnoses that included but were not limited to Alzheimer's disease (1) and dementia with behavioral disturbances (2).

Resident #6's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 10/29/2021,

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coded Resident # 6 as scoring an eleven on the staff assessment for mental status (BIMS) of a score of 0 - 15, with 11 indicating the resident is moderately impaired for making daily decisions. Section N documented Resident # 6 receiving antipsychotic and antidepressant medications.

The POS (physician's order sheet) for Resident # 6 documented in part, "Seroquel Tablet. Give 25MG (milligrams) by mouth at bedtime related to DEMENTIA IN OTHER DISEASES CLASSIFIED ELSEWHERE WITH BEHAVIORAL DISTURBANCES. Order Date: 12/30/2021. Start Date: 12/30/2021."

The comprehensive care plan for Resident # 6 dated 03/01/2019 documented in part, "Focus: [Resident # 6] uses antipsychotics r/t (related to) dementia with behavioral disturbances. Date Initiated: 03/01/2019." Under "Interventions/Tasks" it documented in part, "Monitor/record occurrence of for target behavior symptoms Specify: pacing, wandering, disrobing, inappropriate response to verbal communication, violence/aggression towards staff/others and document per facility protocol. Date Initiated: 03/01/2019."

The eMARs (electronic medication administration records) for Resident # 6 dated 12/01/2021 through 01/26/2022 documented side effect monitoring for the use of psychotropic medications. The eMARs failed to evidence monitoring of behaviors.

The progress notes for Resident # 6 dated 12/01/2021 through 01/26/2022 failed to evidence monitoring of behaviors.

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On 01/27/2022 at approximately 9:20 a.m., an interview was conducted with RN (registered nurse) # 1, unit manager. After reviewing Resident # 6's the comprehensive care plan dated 03/01/2019, the physician's order for Resident # 6's use of Seroquel the facility's progress notes dated 12/01/2021 through 01/26/2022 and the eMAR dated 12/01/2021 through 01/26/2022, RN # 1 was asked if Resident # 6's comprehensive care plan was implemented for behavior monitoring. RN # 1 stated no.

On 01/27/2022 at approximately 1:30 p.m., ASM (administrative staff member) # 1, the administrator and ASM # 2, director of nursing, were made aware of the findings.

No further information was provided prior to exit.

REFERENCES
[1] A brain disorder that seriously affects a person's ability to carry out daily activities) This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/alzheimersdisease.html.

[2] Psychological symptoms and behavioral abnormalities are common and prominent characteristics of dementia. They include symptoms such as depression, anxiety psychosis, agitation, aggression, disinhibition, and sleep disturbances. Approximately 30% to 90% of patients with dementia suffer from such behavioral disorders. There are complex interactions between cognitive deficits, psychological symptoms, and behavioral abnormalities. This information was obtained from the website:

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F 656	Continued From page 29 https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3181717/.	F 656		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, it was determined that the facility staff failed to review and revise the comprehensive care plan for one of 31 residents	F 657	F657 Care Plan Timing and Revision Criterion #1 □ Resident #45□s care plan has been reviewed and updated to reflect use of anticoagulant medication.	2/22/22

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F 657	Continued From page 30 in the survey sample, Resident #45. The facility staff failed to review and revise Resident #45's comprehensive care plan for anticoagulant (blood thinning) medication use. The findings include: Resident #45 was admitted to the facility on 9/13/16. Resident #45's diagnoses included but were not limited to high blood pressure, heart disease and major depressive disorder. Resident #45's quarterly minimum data set assessment with an assessment reference date of 11/22/21, coded the resident's cognition as severely impaired. Review of Resident #45's clinical record revealed a physician's order dated 8/10/21 for Xarelto (1) 20 mg (milligrams) - one tablet by mouth in the evening for a right lower extremity deep vein thrombosis (blood clot). Review of Resident #45's January 2022 medication administration record revealed the resident was administered Xarelto 20 mg each evening during the month. Resident #45's comprehensive care plan dated 9/14/16 failed to reveal the care plan was reviewed and revised to include anticoagulant use. On 1/26/22 at 1:56 p.m., an interview was conducted with LPN (licensed practical nurse) #1. LPN #1 stated the purpose of the care plan is to have a patient's plan of care in place so everyone knows how to care for someone and what their needs are. LPN #1 stated anticoagulant use should be included on residents' care plans. On 1/26/22 at 2:11 p.m., RN (registered nurse) #1	F 657	Criterion #2 □ The facility will review changes to resident care to ensure that care planning has been implemented. Identified variances will be investigated and corrected. Criterion #3 □ MDS Coordinator/designee will re-educate licensed nursing staff on review of physician orders for anti-coagulants and the subsequent care planning of those orders. Criterion #4 □ New admissions and residents with new orders for anticoagulant medication will have audits completed weekly by the MDS Coordinator/designee x8 weeks. Variances will be corrected, and a summary of the weekly audits will be provided to QAPI Committee for additional oversight. Criterion #5 □ Date of compliance 2/22/22.	

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F 657	Continued From page 31 stated Resident #45's anticoagulant use was not included on the resident's care plan. On 1/26/22 at 5:33 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern. The facility policy titled, "Baseline Care Assessment and Comprehensive Care Plan" documented, "12. The care plan is evaluated and changed in reference to the resident's response to treatment and whenever there is a change in the resident. All disciplines participate in maintaining the care plan so that it reflects the current status of the resident..." No further information was presented prior to exit. Reference: (1) Xarelto is a blood thinning medication used to treat blood clots. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a611049.html	F 657		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, it was determined the facility staff failed to follow professional standards	F 658	F658 Services Provided Meet Professional Standards Criterion #1 □ Resident # 51□s pain	2/22/22

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F 658	Continued From page 32 of practice for the clarification of physician orders for pain medications for one of 31 residents in the survey sample, Resident #51. The findings include: Resident #51 was admitted to the facility on 6/6/2017 with diagnoses that included but not limited to: stroke (abnormal condition in which hemorrhage or blockage of the blood vessels of the brain leads to oxygen lack and resulting symptoms - sudden loss of ability to move a body part [as an arm or parts of the face], or to speak, paralysis weakness or if severe, death) (1), hemiplegia (paralysis affecting only one side of the body (2), Bipolar Disorder (a mental disorder characterized by episodes of mania and depression) (3), and chronic pain syndrome. The most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 1/5/2022, coded the resident as scoring a "13" on the BIMS (brief interview for mental status) score, indicating the resident is capable of making daily cognitive decisions. The resident was coded as requiring extensive assistance for most of her activities of daily living such as bathing, eating, transfers and dressing. In Section J - Health Conditions, the resident was coded as having pain in the past five days. The resident was coded as having almost constant pain and the pain was coded as being severe in nature. The physician orders dated 11/20/2021 documented, "Acetaminophen (Tylenol - used to treat mild to moderate pain) (4) Tablet 325 mg (milligrams); give 650 mg by mouth every 8 hours as needed for Pain scale 1-5.	F 658	medication orders have been reviewed and the medical record documents accurate administration of the pain medication in accordance with the physician□s orders. Criterion #2 □ The facility will review residents who are receiving pain management regimens to ensure that parameters/physician orders are being followed. All charts with discrepancies will be identified and licensed nurses will be re-educated on facility for clarifying physician orders and documentation of medication administration. Criterion #3 □ DON/designee will re-educate licensed nursing staff on clarification/implementation of physician's orders. Criterion #4 □ DON or designee will conduct weekly audits x8 weeks to monitor clarity of pain medication orders and that administration of pain medications are consistent with physician orders. Variances will be investigated, and appropriate actions will be taken based on the audit findings and a summary of the audits will be provided to QAPI Committee for additional oversight. Criterion #5 □ Date of compliance 2/22/22.	

