| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495375 | A. BUILDING _____ B. WING _____ | C 10/16/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| EMPORIA REHABILITATION AND HEALTHCARE CENTER | 200 WEAVER AVENUE EMPORIA, VA 23847 |

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| F 000 | INITIAL COMMENTS<br><br>An unannounced Medicare/Medicaid abbreviated standard survey was conducted 10/11/2023-10/13/2023 and 10/16/2023. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements.<br><br>Two complaints were investigated during the survey (VA00059829- substantiated with deficiency and VA00058833-substantiated with deficiency).<br><br>The census in this 120 certified bed facility was 110 at the time of the survey. The survey sample consisted of 8 resident reviews. | F 000 | | |
| F 580 SS=D | Notify of Changes (Injury/Decline/Room, etc.)<br>CFR(s): 483.10(g)(14)(i)-(iv)(15)<br><br>§483.10(g)(14) Notification of Changes.<br>(i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is-<br>(A) An accident involving the resident which results in injury and has the potential for requiring physician intervention;<br>(B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications);<br>(C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or<br>(D) A decision to transfer or discharge the resident from the facility as specified in | F 580 | | 12/19/23 |

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

Electronically Signed | 12/11/2023

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| F 580 | Continued From page 1<br>§483.15(c)(1)(ii).<br>(ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician.<br>(iii) The facility must also promptly notify the resident and the resident representative, if any, when there is-<br>(A) A change in room or roommate assignment as specified in §483.10(e)(6); or<br>(B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section.<br>(iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s).<br><br>§483.10(g)(15)<br>Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9).<br>This REQUIREMENT is not met as evidenced by:<br>Based on staff interview, clinical record review, the facility staff failed to notify the family of a change in condition for one Resident (Resident # 4) in a survey sample of 8 residents.<br><br>Findings included:<br><br>For Resident # 4, the facility staff failed to notify the family of changes in condition related to | F 580 | 1. Resident #4 no longer resides at the facility.<br><br>2. All residents have the ability to be afffected by the deficiency.<br><br>3. All licensed nursing staff will be reeducated by the DON or designee on ensuring that the Responsible Party is | |

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| F 580 | Continued From page 2<br>eating.<br><br>Resident # 4 was admitted to the facility with diagnoses including but not limited to: Dementia, Diabetes Mellitus-type 2, Chronic Kidney Disease Stage 3, Hypertension and history of a stroke in 2017.<br><br>The Admission MDS (Minimum Data Set) assessment tool with an ARD (Assessment Review Date) of 7/22/2023, coded Resident # 4 with a BIMS (Brief Interview for Mental Status) score of "00" out of 15, indicating severe cognitive impairment. It coded Resident # 4 as requiring extensive assistance of one staff person for ADLs (Activities of Daily Living) except for eating which required supervision and set up only.<br><br>Review of the clinical record was conducted on 10/11/2023 -10/13/2023 and 10/16/2023.<br><br>Review of the Progress Notes revealed that Resident # 4 was admitted to the facility on 7/19/2023 and discharged to the hospital on 8/28/2023.<br><br>Review of the Transfer Form dated 8/28/2023 (the day of discharge to the hospital) revealed documentation about Resident # 4's "usual status prior to the acute change in condition." Documentation on the Transfer Interact Form denoted that prior to the acute change in condition, Resident # 4's usual mental status/cognitive function was not alert, not ambulatory and dependent in all activities of daily living.<br><br>From 8/11/2023-8/15/2023, there were 5 times | F 580 | notified when a resident has a significant change in condition.<br><br>4. The DON or designee will review 2 residents weekly for two weeks and 4 residents monthly for two months that the Responsible Parties are notified when a resident has a significant change in condition. Results of these audits will be presented to the facility QAPI committee monthly for three months for review, and if warranted, further action. | |

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| F 580 | Continued From page 3 | F 580 | | |

out of 15 meals that "0" was documented, the "1" was documented three times and "2" was documented three times. These numbers indicated that Resident #4 ate zero to less than 50 percent of meals for 8 out of 15 meals and 50%-75% of three meals.

From 8/24/2023 breakfast until 8/27/2023 supper meal, "0" was documented nine times out of 12 meals. The initials "RR" was documented for lunch on 8/25/2023 indicating that Resident # 4 refused lunch. The number "2" was written for the supper meal on 8/25/2023 and 8/26/2023 supper meal. Four meals (breakfast and lunch each day) after 8/25/2023 were documented as "0".

There was no documentation of the family being informed that Resident # 4 had not eaten several meals and required more assistance with Activities of Daily Living.

