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E 000	Initial Comments An unannounced Emergency Preparedness Survey was conducted 8/29/23 to 9/7/2023. The facility was in substatial compliance with 42 CFR Part 483.73, Requirement for Long Term Care Facilities. No emergency preparedness complaints were investigated during the survey.	E 000		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid survey was conducted 8/29/23 through 9/07/23. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. Two (2) complaints were investigated during the survey: 1. VA00059641 - Compliant with regulations 2. VA00057256 - Compliant with regulations The Life Safety Code survey/report will follow. The census in this 180 certified bed facility was 169 at the time of the survey. The survey sample consisted of 35 current resident reviews and 2 closed record reviews.	F 000		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced	F 684		10/30/23

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

Electronically Signed | 10/04/2023

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F 684	Continued From page 1 by: Based on observation, resident interview, staff interview, local ombudsman interview, clinical record review, and facility document review, the facility staff failed to provide care and services to meet the needs of the residents for 2 of 35 current residents in the survey sample, Resident #112 and #114. The findings included: 1. For Resident #112, the facility staff failed to administer the physician ordered antibiotic medication, Cephalexin to treat cellulitis and failed to address the wound specialist's recommendations for lab testing related to concern for cellulitis. Resident #112's diagnosis list indicated diagnoses, which included, but not limited to Hypocalcemia, Aortic Valve Stenosis, Essential Hypertension, Bilateral Open-Angle Glaucoma, Polyosteoarthritis, and Major Depressive Disorder. The most recent quarterly minimum data set (MDS) with an assessment reference date (ARD) of 6/26/23 assigned the resident a Brief Interview for Mental Status (BIMS) summary score of 9 out of 15 indicating the resident was moderately cognitively impaired. Resident #112's clinical record included a physician's progress note dated 8/14/23 which documented in part " ...The patient is seen today at the request of nursing staff to evaluate the patient's left lower leg. The patient has skin tear to this leg, which one of the wound nurses is concerned has become infected ...There is an	F 684	The facility sets forth the following plan of correction to remain in compliance with all federal and state regulations. The facility has taken or will take the actions set forth in the plan of correction. The following plan of correction constitutes the facility□s allegation of compliance. All deficiencies cited have been or will be corrected by the date or dates indicated. F 684 Resident # 112 Physician was notified of resident missing medication and no new orders obtained. Resident # 114 Physician was notified of missed appointment and new appointment scheduled. Current residents were audited for appointments with Nephrologist and new orders for antibiotics with wound care by 10.30.2023. Licensed staff were in-serviced by Staff Development Director on following MD orders for appointments and for antibiotics for wound care by 10.23.2023 DON / Designee will audit new order report at least 5 times per week to assure appointments are scheduled and antibiotic orders in place for wound care. Any non- compliance will be reported to the QAAP committee for tracking and trending and progressive disciplinary action as indicated. Date of completion: October 30, 2023	

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F 684	Continued From page 2	F 684		

area measuring 7 cm by 5 ½ cm, superficial, no drainage, increased erythema extending out from the borders. No induration ...Lower leg ulceration: Initially started as the skin tear, but not has developed cellulitis. Most likely Strep Infection. We will order Keflex ..."

An 8/14/23 12:12 PM nursing progress note read in part "LT [left] leg skin tear wound worsening, increasing in size and small amount of bloody drainage noted. Peri-wound is warm, red, and has scattered red, flat rash present to peri-wound. Dr. [name omitted] made aware. N.O. [new order] Cephalexin 250 mg Q [every] 8 hours x [times] 10 days for Cellulitis..." Cephalexin is the generic name for the antibiotic Keflex.

On 9/01/23, surveyor reviewed Resident #112's clinical record and was unable to locate evidence of the order being transcribed to the resident's orders or evidence that the resident received Cephalexin.

Surveyor requested to speak with the author of the 8/14/23 12:12 PM nursing note, however, they were no longer employed by the facility.