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The physician order dated 11/20/2021 documented, "Morphine Sulfate (used to treat moderate to severe pain) (5) solution 20MG/ML (milligrams per milliliter) Give 5 mg by mouth every 4 hours as needed for pain scale 5-10 = administration of Give 0.25 M: (5 mg).

The December 2021 MAR (medication administration record) documented the above orders. On 12/30/2021 at 9:39 p.m., Resident #51 received Acetaminophen for a documented pain level of "5."

The January 2022 MAR documented the above orders. On 1/9/2022 at 10:32 a.m. and 1/22/2022 at 11:48 p.m., Resident #51 received Morphine for a documented pain level of "5."

The comprehensive care plan dated, 6/9/2017 and revised on 8/24/2021, documented in part, "Focus: (Resident #51) has potential for pain related to S/P (status post) left hip fx (fracture), left hemi (hemiplegia) S/P CVA (stroke), depression, and other generalized discomforts such as neuropathic pain S/P CVA, c/o (complaint of) muscle spasms." The "Interventions" documented in part, "Anticipate (Resident #51)'s need for pain relief and respond immediately to any complaint of pain. Monitor/document for probable cause for each pain episode. Remove/limit cases where possible. Monitor/record pain characteristics as patient complains of pain and PRN (as needed), Quality (e.g. sharp, burning); Severity (1 to 10 scale); Anatomical location; Onset, Duration (e.g., continuous, intermittent); Aggravating factors; Relieving factors. Provide non-pharmacological interventions for pain relief prior to administering

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PRN medications such as change in position, cool compress or heat, diversional activities such as TV, snack, drink, others as desired."

An interview was conducted with LPN (licensed practical nurse) #1, the unit manager, on 1/27/2022 at 9:41 a.m. The above orders for Acetaminophen and Morphine were reviewed with LPN #1. When asked what medication should the nurse give if the resident states their pain level is a "5," LPN #1 stated I don't know, that needs to be clarified. LPN #1 further stated it should be for one to five and then six to ten.

An interview was conducted with ASM (administrative staff member) #2, the director of nursing, on 1/27/2022 at 10:39 a.m. The above orders for Acetaminophen and Morphine were reviewed with ASM #2. When asked what medication should the nurse give if the resident states their pain level is a "5," ASM #2 stated that's not right. ASM #2 was asked what needed to be done; ASM #2 stated the orders needed to be clarified with the doctor.

A policy on the clarification of orders was requested on 1/27/2022 at approximately 10:30 a.m. The following policy was presented, "Admission of Resident." The policy documented in part, "Fax physician for clarification orders and transcribe telephone order to note clarification. Clarify ALL medications with MD (medical doctor) and note clarifications."

On 1/27/2022 at 1:33 p.m. ASM #2, the director of nursing, stated their standard of practice the facility followed was Nursing by Lippincott.

According to Lippincott's "Fundamentals of

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F 658	Continued From page 35 Nursing, 5th edition, page 553 documents the following statement, "Always clarify with the prescriber any medication order that is unclear or seems inappropriate." ASM (administrative staff member) #1, the administrator, and ASM #2, the director of nursing, were made aware of the above concern on 1/27/2022 at 1:33 p.m. No further information was provided prior to exit. References: (1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 114. (2) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 266. (3) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 72. (4) This information was obtained from the following website: https://medlineplus.gov/druginfo/meds/a681004.html. (5) This information was obtained from the following website: https://medlineplus.gov/druginfo/meds/a682133.html	F 658		
F 684 SS=E	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	F 684		2/22/22

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F 684	Continued From page 36 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 clinical record review and staff interview, it was determined that the facility staff failed to obtain daily weights according to the physician's orders for 1 of 31 residents in the survey sample, Resident # 5. The findings include: Resident # 5 was admitted to the facility with diagnoses that included but were not limited to: high blood pressure, heart failure and cancer of the liver. Resident # 5's most recent MDS (minimum data set) assessment, a quarterly assessment with an ARD (assessment reference date) of 10/27/2021, coded Resident # 5 as scoring a four on the brief interview for mental status (BIMS), indication the resident is severely impaired of cognition for making daily decisions. The POS [physician's order sheet] for Resident # 5 documented in part, "Daily weight every day for Heart Failure. If weight greater than 3LBS (three pounds) in 1 day and/or greater than 5LBS (five pounds) in 1 week - reweigh immediately notify MD (medical doctor) loss/gain. Date Order: 03/26/2021. Start Date: 03/27/2021." The comprehensive care plan for Resident # 5 with a revision date of 05/07/2021 documented. "FOCUS: [Resident # 5] is at increased nutritional risk r/t requiring a therapeutic diet, PMH (past	F 684	F684 Quality of Care Criterion #1 □ Resident #5□s weights are being obtained and documented per physician order. Criterion #2 □ The facility will review, and address weights entered for all residents who have daily weights ordered to ensure accuracy/completion. Criterion #3 □ DON/designee will re-educate licensed staff on process/procedure for obtaining and documenting daily weights. Criterion #4 □ DON/designee will conduct daily audits of daily weights during clinical morning meetings. Variances will be investigated, appropriate action taken, and findings from the daily audits will be submitted to QAPI for review and oversight. Criterion #5 □ Date of compliance 2/22/22.	

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F 684	Continued From page 37	F 684		

medical history) of T2DM (type two diabetes mellitus), diabetic foot wound, HF (heart failure), Alzheimer's disease, dementia, chronic pain syndrome. She chooses to follow own eating plan that may contradict physician-ordered plan. Current BMI is 47.4 (obese classification). Revision on: 05/07/202." Under "Interventions" it documented in part, "Monitor weight, notify MD/RP (medical doctor/responsible party) of weight change 5 % (five percent) x (times) 30 days, 7.5 (seven and a half) % x 90 days, 10% x 180 days, if indicated, anticipate variations and investigate causative factors upon occurrence. Date Initiated: 02/17/2021."

The eTAR (electronic treatment record) for Resident # 5 dated November 2021 through January 2022 documented in part, "Daily weight every day for Heart Failure. If weight greater than 3LBS (three pounds) in 1 day and/or greater than 5LBS (five pounds) in 1 week - reweigh immediately notify MD (medical doctor) loss/gain. Start Date: 03/27/2021." Further review of the eTARs revealed a blank on 11/24/2021, 12/17/2021, 12/23/2021, 12/25/2021, 12/29/2021, 12/30/2021, 01/08/2022 and on 01/14/2022.

The facility's "Weights and Vitals Summary" sheet for Resident # 5 dated November 2021 through January 2022 failed to evidence weights for the same dates as listed above.
The facility's progress notes for Resident # 5 dated November 2021 through January 2022 failed to evidence weights for the same dates as listed above.