On the morning of 8/28/2023, the initials "RR" was documented indicating the resident refused the breakfast meal. That was the morning Resident # 4 was discharged to the hospital for being "unresponsive."

During the end of day debriefing on 10/16/2023, the facility's Corporate Nurse Consultant, Assistant Director of Nursing and Unit Manager were informed of the lack of evidence that the family of Resident # 4 were made aware of the changes in condition. They stated the facility staff should notify family members of changes in condition.

No further information was received by the facility.

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| F 656 | Continued From page 4 | F 656 | | |
| F 656 SS=D | Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3)<br><br>§483.21(b) Comprehensive Care Plans<br>§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 -<br>(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<br>(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).<br>(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.<br>(iv)In consultation with the resident and the resident's representative(s)-<br>(A) The resident's goals for admission and desired outcomes.<br>(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 | F 656 | | 12/19/23 |

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| F 656 | Continued From page 5<br>entities, for this purpose.<br>(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.<br>§483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-<br>(iii) Be culturally-competent and trauma-informed.<br>This REQUIREMENT is not met as evidenced by:<br>two Residents (Resident # 2 and #6) in a survey sample of 8 Residents.<br><br>Findings included:<br><br>1. For Resident # 2, the facility staff failed to develop a care plan with measurable objectives in regard to several identified focus areas.<br><br>Resident # 2 was admitted to the facility on 12/28/2021. Resident # 2's diagnoses included but were not limited to: Heart failure, Vascular Dementia, and Dysphagia.<br><br>Review of Resident # 2's care plan revealed goals that were not measurable. Examples included but were not limited to:<br>Focus-Hypertension Interventions to remain in place to minimize the risk of complications related to hypertension through next review.<br><br>Focus-Hyperthyroidism, Goal: "interventions to remain in place to minimize the risk of complications related to hyperthyroidism through next review.<br><br>Focus-Potential for impaired skin integrity, Goal-Interventions to remain in place to minimize | F 656 | 1. Resident #2's care plan was revised to include measurable objectives. Resident #6 no longer resides at the facility.<br><br>2. All residents have the ability to be affected by the deficiency. An audit was completed by the MDS coordinator to ensure residents have measurable objectives.<br><br>3. Interdisciplinary team members will be reeducated to ensure care plans have measurable objectives.<br><br>4. The Administrator or designee will review 2 residents weekly for two weeks and 4 residents monthly for two months that care plans have measurable objectives. Results of these audits will be presented to the facility QAPI committee monthly for 3 months for review, and if warranted, further action. | |

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| F 656 | Continued From page 6 | F 656 | | |

the risk of impaired skin integrity through the next review

Focus: Potential risk for further falls, Goal-Interventions to remain in place to minimize the risk of injuries from falls through next review.

On 10/16/2023 at 2:20 p.m., an interview was conducted with the Assistant Director of Nursing who stated care plans should be tailored for each resident and have measurable goals and interventions to reach the goals.

No further information was provided.

2. For Resident # 6, the facility staff failed to develop a care plan with measurable objectives in regard to activities of daily living deficit and a potential nutritional problem.

Resident # 6 was admitted to the facility on 8/25/2023 with diagnoses that included but were not limited to Diabetes Mellitus and Coronary Artery Disease.

Review of the clinical record was conducted on 10/12/2023 and 10/13/2023.

Review of the care plan revealed a template had been utilized for focus areas and had not been completed with the information specific to Resident # 6.

Focus- The resident has an ADL (Activities of Daily Living) self-care performance deficit r/t Impaired balance
"Goal: The resident will improve current level of function in (SPECIFY ADLs) through the review

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| F 656 | Continued From page 7<br>date. Resident will be able to: (SPECIFY) Date Initiated: 09/06/2023" There was no documentation of the specific information related to Resident # 6.<br><br>Focus- "The resident has nutritional problem or potential nutritional problem (SPECIFY) r/t [related to] Obesity (Specify weight and BMI/IBW) [body mass index/ideal body weight]<br>Date Initiated: 09/06/2023<br>Goal: The resident will maintain adequate nutritional status as evidenced by maintaining weight within (X)% of (SPECIFY BASELINE), no s/sx (signs/symptoms) of malnutrition, and consuming at least (X)% of at least (SPECIFY) meals daily through review date. Date Initiated: 09/06/2023"<br><br>On 10/16/2023 at 2:20 p.m., an interview was conducted with the Assistant Director of Nursing who stated care plans should be tailored for each resident and have measurable goals and interventions to reach the goals.<br><br>No further information was provided. | F 656 | | |
| F 657 SS=D | Care Plan Timing and Revision<br>CFR(s): 483.21(b)(2)(i)-(iii)<br><br>§483.21(b) Comprehensive Care Plans<br>§483.21(b)(2) A comprehensive care plan must be-<br>(i) Developed within 7 days after completion of the comprehensive assessment.<br>(ii) Prepared by an interdisciplinary team, that includes but is not limited to--<br>(A) The attending physician.<br>(B) A registered nurse with responsibility for the resident. | F 657 | | 12/19/23 |