Resident #112 was seen by the wound specialist nurse practitioner (NP) on 8/28/23, the progress note read in part " ...Wound is closed however concerning for cellulitis. Recommend CBC [complete blood count], CRP [C-reactive protein], ESR [erythrocyte sedimentation rate], and culture ..." Resident #112 was again seen by the wound specialist NP on 9/04/23, the progress note read in part " ...Wound is closed however concerning for cellulitis. Recommend CBC, CRP, ESR, and culture ..." On 9/05/23, surveyor reviewed Resident #112's clinical record and was unable to

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locate evidence of the lab recommendations being addressed by the attending provider.

On 9/05/23 at 3:25 PM, surveyor spoke with the wound specialist NP who stated they typically provided recommendations to the in-house provider, and they entered any orders. NP further stated if the provider was present in the facility, they spoke with them and if not, the facility wound nurse relayed the message/recommendations to the provider. NP stated they saw Resident #112 again on 9/04/23 and did not see the orders for their previous lab recommendations in the clinical record and recommended the orders again. NP stated upon assessment on 9/04/23, the area looked about the same as last week and they were still concerned because the area around the tissue was red.

On 9/05/23 at 3:40 PM, the surveyor met with the administrator and director of nursing (DON) and discussed the concern of being unable to locate evidence of the resident receiving Cephalexin for cellulitis or the 8/28/23 wound specialist NP lab recommendations being addressed by the provider.

Surveyor attempted to contact the medical director without success on 9/05/23 at 4:42 PM and 9/06/23 at 9:04 AM. Surveyor spoke with the DON on 9/06/23 at 9:06 AM and requested assistance in contacting the medical director, the DON stated they were unavailable today.

On 9/06/23 at 9:25 AM, surveyor spoke with the Unit Manager (UM) who stated they spoke with the medical director yesterday and they approved the wound NP's lab recommendations but not the culture as there was no drainage to culture.

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F 684	Continued From page 4	F 684		

On 9/06/23 at 10:48 AM, surveyor spoke with the DON who stated they believed the antibiotic was a recommendation from the wound NP and the facility nurse addressed it with the physician but failed to enter the actual order. The DON clarified that the physician initially ordered the antibiotic but when they spoke to the physician yesterday, they wanted to wait for the lab results to return before reordering the antibiotic at that time.

On 9/06/23 at 10:55 AM, the surveyor and DON observed the area to Resident #112's left lower leg. The area appeared dry with no drainage present with a dry white center surrounded by multiple dark scabbed-like areas. Redness was present to the surrounding skin tissue. The DON felt the areas of redness and stated there was no increased warmth present when compared to the right lower leg.

On 9/06/23 at 12:17 PM, surveyor spoke with licensed practical nurse (LPN) #4 who rounded with the wound specialist NP on 8/28/23 regarding the lab and wound culture recommendations. LPN #4 stated they were new in the position and thought the providers received a copy of the wound NP report and entered the orders themselves.

On 9/06/23 at 5:30 PM, the survey team met with the facility management team including the administrator and DON and discussed the concern of Resident #112 not receiving an antibiotic as ordered and staff failing to address the wound NP's recommendations.

No further information regarding this concern was presented to the survey team prior to the exit

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F 684	Continued From page 5	F 684		

conference on 9/07/23.

2. For Resident #114, the facility staff failed to follow-up with the nephrologist/urologist following an appointment in which the resident returned to the facility without the date of the next scheduled appointment resulting in a missed appointment.

Resident #114's diagnosis list indicated diagnoses, which included, but not limited to Chronic Kidney Disease Stage 3B, Type 2 Diabetes Mellitus, Hemiplegia and Hemiparesis following Cerebral Infarction, Chronic Obstructive Pulmonary Disease, Pseudobulbar Affect, and Polyneuropathy.

The most recent quarterly minimum data set (MDS) with an assessment reference date (ARD) of 6/13/23 assigned the resident a Brief Interview for Mental Status (BIMS) summary score of 15 out of 15 indicating the resident was cognitively intact.

On 8/30/23 at 11:00 AM, surveyor met with the local ombudsman who stated Resident #114 returned from a nephrology/urology appointment with papers and an appointment card attached for a follow-up appointment which was given to a staff member, but the facility never scheduled transport for the appointment and the resident missed the appointment.