On 01/27/2022 at approximately 9:20 a.m., an interview was conducted with RN (registered nurse) # 1, unit manager. When asked why

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F 684	Continued From page 38 Resident # 5's weight was being monitored RN # 3 stated, "For congestive heart failure to ensure there is no fluid build-up around their heart." After reviewing Resident # 5's the comprehensive care plan dated 05/07/2021, the physician's order for Resident # 5's weigh and the blanks on the eTARs for the dates listed above, RN # 3 was asked what the blanks on the eTAR indicated. RN # 3 stated, "It wasn't done. If it's blank I can't say it was done." On 01/27/2022 at approximately 1:30 p.m., ASM (administrative staff member) # 1, the administrator and ASM # 2, director of nursing, were made aware of the findings. No further information was provided prior to exit.	F 684		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on clinical record review and staff interview, it was determined that the facility staff failed to check the placement and function of the wander guard according to the physician's orders for 1 of 31 residents in the survey sample, Resident # 8.	F 689	F689 Free of Accident/Hazards/Supervision/Devices Criterion #1 □ Resident #8□s wander guard is being monitored for placement and function and documented in the resident□s medical record. Criterion #2 □ The facility will review all	2/22/22

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F 689	Continued From page 39 The findings include: Resident # 8 was admitted to the facility with diagnoses that included but were not limited to: high blood pressure, low iron and breast cancer. Resident # 8's most recent MDS (minimum data set) assessment, a quarterly assessment with an ARD (assessment reference date) of 11/01/2021, coded Resident # 8 as scoring a 0 (zero) on the brief interview for mental status (BIMS), indicating the resident is severely impaired of cognition for making daily decisions. Section P "Restraints and Alarms" coded Resident # 8 for a wander guard "Used daily." The POS (physician's order sheet) for Resident # 8 documented in part, "Wanderguard to wheelchair check function & (and) placement every shift. Date Order: 08/06/2021. Start Date: 08/06/2021." The comprehensive care plan for Resident # 8 dated 08/03/2021 documented. "FOCUS: [Resident # 8] is an elopement risk/wanderer AEB (as evidenced by) impaired safety awareness. Date Initiated: 11/08/2021." Under "Interventions" it documented in part, "WANDER ALERT: Wander guard to wheelchair. Check placement every shift. Date Initiated: 11/08/2021." The facility's "Elopement Risk Assessment" for Resident # 8 dated 11/22/2021 documented in part, "1. Is the resident cognitively impaired with poor decision-making skills? i.e. intermittent confusion, cognitive deficit or disoriented all the time?): Yes. 2. Is the resident able to ambulate or move around the facility independently or with limited assistance? (including w/c and assistive	F 689	orders for residents with wander guards to ensure that the medical record documents monitoring of the device for placement and function. If variances are identified, staff will be re-educated. Criterion #3 □ DON/designee will re-educate licensed staff on implementation and review of orders regarding wander guards to ensure documentation of monitoring the device for placement and function. Criterion #4 □ DON/designee will conduct weekly audits x 8 weeks to ensure that residents who are using wander guard have documentation that the device is being monitored for placement and function per facility protocol. Any identified variances will be investigated, and appropriate action will be taken. Findings from the weekly audits will be reported to QAPI Committee for additional oversight and recommendation. Criterion #5 □ Date of compliance 2/22/22.	

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devices): Yes." Under section "I" it documented, "Obtain wanderguard order if any of the following are met: 1. All questions are answered YES. 2. If #'s 1&2 are answered YES."

The eTAR (electronic treatment record) for Resident # 8 dated January 2022 documented in part, "Wanderguard to wheelchair check function & (and) placement every shift. Start Date: 08/06/2021." Further review of the eTAR revealed blanks on 01/17/2022 on the night shift and on 01/23/2022 on the evening shift.

On 01/27/2022 at approximately 9:20 a.m., an interview was conducted with RN (registered nurse) # 1, unit manager. After reviewing Resident # 8's the comprehensive care plan dated 11/08/2021, the physician's order for Resident # 8's wander guard and the blanks on the eTAR dated January 2022 for the dates listed above, RN # 1 was asked what the blanks on the eTAR indicated. RN # 1 stated, "It wasn't done. If it's blank I can't say it was done."

The facility's policy "Elopement Disoriented Residents Leaving Premises Without Notification of Staff, 831-023" documented in part, "Wanderguards will be checked out from the nurse manager or charge nurse. The placement or removal of wanderguards from individual residents will be communicated to the administrative assistant, transport coordinator, or designee for updating information in the elopement risk binder. Every shift, nursing staff assigned to the resident will ensure proper placement of the wanderguard. Functionality of the wanderguard will be checked weekly by nursing staff or designee."

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F 689	Continued From page 41 On 01/27/2022 at approximately 1:30 p.m., ASM (administrative staff member) # 1, the administrator and ASM # 2, director of nursing, were made aware of the findings. No further information was provided prior to exit.	F 689		
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 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 and staff interview, it was determined that the facility staff failed to provide a therapeutic diet according to the physician's orders for 1 of 31 residents in the survey sample, Resident # 5. The facility staff failed to provide Resident # 5 with a NAS (No	F 692	F692 Nutrition/Hydration Status Maintenance Criterion #1 □ Resident #5□s diet order has been reviewed with the physician and the resident and clearly communicated to the dietary staff; the resident is receiving	2/22/22

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F 692	Continued From page 42 Added Salt) and NCS (no concentrated sugar) diet according to the physician ' s orders. The findings include: Resident # 5 was admitted to the facility with diagnoses that included but were not limited to: high blood pressure, heart failure and diabetes mellitus [1]. Resident # 5's most recent MDS (minimum data set) assessment, a quarterly assessment with an ARD (assessment reference date) of 10/27/2021, coded Resident # 5 as scoring a four on the brief interview for mental status (BIMS) of a score of 0 - 15, four - being severely impaired of cognition for making daily decisions. The POS (physician's order sheet) for Resident # 5 documented in part, "Accu checks [2] at bed time related to TYPE 2 (two) DIABETES MELLITUS WITH DIABETIC NEUROPATHY [3]. Date Order: 02/18/2021. Start Date: 02/18/2021." "Insulin [4] Glargine [5] Solution. Inject 20 unit subcutaneously [6] at bedtime for Diabetes. Date Order: 12/15/2019. Start Date: 12/15/2019." "NAS No Added Salt) diet. Regular texture, Regular consistency, NCS/(no concentrated sugar)/NAS/Low sodium. Date Order: 03/21/2021. Start Date: 03/21/2021." The facility's "Dietary/Nutritional Assessment" for Resident # 5 dated 01/21/2022 documented in part, "III. Diet. Type. NAS - No Added Salt." The facility's meal tickets for Resident # 5	F 692	the diet as ordered by the physician. Criterion #2 □ The facility will review charts for residents who are on specialty diets to ensure accuracy. The facility will discuss with the physician any discrepancies and will review and revise orders, as necessary. Registered Dietitian will complete dietary assessments including resident preferences which will then be communicated to physician for review and comment/revisions. Diet orders will be clearly communicated to the dietary department. Criterion #3 □ RD/designee will re-educate necessary staff on proper documentation/orders regarding diet orders. Criterion #4 □ Registered Dietitian/designee to conduct monthly chart audits for residents on specialty diets to ensure resident preferences and accuracy of their diet order x3 months. Any identified discrepancies will be investigated and reviewed with the resident and physician for clarification. Variances will be reconciled. Findings of the monthly audits will be submitted to QAPI for additional oversight. Criterion #5 □ Date of compliance 2/22/22.	