On 8/30/23 at 4:04 PM, surveyor spoke with Resident #114 who stated they were worried about their kidneys. The resident stated they returned from a nephrology/urology appointment and gave the papers with an appointment card stapled to the front to (name omitted) but transport was not scheduled, and they missed the

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F 684	Continued From page 6	F 684		

appointment, and the appointment could not be rescheduled until late September.

Resident #114's current physician's orders included an order dated 4/04/23 for a nephrology consult. The resident's clinical record included a nursing progress note dated 5/18/23 5:51 PM which read in part "Resident had an outside appt [appointment] at [name omitted] Nephrology ...Several recommendations made by [name omitted] Nephrology, stop Amlodipine, consider lowering Lasix, start Losartan 25 mg daily, avoid NSAIDS [nonsteroidal anti-inflammatory drugs], IV contrast, renal panel after one month on Losartan and another renal panel one week before next visit (next visit not on consultation form ..."

An 8/21/23 1:12 PM nursing progress note stated "Resident and Family stated Resident has an Apt [appointment] with [name omitted] Urology today. Facility un-aware of apt at this time. Writer called [name omitted] Urology to verify apt. Resident does have an appointment schedule [sic] for today (8/21/23) at 1:45pm. Writer called and Rescheduled [sic] apt for (9/28/23) at 3:15pm D/t [due to] transportation hasn't been scheduled D/t facility not aware of apt. RP [responsible party] [name omitted] aware and apt time and date given to Transportation scheduler for transportation to be setup for apt on 9/28/23 at 3:15pm."

On 9/05/23 at 5:07 PM, surveyor requested to speak with the writer of the 5/18/23 5:51 PM nursing note, however, they were off and unavailable.

On 9/06/23 at 9:31 AM, surveyor spoke with the

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F 684	Continued From page 7 Unit Manager (UM) regarding Resident #114's missed nephrology/urology appointment and asked what their expectation was for the nurse present when the resident returned from the consult with no date for the follow-up appointment despite orders for labs one week prior to the next appointment. The UM stated the nurse on 5/18/23 should have called the office and asked about the follow-up appointment or passed it along in report for someone else to find out, UM stated they had no clue why the nurse did not do this. The UM further stated that no one had notified them of the resident returning from the appointment with no follow-up appointment date. Surveyor reviewed Resident #114's clinical record and was unable to locate documentation from the resident's 5/18/23 nephrology/urology appointment. On 9/06/23 at 5:30 PM, the survey team met with the facility management team including the administrator and director of nursing and discussed the concern of staff failing to contact the physician's office to inquire about the date of the follow-up appointment resulting in Resident #114 missing a nephrology/urology appointment. No further information regarding this concern was presented to the survey team prior to the exit conference on 9/07/23.	F 684		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to	F 690		10/30/23

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F 690	Continued From page 8 maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, clinical record review, and facility document review, the facility staff failed to ensure medical provider orders were obtained/provided to address the urinary catheter needs of 1 of 35 current residents in the survey sample, Resident #145.	F 690	F 690 Resident 145 orders were obtained for foley catheter were obtained during survey. Current residents were assessed for foley catheters and orders obtained as needed. Licensed staff were educated by Staff	

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F 690	Continued From page 9 The findings included: For Resident #145, the facility staff failed to obtain provider orders for an indwelling urinary catheter present on readmission. Resident #145's diagnosis list indicated diagnoses, which included, but not limited to Hemiplegia and Hemiparesis following Cerebral Infarction, Dementia, Adult Failure to Thrive, and Unstageable Pressure Ulcer of the Right Buttocks. The most recent significant change minimum data set (MDS) with an assessment reference date (ARD) of 8/23/23 coded the resident as rarely/never understood and rarely never understanding others with short-term and long-term memory loss. Resident #145 was coded for the presence of an indwelling catheter. On 8/29/23 at approximately 3:15 PM, surveyor observed Resident #145 with an indwelling urinary catheter in place. Following the observation on 8/29/23, surveyor reviewed Resident #145's clinical record and was unable to locate a provider order for the indwelling urinary catheter or documentation of urinary catheter care. Resident #145's clinical record included an Admission/Readmission Nursing Collection Tool dated 8/20/23 documenting the resident was admitted to the facility on 8/20/23 with an indwelling catheter for prevention of contamination of a wound. On 9/05/23 at 1:05 PM, surveyor spoke with the Unit Manager (UM) who stated while in Resident #145's room, they noticed the resident had a catheter but there was no order. The UM stated	F 690	Development Coordinator for obtaining and following MD orders for Foley Catheter by 10.23.2023 DON/Designee will monitor Physician order report at least 5 times per week to assure orders for catheter are in place. Any non-compliance will be reported to the QAAP committee for tracking and trending and progressive disciplinary action as needed. Date of compliance: October 30, 2023	

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F 690	Continued From page 10 at that time they obtained a provider order for the catheter. The UM stated staff did not obtain an order for the catheter when the resident was readmitted from the hospital. Surveyor asked if catheter care was being provided prior to the order being obtained and the UM stated the catheter did not look dirty but there was no order for catheter care. Resident had been at the facility for 11 days without orders for the indwelling catheter and catheter care. On 9/05/23 after speaking with the UM, the surveyor again reviewed Resident #145's clinical record and noted provider orders each dated 8/31/23 for a foley catheter and foley care every shift. Surveyor requested and received the facility policy entitled, "Physician's Orders" with an effective date of 3/24/20 which read in part " ... Admission orders should include ...Foley catheter order if applicable. Size of foley/bulb and care instructions ..." On 9/05/23 at 5:45 PM, the survey team met with the facility management team including the administrator and Director of Nursing and discussed the concern of facility staff failing to ensure Resident #145 had provider orders in place for an indwelling urinary catheter and orders for the care of the catheter. No further information regarding this concern was presented to the survey team prior to the exit conference on 9/07/23.	F 690		
F 744 SS=D	Treatment/Service for Dementia CFR(s): 483.40(b)(3)	F 744		10/30/23

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F 744	Continued From page 11 §483.40(b)(3) A resident who displays or is diagnosed with dementia, receives the appropriate treatment and services to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, facility staff failed to ensure that a resident diagnosed with dementia received the appropriate treatment and services by monitoring targeted behaviors associated with the use of an antipsychotic medication for 1 of 21 residents in the survey sample, Resident #75. The findings were: The facility staff failed to monitor behaviors for Resident #75 who had a dementia diagnosis. Resident #75's facesheet listed diagnoses which included but were not limited to hemiplegia and hemiparesis following cerebral infarction affecting right dominant side, dysphagia, epilepsy, stage 4 sacral pressure ulcer, dementia, adult failure to thrive, and bipolar disorder. The resident's minimum data set with an assessment reference date of 07/30/23 coded the resident's brief interview for mental status a 99 which indicated the resident was unable to complete the interview. The resident was coded to have both short and long-term memory problems and severely impaired cognitive skills for daily decision making. A provider order for "Behaviors - monitor for the following: (specify) itching, picking at skin, restlessness (agitation), hitting, increase in complaints, biting, kicking, spitting, cussing, racial	F 744	F 744 Resident 75 behaviors were reviewed and updates were made as indicated at the time of survey. Current resident with the diagnosis of Dementia were audited for behaviors and monitoring was put in place as indicated. Licensed Nurses were educated by Staff Development Coordinator on assessing and monitoring of behaviors by 10.23.2023 DON/Designee will monitor documentation of behaviors on the shift report at least 5 times per week for resident with diagnosis of Dementia and assure monitoring of behaviors are in place Any non- compliance will be reported to the QAAP committee for tracking and trending and progressive disciplinary action as needed Date of compliance: October 30, 2023	