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documented in part, "Jan (January) 27, 2022 (Thursday - Dinner). Diet: NAS, Jan (January) 27, 2022 (Friday - Lunch). Diet: NAS, Jan (January) 27, 2022 (Friday - Dinner). Diet: NAS."

On 01/27/2022 at approximately 11:03 a.m., an interview was conducted with OSM (other staff member) # 8, clinical nutritional manager, and OSM # 2, food service director. When asked to describe the process for completing the dietary assessment for a resident OSM # 8 stated that they interview the resident, conduct a medical record review including review of the physician's orders, and input from the IDT (interdisciplinary team). When asked if a resident with who is diagnosed with diabetes should be on a low carbohydrate diet OSM #3 stated, "They should be on a diabetic diet." After reviewing the physician's order for Resident # 5's diet for no added salt and no concentrated sugar and the "dietary/nutritional assessment" for Resident # 5 dated 01/21/2022, OSM # 8 and OSM # 3 were asked the dietary/nutritional assessment accurately reflected the physician's order as stated above OSM # 8 stated that the part of the order that documented, "NCS/NAS/Low sodium" was not part of the physician's order and was a food preference.

On 01/27 2022 at 12:23 p.m. a telephone interview was conducted with ASM (administrative staff member) # 3, medical director. When asked about the diet order of no concentrated sugar and no added salt for Resident # 5, ASM # 3 stated that it was not their order and stated that they would check with the nurse practitioner.

On 01/27/2022 at 12:27 p.m. an interview was conducted with ASM # 2, director of nursing.

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When asked to interpret the section on the physician's order that documented, "NCS/NAS/Low sodium" ASM # 2 stated that it was all part of the physician's order and that the resident should be on a no concentrated sugar, no added salt and a low sodium diet. After reviewing Resident # 5's dietary/nutritional assessment and meal ticket at stated above, ASM # 2 was asked if the meal ticket and assessment were accurate according to the physician's order ASM # 2 stated no. When asked if Resident # 5 was receiving the correct therapeutic diet ASM # 2 stated no.

On 01/27/2022 at approximately 12:40 a telephone interview was conducted with ASM (administrative staff member) # 4, nurse practitioner. After being read Resident # 5's dietary/nutritional assessment and the physician's dietary order as stated above, ASM # 4 was asked to describe the type of diet Resident # 5 should have been receiving. ASM # 4 stated, "Should continue with a no concentrated sugar, no added salt and low sodium diet."

On 01/27/2022 at approximately 1:30 p.m., ASM (administrative staff member) # 1, the administrator and ASM # 2, director of nursing, were made aware of the findings.

No further information was provided prior to exit.

References:
[1] A chronic disease in which the body cannot regulate the amount of sugar in the blood. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/ency/article/001214.htm.

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[2] A glucometer, also known as a glucose meter or blood glucose monitoring device, is a home measurement system you can use to test the amount of glucose (sugar) in your blood. This information was obtained from the website: https://www.dexcom.com/faq/what-glucometer.

[3] Nerve damage. This information was obtained from the website: https://www.google.com/#q=neuropathy+nih.

[4] Type 2 diabetes, the most common type, can start when the body doesn't use insulin as it should. If your body can't keep up with the need for insulin, you may need to take pills. Along with meal planning and physical activity, diabetes pills help people with type 2 diabetes or gestational diabetes keep their blood glucose levels on target. Several kinds of pills are available. Each works in a different way. Many people take two or three kinds of pills. Some people take combination pills. Combination pills contain two kinds of diabetes medicine in one tablet. Some people take pills and insulin. This information was obtained from the website: https://medlineplus.gov/diabetesmedicines.html.

[5] A long-acting, manmade version of human insulin. Insulin glargine products work by replacing the insulin that is normally produced by the body and by helping move sugar from the blood into other body tissues where it is used for energy. It also stops the liver from producing more sugar. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a600027.html#:~:text=Insulin%20glargine%20is%20a%20long,liver%20from%20producing%20more%20sugar.

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F 692	Continued From page 46 [6] The term "cutaneous" refers to the skin. Subcutaneous means beneath, or under, all the layers of the skin. For example, a subcutaneous cyst is under the skin. This information was obtained from the website: https://medlineplus.gov/ency/article/002297.htm.	F 692		
F 697 SS=D	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review and clinical record review, it was determined the facility staff failed to maintain a complete pain management program for one of 31 residents in the survey sample, Resident #51. The facility staff failed to document the location of pain and failed to off non-pharmacological interventions prior to the administration of pain medication. The findings include: Resident #51 was admitted to the facility on 6/6/2017 with diagnoses that included but not limited to: stroke (abnormal condition in which hemorrhage or blockage of the blood vessels of the brain leads to oxygen lack and resulting symptoms - sudden loss of ability to move a body part [as an arm or parts of the face], or to speak, paralysis weakness or if severe, death) (1),	F 697	F697 Pain Management Criterion #1 □ Resident 51□s pain management regimen and non-pharmacological interventions were reviewed by the Director of Nursing with orders for corrected pain-scale parameters were instituted. Criterion #2 □ The facility will review orders and care plans for residents pertaining to pain regimen and non-pharmacological interventions. Criterion #3 - The DON/designee will re-educate all licensed nursing staff on proper documentation of non-pharmacological interventions. Criterion #4 - The DON/designee will conduct weekly audits x 8 weeks to compare care plan interventions to medical record documentation with regard to pain management and	2/22/22

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hemiplegia (paralysis affecting only one side of the body) (2), Bipolar Disorder (a mental disorder characterized by episodes of mania and depression) (3), and chronic pain syndrome.

The most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 1/5/2022, coded the resident as scoring a "13" on the BIMS (brief interview for mental status) score, indicating the resident is capable of making daily cognitive decisions. The resident was coded as requiring extensive assistance for most of her activities of daily living such as bathing, eating, transfers and dressing. In Section J - Health Conditions, the resident was coded as having pain in the past five days. The resident was coded as having almost constant pain and the pain was coded as being severe in nature.

The physician orders dated 11/20/2021 documented, "Acetaminophen (Tylenol - used to treat mild to moderate pain) (4) Tablet 325 mg (milligrams); give 650 mg by mouth every 8 hours as needed for Pain scale 1-5. Administration of Tylenol Document non - pharmacological interventions prior to administration of analgesic. For # - enter 1=reposition, 2=diversion/distraction activity, 3=reduce stimulation, 4=other = DOC (document) in nurse note. For LOC (location) enter location of pain."

The physician order dated 11/20/2021 documented, "Morphine Sulfate (used to treat moderate to severe pain) (5) solution 20MG/ML (milligrams per milliliter) Give 5 mg by mouth every 4 hours as needed for pain scale 5-10 = administration of Give 0.25 M: (5 mg). Document non-pharmacological interventions prior to

non-pharmacological interventions. Variances will be investigated; staff education or correction will be completed based on the weekly audits and summary of the audits will be provided to QAPI Committee for additional oversight. Criterion #5 □ Date of compliance 2/22/22.