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F 744	Continued From page 12 slurs, elopement, stealing, delusions, hallucinations, psychosis, aggression [sic], refusing care" was ordered on 01/12/23. Monitoring for behaviors was not noted on the resident's medication administration review (MAR), treatment administration review (TAR) or elsewhere within Resident #75's clinical record. On 09/06/23 at 1:20 p.m., the director of nursing (DON) acknowledged there was no evidence of behavior monitoring found for Resident #75. The DON reported her expectation was that behaviors monitoring would be evident in the MAR and signed off every shift as ordered. The policy titled, "Behavioral Assessment/Behavior Monitor" policy number 401 with an effective date of 03/28/23 read in part, "Policy: Behaviors will be assessed and monitored. Factors influencing behaviors as well as management interventions will be evaluated and care planned. Procedure: 6. A licensed nurse will document targeted behaviors, side effects, and interventions in the clinical record." On 09/06/23 at 05:26 p.m. during a summary meeting with the assistant administrator, administrator, regional nurse consultant, and DON, the concern regarding there being no evidence of behavior monitoring for Resident #75 was discussed. No further information was provided prior to the exit conference.	F 744		
F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a	F 756		10/30/23

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F 756	Continued From page 13 licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review, and facility document review, the facility staff failed to ensure the attending physician reviewed	F 756	F 756 Pharmacy Reviews for resident 57, 75 and 128 were reviewed by the physician	

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F 756	Continued From page 14 the pharmacists recommendations for 3 of 35 current sampled residents, Resident #57, 75, and 128. The findings include: For resident #57, the facility staff failed to ensure the physician reviewed the pharmacists recommendations for the months of May 2023 and July 2023. #57's diagnoses included but was not limited to the following; dementia, anxiety, major depressive disorder, post traumatic stress disorder, bipolar disorder and hypertension. The most recent minimum data set (MDS) assessment with an assessment reference date (ARD) of 8/26/23, assigned resident #57 a brief interview for mental status (BIMS) score of 3, indicating severe cognitive impairment. The clinical record for resident #57 was reviewed 9/6/23. There was a "Consultant Pharmacist Medication Regimen Review" dated 5/31/23 that read in part, "See report for any noted irregularities and/or recommendations." The surveyor was unable to locate the report in the clinical record. A "Consultant Pharmacist Medication Regimen Review" dated July 26, 2023 read in part, "See report for any noted irregularities and/or recommendations." The surveyor was unable to locate the report in the clinical record. On 9/6/23 during an end of day meeting with the Director of Nursing (DON), Administrator, and Regional Director of Clinical Services, the surveyor asked for documentation that the	F 756	at the time of survey and new orders obtained. Current resident have the potential to be affected by this practice of not reviewing pharmacy recommendations DON/Designee were educated by the Regional Director of Clinical Services on the process to review and complete Pharmacy recommendations DON/Designee will review pharmacy recommendations daily/ monthly at least 5 times per week to assure all recommendations are completed and new orders obtained. Any non- compliance will be reported to the QAAP committee for tracking and trending and progressive disciplinary action as needed. Date of compliance: October 30, 2023	

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F 756	Continued From page 15	F 756		

physician had seen and addressed the pharmacist reports for May and July. The DON stated that they could print off the reports for the surveyor to review but they had not been addressed by the physician.

On 9/7/23 the DON provided two documents entitled, "Consultant Pharmacist Recommendation to Physician" the first was dated 5/31/23. The document had no physician response or signature. The pharmacist recommendation was for a gradual dose reduction (GDR) of resident #57's antipsychotic medication. The second document was dated 7/26/23 and had no physician response or signature. The recommendation was for a GDR of the same antipsychotic medication. The DON confirmed that the physician had not seen the recommendations. They stated they had been in the position of DON two weeks and was not able to speak to the process that was in place in May and July of this year.

The surveyor was provided with a Pharmacy policy entitled, "Medication Regimen Review" with an effective date of 8/2020. The policy read in part, "6. Resident specific irregularities and/or clinically significant risks resulting from or associated with medication are documented in the resident's active record and reported to the Director of Nursing, Medical Director, and/or prescriber as appropriate" and, "7. Recommendations are acted upon and documented by the facility staff and/or the prescriber."

The survey team met with the Administrator, DON and Regional Director of Clinical Services 9/7/23 at 1:45 PM and this concern was reviewed with

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them.

No further information was presented to the survey team prior to the exit conference.

2. The facility staff failed to ensure Resident #75's Medication Regimen Reviews (MRRs) were addressed by a medical provider for two of six months reviewed, April and June 2023.

Resident #75's facesheet listed diagnoses which included but were not limited to hemiplegia and hemiparesis following cerebral infarction affecting right dominant side, dysphagia, epilepsy, stage 4 sacral pressure ulcer, dementia, adult failure to thrive, and bipolar disorder. The resident's minimum data set with an assessment reference date of 07/30/23 coded the resident's brief interview for mental status a 99 which indicated the resident was unable to complete the interview. The resident was coded to have both short and long-term memory problems and severely impaired cognitive skills for daily decision making.

Resident #75's clinical documentation included a pharmacy review for 04/22/23 and 06/30/23 which both read to see the pharmacist's review for recommendations. On 09/06/23, the director of nursing (DON) provided a copy of the pharmacy

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recommendations for both review dates. The DON acknowledged the documents were not signed by the previous DON or the provider; no one's signature was present. The DON acknowledged the pharmacist's recommendations were not addressed (either accepted or declined) and reported having spoken to the psych nursing practitioner (NP) on 09/06/23 who stated she did not want to accept the gradual dose reduction (GDR) recommendation for either review. The practitioner told the DON the system the practitioner works within prompts its own GDRs therefore, the practitioner does not rely solely on the facility's pharmacy recommendation for GDRs.

A pharmacy policy titled, "Medication Regimen Review" policy number 11.1 with an effective date of "08-2020," was reviewed and read in part, "7. Recommendations are acted upon and documented by the facility staff and/or the prescriber. a. The prescriber accepts and acts upon recommendation or rejects [sic] provides an explanation for disagreeing."

On 09/06/23 at 05:26 p.m. during a summary meeting with the assistant administrator, administrator, regional nurse consultant, and DON, the concern regarding there being no evidence a provider reviewed the pharmacist's recommendations was discussed. No further information was provided prior to the exit conference.

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3. For Resident #128, the facility staff failed to provide evidence of the 5/23/23 and 7/26/23 medication regimen reviews being reported to and acted upon by the medical provider.

Resident #128's diagnosis list indicated diagnoses, which included, but not limited to Rheumatoid Arthritis, Essential Hypertension, Major Depressive Disorder, Atrial Fibrillation, and History of Falling.

The most recent minimum data set (MDS) with an assessment reference date (ARD) of 7/17/23 assigned the resident a brief interview for mental status (BIMS) summary score of 14 out of 15 indicating Resident #128 was cognitively intact.

Resident #128's clinical record included Consult Pharmacist Medication Regimen Reviews dated 5/23/23 and 7/26/23, each review was checked by the statement "See report for any noted irregularities and/or recommendations." Upon review of Resident #128's clinical record on 9/01/23, surveyor was unable to locate the 5/23/23 and 7/26/23 medication regimen review reports completed by the pharmacist.

On 9/01/23, surveyor spoke with the director of nursing (DON) and requested the 5/23/23 and 7/26/23 medication regimen review reports for Resident #128. On 9/06/23 at 10:44 AM, the DON provided copies of the 5/22/23 and 7/26/23 medication regimen review reports, the reports had not been addressed or signed by the provider. The DON verified there was no evidence of the medication regimen reviews being reviewed and addressed by the provider.

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The 5/22/23 Medication Regimen Review report recommended a diagnosis clarification for the use of the medication Amiodarone, a diagnosis for the medication Linzess, and a stop date for the antibiotic medication, Macrobid. The 7/26/23 Medication Regimen Review report read in part "Resident currently has an order for: - Metoprolol succinate 25 mg: ½ T [tablet] PO [by mouth] BID [twice a day] for hypertension. Metoprolol is available in two different formulations, tartrate and succinate. Metoprolol tartrate is typically dosed every 12 hours. Metoprolol succinate is typically dosed every 24 hours. Can you please clarify which formulation this resident should be taking ..."