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administration of analgesic. For # - enter 1=reposition, 2=diversion/distraction activity, 3=reduce stimulation, 4=other = DOC (document) in nurse note. For LOC (location) enter location of pain."

The November 2021 MAR (medication administration record) documented the above physician orders. On 11/21/2021 at 1:25 a.m., 11/23/2021 at 12:00 a.m. and 11/29/2021 at 10:00 p.m. the Morphine was administered. The location of the pain was documented as "3." There was no chart code for "3" for location. On 11/23/2021 at 2:07 p.m. the Morphine was administered, documented for non-pharmacological interventions was "y." A "y" was documented also at that time for the location of pain.

The December 2021 MAR documented the above physician orders. The Morphine was administered on 12/10/2021 at 3:08 a.m., 12/30/2021 at 1:51 a.m. and 12/31/2021 at 6:10 a.m., the location of the pain was documented as a "3." On 12/16/2021 at 11:40 p.m., the Morphine was administered. It was documented, a "0" in the box for the non-pharmacological interventions.

The January 2022 MAR documented the above physician orders. The Acetaminophen was administered on 1/10/2022 at 6:25 a.m. In the box for the administration of non-pharmacological interventions and the location of the pain, documented, "N/A." The Morphine was administered on 1/5/2021 at 2:33 p.m. A "N/A" was documented in the box for non-pharmacological interventions and for the location of the pain. On 1/8/2022 at 12:05 p.m.,

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1/9/2022 at 10:32 a.m., 1/10/2022 at 12:02 a.m. and 11:18 a.m., 1/16/2022 at 9:55 a.m., there was a "y" documented in the box for non-pharmacological interventions. On 1/17/2022 at 6:15 a.m. the box for non-pharmacological interventions was blank.

Review of the nurse's notes from 11/1/2021 through 1/127/2022 failed to reveal further explanation of the MAR documentation.

The comprehensive care plan dated, 6/9/2017 and revised on 8/24/2021, documented in part, "Focus: (Resident #51) has potential for pain related to S/P (status post) left hip fx (fracture), left hemi (hemiplegia) S/P CVA (stroke), depression, and other generalized discomforts such as neuropathic pain S/P CVA, c/o (complaint of) muscle spasms." The "Interventions" documented in part, "Anticipate (Resident #51)'s need for pain relief and respond immediately to any complaint of pain. Monitor/document for probable cause for each pain episode. Remove/limit cases where possible. Monitor/record pain characteristics as patient complains of pain and PRN (as needed), Quality (e.g. sharp, burning); Severity (1 to 10 scale); Anatomical location; Onset, Duration (e.g., continuous, intermittent); Aggravating factors; Relieving factors. Provide non-pharmacological interventions for pain relief prior to administering PRN medications such as change in position, cool compress or heat, diversional activities such as TV, snack, drink, others as desired."

An interview was conducted with LPN (licensed practical nurse) #1, the unit manager, on 1/27/2022 at 9:41 a.m. The above orders and MARs were reviewed with LPN #1. When asked

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what a "3" documented in the spot on the MAR for location of the pain, LPN #3 stated, "We don't have a code for that part, they should write where the pain is." When asked what it indicates when it is documented a "0" in the box for non-pharmacological interventions, LPN #1 stated, "To me it indicates they didn't offer any." LPN #1 was asked what a "N/A" indicated on the MAR for non-pharmacological interventions and location of the pain, LPN #1 stated, N/A doesn't apply as an answer for either one of those boxes. When asked what a "y" in the box for non-pharmacological interventions meant, LPN #1 stated, "I guess it means they attempted them but they need to document what they attempted."

An interview was conducted with ASM (administrative staff member) #2, the director of nursing, on 1/27/2022 at 10:39 a.m. The above orders for Morphine and Acetaminophen were reviewed with ASM #2. The above MARs were reviewed with ASM #2. When asked what a "3" documented in the box on the MAR for location of the pain, ASM #2 stated the nurse is not paying attention to what she is documenting. When asked what a zero in the box for non-pharmacological interventions indicated, ASM #2 stated to her it meant nothing was offered. When asked was a N/A indicated on the MAR for non-pharmacological interventions and for the location of pain was, ASM #2 stated N/A is not acceptable for an answer in those boxes. When asked what a "y" in the box for non-pharmacological interventions indicated, ASM #2 stated she thought that they maybe did offer non-pharmacological interventions but they failed to document what they offered which is required. ASM #2 stated this process was changed to what appears on the MAR now.

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The facility policy, "Pain Management" documented in part, "Purpose: To ensure that pain management is provided to residents who require such services consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences....Pain management is a multidisciplinary care process that included the following: assessing the potential for pain, effectively recognizing the presences of pain, identifying the characteristics of pain, addressing the underlying causes of pain, developing and implementing approaches to pain management and identifying and using specific strategies for different levels and sources of pain....Pain management interventions shall reflect the sources, type and severity of pain. Various strategies and modalities may be utilized to assist the resident in achieving optimal comfort. Such as strategies and modalities may include, but are not limited to: Non-pharmacological interventions may be appropriate alone or in conjunction with medications. Some non-pharmacological interventions include: Environment - adjusting the room temperature, smoothing the lines, provided a pressure-reducing mattress, repositioning, etc.; Physical - ice packs, cool or warm compresses, baths, transcutaneous electrical nerve stimulation (TENS), massage, acupuncture, etc.; Exercise - range of motion exercises to prevent muscle stiffness and contractures; and cognitive or behavioral - relaxation, music, diversions activities, etc."

According to Fundamentals of Nursing, Fifth Edition, 2007, Lippincott Williams & Wilkins, page 1176 to 1207. "Pain, one of the most complex human experiences, is an invisible phenomenon

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influenced by the interaction of affective (emotional), behavioral, cognitive, and physiologic-sensory factors. Because pain is a highly individual experience, the basis for pain management is simply the client's description of pain. Pain exists whenever the person says it does....Typically people describe pain by its location, intensity, quality, and temporal pattern. Sensory components of the pain experience are subjective but can be measured using standardized tools....Assessment: An accurate assessment focusing on pain's cause is essential for determining proper therapy. Ongoing assessment also is important for implementing an effective pain management plan....Document pain assessment information in an accessible location. Even the best pain assessment conducted by the one nurse is of limited value unless he or she shares the information with other healthcare professionals responsible for the client's care. Subjective Data: In an attempt to assess the client's pain, obtain answers to the following questions: Where is the pain located? What is the magnitude or intensity (level) of the pain? What level of pain would the client like to have? What level of pain would the client be willing to tolerate? How does the pain feel to the client; how is it described (its quality)? How does the pain change with rest, activity, or time (its temporal pattern)?...Inadequate or poor pain assessment is a leading factor in poor pain control...Objective data....Physiologic responses to pain are the result of the activation of the autonomic nervous system. With acute pain, the general responses observed include tachycardia, elevated blood pressure, increased respiratory rate, diaphoresis, and gastric distress. With persistent chronic pain, these responses may be modified or absent....Related symptoms may give