Surveyor requested and received the facility policy entitled, "Medication Regimen Review" which read in part " ...Resident-specific irregularities and/or clinically significant risks resulting from or associated with medication are documented in the resident's active record and reported to the Director of Nursing, Medical Director, and/or prescriber as appropriate ...Recommendations are acted upon and documented by the facility staff and/or the prescriber ..."

On 9/06/23 at 5:30 PM, the survey team met with the facility management team including the administrator and DON and discussed the concern of Resident #128's medication regimen review reports not being reviewed and addressed by the provider.

No further information regarding this concern was presented to the survey team prior to the exit conference on 9/07/23.

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F 757	Continued From page 20	F 757		
F 757 SS=D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review, and facility document review, the facility staff failed to ensure each resident's drug regimen was free from unnecessary drugs for 1 of 35 current residents in the survey sample, Resident #128. The findings included: For Resident #128, the facility staff failed to obtain a stop date for the antibiotic medication, Macrobid which resulted in the medication being administered for greater than four (4) weeks.	F 757	F 757 Resident 128 orders for antibiotics were up dated with a stop date at the time of survey Current resident receiving antibiotic were audited to assure that stop dates are in place for each medication Licensed nurses were educated by the Staff Development Coordinator for obtaining stop dates with antibiotic usage by 10.23.2023 DON/ Designee will monitor order listing	10/30/23

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F 757	Continued From page 21 Resident #128's diagnosis list indicated diagnoses, which included, but not limited to Rheumatoid Arthritis, Essential Hypertension, Major Depressive Disorder, Atrial Fibrillation, and History of Falling. The most recent minimum data set (MDS) with an assessment reference date (ARD) of 7/17/23 assigned the resident a brief interview for mental status (BIMS) summary score of 14 out of 15 indicating Resident #128 was cognitively intact. Resident #128's order history included an order dated 5/22/23 for Macrobid 100 mg by mouth two times a day for "cellulitis related urinary tract infection." The Macrobid order did not include a duration or a stop date. Resident #128's clinical record included emergency department instructions dated 5/19/23 which included an order for Macrobid 100 mg by mouth every 12 hours for 7 days to treat a urinary tract infection. Resident #128's clinical record included a "Consult Pharmacist Medication Regimen Review" dated 5/23/23, the review was checked by the statement "See report for any noted irregularities and/or recommendations." Upon review of Resident #128's clinical record on 9/01/23, surveyor was unable to locate the 5/23/23 drug regimen report completed by the pharmacist. On 9/01/23, surveyor spoke with the director of nursing (DON) and requested the 5/23/23 medication regimen review report for Resident #128. On 9/06/23 at 10:44 AM, the DON provided a copy of the 5/23/23 medication regimen review which in part recommended a	F 757	report at least 5 times per week to assure stop dates are included in the orders Any non- compliance will be reported to the QAAP committee for tracking and trending and progressive disciplinary action as needed. Date of compliance: October 30, 2023	

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stop date for Macrobid. The DON verified there was no evidence that the medication regimen review report was reviewed or addressed by the physician. Surveyor asked if the Macrobid was addressed when the pharmacist requested a stop date in May and the DON stated not that they could see from the clinical record.

Resident #128 continued to receive the Macrobid until it was discontinued by the nurse practitioner (NP) on 6/22/23. The NP documented within the discontinuation order the reason for discontinuation as "was only be [sic] for 5 days per dc [discharge] instructions - tx [treatment] UTI [urinary tract infection]."

Surveyor requested and received the facility policy entitled, "Medication Regimen Review" which read in part " ...Resident-specific irregularities and/or clinically significant risks resulting from or associated with medication are documented in the resident's active record and reported to the Director of Nursing, Medical Director, and/or prescriber as appropriate ...Recommendations are acted upon and documented by the facility staff and/or the prescriber ..."

On 9/06/23 at 5:30 PM, the survey team met with the facility management team including the administrator and DON and discussed the concern of staff failing to obtain a stop date of the administration of Macrobid.

No further information regarding this concern was presented to the survey team prior to the exit conference on 9/07/23.