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F 697	Continued From page 53 additional clues about pain. Nausea and vomiting, fatigue, anorexia, and withdrawal are common with pain....Observe the client's facial expressions and body movements. Wincing, frowning, and grimacing can indicate pain...Body movements may represent protective actions to decrease the pain. Body movements such as rubbing, splinting, guarding, immobilizing, elevating the painful extremity, or changing positions frequently may increase with pain..." ASM (administrative staff member) #1, the administrator, and ASM #2, the director of nursing, were made aware of the above concern on 1/27/2022 at 1:33 p.m. No further information was provided prior to exit. References: (1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 114. (2) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 266. (3) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 72. (4) This information was obtained from the following website: https://medlineplus.gov/druginfo/meds/a681004.html. (5) This information was obtained from the following website: https://medlineplus.gov/druginfo/meds/a682133.html	F 697		
F 757 SS=D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6)	F 757		2/22/22

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F 757	Continued From page 54 §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, it was determined the facility staff failed to ensure one of 31 residents in the survey sample was free of unnecessary pain medication, Resident #51. For Resident #51, the facility staff administered pain medication when the documented pain level was outside the parameters of the physician ordered pain medication. The findings include: Resident #51 was admitted to the facility on 6/6/2017 with diagnoses that included but not	F 757	F757 Drug Regimen is Free from Unnecessary Drugs Criterion #1 □ Resident #51□s pain medication orders have been reviewed and clarified. The resident is receiving pain medication in accordance with prescribed physician parameters for administration. Criterion #2 □ The facility will review physician orders, for current residents with PRN pain medication orders, to ensure that orders are complete. Identified variances will be investigated	

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F 757	Continued From page 55 limited to: stroke (abnormal condition in which hemorrhage or blockage of the blood vessels of the brain leads to oxygen lack and resulting symptoms - sudden loss of ability to move a body part [as an arm or parts of the face], or to speak, paralysis weakness or if severe, death) (1), hemiplegia (paralysis affecting only one side of the body) (2), Bipolar Disorder (a mental disorder characterized by episodes of mania and depression) (3), and chronic pain syndrome. The most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 1/5/2022, coded the resident as scoring a "13" on the BIMS (brief interview for mental status) score, indicating the resident is capable of making daily cognitive decisions. The resident was coded as requiring extensive assistance for most of her activities of daily living such as bathing, eating, transfers and dressing. In Section J - Health Conditions, the resident was coded as having pain in the past five days. The resident was coded as having almost constant pain and the pain was coded as being severe in nature. The physician orders dated 11/20/2021 documented, "Acetaminophen (Tylenol - used to treat mild to moderate pain) (4) Tablet 325 mg (milligrams); give 650 mg by mouth every 8 hours as needed for Pain scale 1-5. Administration of Tylenol Document non - pharmacological interventions prior to administration of analgesic. For # - enter 1=reposition, 2=diversion/distraction activity, 3=reduce stimulation, 4=other = DOC (document) in nurse note. For LOC (location) enter location of pain. The physician order dated 11/20/2021	F 757	and corrected. Criterion #3 □ DON/designee will re-educate licensed staff on implementation of pain level parameters per resident's physician orders. Criterion #4 - DON/designee will conduct weekly audits of 25% of residents receiving PRN pain medication x30 days, then weekly x1 month, and then monthly x1 month. If variances are identified in PRN pain medication administration, orders will be clarified with the physician and re-education will be done with the licensed nurse. Findings from the audits will be submitted to the QAPI Committee. Criterion #5 □ Date of compliance 2/22/22.	

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documented, "Morphine Sulfate (used to treat moderate to severe pain) (5) solution 20MG/ML (milligrams per milliliter) Give 5 mg by mouth every 4 hours as needed for pain scale 5-10 = administration of Give 0.25 M: (5 mg). Document non-pharmacological interventions prior to administration of analgesic. For # - enter 1=reposition, 2=diversion/distraction activity, 3=reduce stimulation, 4=other = DOC (document) in nurse note. For LOC (location) enter location of pain."

The review of the November 2021 MAR (medication administration record) documented the above orders for Morphine. On 11/21/2021 at 1:25 a.m., Resident #51 received Morphine Sulfate for a documented pain level of "3." On 11/23/2021 at 12:00 a.m., Resident #51 received Morphine Sulfate for a documented pain level of "4." Both pain levels were outside of the physician ordered parameters for the administration of the Morphine.

The review of the December 2021 MAR documented the above orders for Morphine. The Morphine was documented as given on the following dates with the following documented pain levels:
12/10/2021 at 3:08 a.m. - pain level documented, "3."
12/29/2021 at 4:15 a.m. - pain level documented, "4."
12/30/2021 at 1:51 a.m. - pain level documented, "4."
12/31/2021 at 6:10 a.m. - pain level documented, "4."

The pain levels were outside of the physician ordered parameters for the administration of

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Morphine.

The review of the January 2022 MAR documented the above orders for Acetaminophen and Morphine. The Acetaminophen was documented as given on 1/10//2022 for a documented pain level of "10." The pain levels were outside of the physician ordered parameters for the administration of Acetaminophen. The Morphine was documented as given on the following dates with the following documented pain levels:
1/5/2022 at 2:33 p.m. - pain level documented, "0."
1/15/2022 at 11:30 p.m. - pain level documented, "4."
1/16/2022 at 5:00 p.m. - pain level documented, "4."

The pain levels were outside of the physician ordered parameters for the administration of Morphine.

Review of the nurse's notes from November 2021 through January 27, 2022, failed to evidence documentation related to the reason the pain medications were given outside of the physician ordered parameters.

The comprehensive care plan dated, 6/9/2017 and revised on 8/24/2021, documented in part, "Focus: [Resident #51] has potential for pain related to S/P (status post) left hip fx (fracture), left hemi (hemiplegia) S/P CVA (stroke), depression, and other generalized discomforts such as neuropathic pain S/P CVA, c/o (complaint of) muscle spasms." The "Interventions" documented in part, "Anticipate [Resident #51]'s need for pain relief and respond immediately to

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any complaint of pain. Monitor/document for probable cause for each pain episode. Remove/limit cases where possible. Monitor/record pain characteristics as patient complains of pain and PRN (as needed), Quality (e.g. sharp, burning); Severity (1 to 10 scale); Anatomical location; Onset, Duration (e.g., continuous, intermittent); Aggravating factors; Relieving factors. Provide non-pharmacological interventions for pain relief prior to administering PRN medications such as change in position, cool compress or heat, diversional activities such as TV, snack, drink, others as desired."

An interview was conducted with LPN (licensed practical nurse) #1, the unit manager, on 1/27/2022 at 9:41 a.m. The above orders for Acetaminophen and Morphine were reviewed with LPN #1. When asked if the Morphine should have been given when the pain level was zero or four, LPN #1 stated, no, the Acetaminophen should have been given for that pain level. When asked if the Acetaminophen should have been given for the pain level of ten, LPN #1 stated the order doesn't say that and the Morphine should have been given.

An interview was conducted with ASM (administrative staff member) #2, the director of nursing, on 1/27/2022 at 10:39 a.m. The above orders for Acetaminophen and Morphine were reviewed with ASM #2. When asked if the Acetaminophen should have been given for a pain level of "10," ASM #2 stated that unless the resident requested the Tylenol, then the Morphine should have been given. When asked if the Morphine should have been given for a pain level of "4," ASM #2 stated, no, that is not per the physician orders.

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F 757	Continued From page 59 The facility policy, "Medication Management and Pharmaceutical Services," documented in part, "The objectives of the pharmaceutical services are to: Assure that medications are administered as ordered... ensure the resident's drug regime is free of unnecessary medications." ASM (administrative staff member) #1, the administrator, and ASM #2, the director of nursing, were made aware of the above concern on 1/27/2022 at 1:33 p.m. No further information was provided prior to exit. References: (1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 114. (2) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 266. (3) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 72. (4) This information was obtained from the following website: https://medlineplus.gov/druginfo/meds/a681004.html. (5) This information was obtained from the following website: https://medlineplus.gov/druginfo/meds/a682133.html.	F 757		
F 758 SS=E	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that	F 758		2/22/22

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affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories:
(i) Anti-psychotic;
(ii) Anti-depressant;
(iii) Anti-anxiety; and
(iv) Hypnotic

Based on a comprehensive assessment of a resident, the facility must ensure that---

§483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record;

§483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs;

§483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and

§483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or 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.

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F 758	Continued From page 61 §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, it was determined the facility staff failed to identify and monitor targeted behaviors for the use of psychotropic medications for two of 31 residents in the survey sample, Residents #40 and #6. The findings include: 1. The facility staff failed to identify and monitor targeted behaviors for the use of Seroquel (used to treat schizophrenia, bipolar disorder, and in combination with other medications to treat depression) (1) for Resident #40. Resident #40 was admitted to the facility on 3/17/2011 with diagnoses that included but were not limited to: anxiety disorder (state of mild to severe apprehension, often without specific cause, resulting in body changes such as quickened heartbeat and sweat.) (2), mood disorder (a mood disorder, feeling sad or irritable, affects a person's everyday emotional state.) (3), depression (a dejected state of mind with feelings of sadness, discouragement, and hopelessness, often accompanied by reduced activity and ability to function, apathy and sleep disturbance) (4), and dementia (a progressive state of mental decline, especially memory function and judgement, often accompanied by disorientation.) (5).	F 758	F758 Free from Unnecessary Psychotropic Medications/PRN use Criterion #1 - Residents # 40 has been reviewed and targeted behaviors have been identified and are being monitored for administration of psychotropic medication. Resident #6 has been reviewed and targeted behaviors have been identified and are being monitored for administration of the psychotropic medication. Criterion #2 - The facility will review resident charts and ensure proper documentation regarding targeted behaviors for residents on psychotropic medications per physician orders. Residents who are missing targeted behavior documentation will be identified and targeted behaviors will be identified and documented moving forward. Criterion #3 - DON/designee will re-educate licensed staff on implementing/ensuring documentation of targeted behaviors. Criterion #4 - DON/designee will conduct weekly audits of 25% of the residents receiving psychotropic medications x2 months and then monthly x1 month to ensure documentation of identification and monitoring of targeted behaviors for residents receiving psychotropic	

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F 758	Continued From page 62 The most recent MDS (minimum data set) assessment, an annual assessment, with an assessment reference date of 12/28/2021, coded the resident as scoring a "15" on the BIMS (brief interview for mental status) score, indicating the resident was capable of making daily cognitive decisions. The resident was coded as being independent or requiring supervision of one staff member for all of his activities of daily living. In Section N - Medications, the resident was coded as receiving an anti-psychotic medication for all seven days of the look back period. The physician order dated, 1/23/2022, documented, "Seroquel Tablet 25 MG (milligrams); Give 1 tablet by mouth at bedtime for BPSD (behavioral and psychological symptoms of dementia) (6) r/t (related to) Dementia. A physician order dated, 10/14/2020, documented, "Seroquel Tablet 25 MG; Give 25 mg by mouth in the morning for BPSD r/t dementia." The physician orders dated, 8/3/2019, documented, "Observe for absence of behaviors to indicate effectiveness of psychotropic medication. Document Y if none observed. Document N, if behaviors observed and record in nurses' notes, every shift." The MARs (medication administration records) for November, December of 2021 and January 2022, were reviewed. The above orders were documented on the MARs. The MARs documented the behavior monitoring. For all three months, a check mark was documented in each block for each shift, not a Y or N.	F 758	medications. If variances are identified they will be investigated and appropriate corrective action and/or education will be conducted. Findings from the audits will be communicated to QAPI for oversight. Criterion #5- Date of compliance 2/22/22.	

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The comprehensive care plan dated, 5/8/2021 and revised on 8/22/2019, documented in part, "Focus: (Resident #40) is at risk for ineffective coping related to insomnia, depression, mood disorder, anxiety and utilizes psychotropic medications. The "Interventions" documented in part, "Monitor for behaviors every shift and record accordingly in EMR (electronic medical record). Contact family members if (Resident #40) becomes agitated (recently tapered off of other antipsychotic medications [this intervention was dated 11/26/2018]. Provide 1:1 assistance during episodes of ineffective coping. Allow (Resident #40) to vent feelings and offer support."

Review of the progress notes to include physician notes and nurse's notes was conducted. The attending physician note dated, 11/29/2021, documented in part, "Insomnia: controlled with Seroquel and temazepam (sleeping pill). Has failed other options. Failed tapers. Unable to get THC (The main, active ingredient in marijuana is THC [short for delta-9-tetrahydrocannabinol]) (7). Depression controlled with current rx (medications). No more psychosis." The social services note dated, 1/5/2022 documented in part, "Resident does not do well with change and the smallest change, such as Bingo time changing and can cause major distress for the resident." The Care Plan Meeting notes dated 1/12/2022, documented in part, "Resident was also upset because the resident's shower was late yesterday. Resident becomes upset if anything changes."

The psychiatric nurse practitioner notes dated 11/23/2021 documented in part, "Mental Status Exam: Attitude: Cooperative, Pleasant, Friendly. Appearance: Appropriate, Alert. Behavior: No

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agitation, good eye contact, no psychomotor retardation. Mood: good. Affect: Mood congruent. Thought Content: no hallucinations, no delusions, no illusions. The psychiatric nurse practitioner note dated, 12/30/2021, documented in part, "Mental Status Exam: Attitude: Cooperative, pleasant, friendly. Appearance: appropriate, alert. Behavior: no agitation, good eye contact, no psychomotor retardation. Speech: Coherent, fluent, spontaneous. Mood: good. Affect: mood congruent. Thought content: no hallucinations, no delusions, no illusions." The psychiatric nurse practitioner note dated, 1/21/2022, documented in part, "Mental Status Exam: Attitude: Cooperative, pleasant, friendly. Appearance: appropriate, alert. Behavior: no agitation, good eye contact, no psychomotor retardation. Speech: Coherent, fluent, spontaneous. Mood: good. Affect: mood congruent. Thought content: no hallucinations, no delusions, no illusions."

An interview was conducted with LPN (licensed practical nurse) #5 on 1/26/2022 at 3:25 p.m. When asked what Resident #40's behaviors are, LPN #5 stated he has commanding behaviors. He wants things very specific if it's not done for him, he becomes demanding. He will scream at staff if he doesn't want something. Once you give him what he wants he calms down.

An interview was conducted with RN (registered nurse) #1, the unit manager, on 1/26/2022 at 3:32 p.m. When asked what is the targeted behavior for Resident #40 for the use of Seroquel, RN #1 stated she would have to look and get back with the surveyor. At 3:52 p.m. RN #1 stated (Resident #40) is on it for behavioral disturbances such as aggressiveness, agitation. He's been on it long term and when they tried to decrease it he

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became verbally abusive.

An interview was conducted with RN #1 on 1/27/2022 at 9:20 a.m. The MARs were reviewed with RN #1. When asked what the check marks indicate, RN #1 stated a check mark would equal a yes. When asked how nurses know what the resident's behavior is that they are monitoring, RN #1 stated all nurses are oriented to all units. There is nothing in place that would give the nurse the information. When asked is there anywhere the nurse can review what the behaviors are for each resident, RN #1 stated, "It is our responsibility to read the psych (psychiatric) notes and you are given information in report at the change of shift." The care plan above was reviewed with RN #1. When asked what "ineffective coping" was, RN #1 stated she was not sure. When asked what the targeted behavior for Resident #40 is, RN #1 stated, "I've never seen them but I've heard he can be verbally abusive." When asked if it would be helpful for the nurse to have that information on the MAR that they are signing off on, RN #1 stated, "Yes."

An interview was conducted with LPN #3, the MDS coordinator, on 1/27/2022 at 10:19 a.m. When asked what "ineffective coping" was, LPN #3 stated, "It may be he is having difficult time dealing with his disease process." The care plan above was reviewed with LPN #3. When asked if she saw the targeted behaviors in Resident #40's care plan, LPN #3 stated, "No, you didn't miss them, they aren't there." When asked if the targeted behaviors for the use of an antipsychotic medication be on the care plan, LPN #3 stated, yes.

An interview was conducted with ASM

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(administrative staff member) #2, the director of nursing, on 1/27/2022 at 10:29 a.m. The MARs were reviewed with ASM #2. When asked what the check marks indicated on the MAR, ASM #2 stated, "The way you have to answer this in the system, the check marks would be equivalent of a yes. If they check no, it should force them to satisfy it and document the behavior noted. This system was in place before I came." When asked how the nurse can tell what the targeted behavior is for each resident, ASM #2 stated, "For each resident you would want it to be specific to them. The behaviors aren't documented." When asked how then are the nurses monitoring for targeted behaviors for the use of the psychotropic medication, ASM #2 stated, "It needs to be more specific."

The facility policy, "Psychoactive Medication Management and Behavior Monitoring" documented in part, "Policy: To optimize the therapeutic psychoactive medications by observation of behaviors and to minimize adverse effects....Targeted behaviors to be observed are specific to the psychoactive medication being administered and individualized to the patient. Monitoring of behaviors should occur at least daily, and targeted behavior is identified in the care plan."

ASM (administrative staff member) #1, the administrator, and ASM #2, the director of nursing, were made aware of the above concern on 1/27/2022 at 1:33 p.m.

No further information was provided prior to exit.

References:
(1) This information was obtained from the

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following website:
https://medlineplus.gov/druginfo/meds/a698019.htm.
(2) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 43.
(3) This information was obtained from the following website:
https://medlineplus.gov/mooddisorders.html
(4) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 160.
(5) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 124.
(6) This information was obtained from the following website: www.ncbi.nim.nih.gov
(7) This information was obtained from the following website:
https://medlineplus.gov/ency/patientinstructions/000796.htm
2. The facility failed to specify and monitor target Resident # 6's behaviors for the use of Seroquel [1].

Resident#16 was admitted to the facility with diagnoses that included but were not limited to Alzheimer's disease [1] and dementia with behavioral disturbances [2].

Resident #6's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 10/29/2021, coded Resident # 6 as scoring an eleven on the staff assessment for mental status (BIMS) of a score of 0 - 15, eleven- being moderately impaired for making daily decisions. Section N documented Resident # 6 receiving antipsychotic and antidepressant medications.

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The POS (physician's order sheet) for Resident # 6 documented in part, "Seroquel Tablet. Give 25MG (milligrams) by mouth at bedtime related to DEMENTIA IN OTHER DISEASES CLASSIFIED ELSEWHERE WITH BEHAVIORAL DISTURBANCES. Order Date: 12/30/2021. Start Date: 12/30/2021."

The comprehensive care plan for Resident # 6 dated 03/01/2019 documented in part, "Focus: [Resident # 6] uses antipsychotics r/t (related to) dementia with behavioral disturbances. Date Initiated: 03/01/2019." Under "Interventions/Tasks" it documented in part, "Monitor/record occurrence of for target behavior symptoms Specify: pacing, wandering, disrobing, inappropriate response to verbal communication, violence/aggression towards staff/others and document per facility protocol. Date Initiated: 03/01/2019."

The eMARs [electronic medication administration records for Resident # 6 dated 12/01/2021 through 01/26/2022 documented side effect monitoring for the use of psychotropic medications. The eMARs failed to evidence monitoring of behaviors.

The progress notes for Resident # 6 dated 12/01/2021 through 01/26/2022 failed to evidence monitoring of behaviors.

On 01/27/2022 at approximately 9:20 a.m., an interview was conducted with RN [registered nurse] #1, unit manager. After reviewing the Resident # 6's physician's orders as stated above, the facility's progress notes dated 12/01/2021 through 01/26/2022 and the eMAR

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dated 12/01/2021 through 01/26/2022, RN # 1 was asked to identify what specific behaviors were being monitored and to provide documentation evidencing behavior monitoring. RN # 1 stated that they did not specify specific behaviors on the eMAR nor could they provide documentation of behavior monitoring.

On 01/27/2022 at 10:30 a.m., an interview was conducted with ASM (administrative staff member) #2, the director of nursing. After reviewing the Resident # 6's physician's orders as stated above, the facility's progress notes dated 12/01/2021 through 01/26/2022 and the eMAR dated 12/01/2021 through 01/26/2022, ASM # 2 was asked to identify what specific behaviors were being monitored and to provide documentation evidencing behavior monitoring. ASM # 2 stated that they did not specify specific behaviors on the eMAR nor could they provide documentation of behavior monitoring.

On 01/27/2022 at approximately 1:30 p.m., ASM (administrative staff member) # 1, the administrator and ASM # 2, director of nursing, were made aware of the findings.

No further information was provided prior to exit.

References:
[1] Quetiapine is in a class of medications called atypical antipsychotics. It works by changing the activity of certain natural substances in the brain. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a698019.html.

[2] A brain disorder that seriously affects a person's ability to carry out daily activities) This

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information was obtained from the website: https://www.nlm.nih.gov/medlineplus/alzheimersdisease.html.

[3] Psychological symptoms and behavioral abnormalities are common and prominent characteristics of dementia. They include symptoms such as depression, anxiety psychosis, agitation, aggression, disinhibition, and sleep disturbances. Approximately 30% to 90% of patients with dementia suffer from such behavioral disorders. There are complex interactions between cognitive deficits, psychological symptoms, and behavioral abnormalities. This information was obtained from the website: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3181717/.