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| F 657 | Continued From page 8<br>(C) A nurse aide with responsibility for the resident.<br>(D) A member of food and nutrition services staff.<br>(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.<br>(F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.<br>(iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.<br>This REQUIREMENT is not met as evidenced by:<br>Based on staff interview, facility documentation and clinical record review, the facility staff failed to review and revise the care plans for 3 Residents (Residents # 1, #2, and # 3) of 8 Residents in the survey sample.<br><br>The findings include:<br><br>1. For Resident # 1, the facility staff failed to revise the care plan to include a diagnosis of scabies and the use of contact precautions.<br><br>On 10/11/2023, the facility Administrator and Assistant Director of Nursing were asked to provide a list of residents who had been diagnosed with a scabies infection. The Assistant Director of Nursing stated the infections were discovered during the month of May 2023. The Assistant Director of Nursing stated she was the Infection Preventionist at the facility and was | F 657 | 1. Resident#1 and Resident #2's care plans have been reviewed and revised. Resident #3 no longer resides at the facility.<br><br>2. All residents have the ability to be affected by the deficiency. An audit was completed on the current residents to ensure care plans have been reviewed and revised.<br><br>3. Interdisciplinary team members will be reeducated to ensure care plans are revised appropriately.<br><br>4. The Administrator or designee will review 2 residents weekly for two weeks and 4 residents monthly for two months to ensure care plans have been revised appropriately. Results of these audits will | |

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| F 657 | Continued From page 9<br>responsible for reporting infections to the Health Department. A copy of the line listing was requested. A copy of the "Scabies Outbreak Line List Final" was received.<br><br>Review of the facility's documentation of its line listing of infections reported to the local health department revealed documentation of scabies infections in May 2023. Residents # 1's name was listed on 5/8/2023. The prescribed treatment was documented as "Permethrin Cream 5% t/x (treatment) on 5/9/2023."<br><br>Review of the clinical record for Resident # 1 was conducted on 10/11/2023-10/12/2023. Review of the Nurses Progress Notes revealed documentation of a skin rash on 5/8/2023. The note had the following excerpts:<br>"5/8/2023 15:00 (3 p.m.) Nurses Notes<br>Late Entry:<br>Note Text: Notified that patient has skin rash. _____ (name redacted) NP (nurse practitioner).....NP assessed,determined to be probable scabies. New orders given.<br><br>There was documentation of an order for Permethicin Cream.<br><br>Further review of the physicians notes revealed Physician Note- 5/9/2023-included the excerpts:<br>"Skin:<br>Multiple small pimple-like rash noted allover body, unable to see burrow or tracking, suggested of scabies. + (positive) boils to back"<br><br>"Plan:<br>boils to back continue to monitor for acute concerns keflex 500 mg po tid x(milligrams by mouth three times per day for )7 days | F 657 | be presented to the facility QAPI committee monthly for three months for review, and if warranted, further action. | |

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| F 657 | Continued From page 10 | F 657 | | |

scabies-continue to monitor for acute concerns-Premethrin cream 5% apply neck down x 8-14 h (hours) then wash off repeat in 2 weeks"

Review of the care plan revealed no documentation of a scabies infection. There were no notes regarding the need for contact precautions. There were no listed interventions to prevent the spread of infection.

On 10/16/2023 at 2:20 p.m., an interview was conducted with the Assistant Director of Nursing who stated the facility staff members knew who had scabies infection and needed contact precautions because signs were placed on the doors of the residents and isolation carts were placed outside the door of the affected residents. When asked if there should have been documentation on the care plan, she stated "yes."

During the end of day debriefing, the Assistant Director of Nursing, Unit Manager and Corporate Nurse Consultant were informed of the findings. The Corporate Nurse stated there should have been documentation on the care plan to reflect the Scabies infection.

No further information was provided.

2. For Resident # 2, the facility staff failed to revise the care plan to include a diagnosis of scabies and the use of contact precautions.

On 10/11/2023, the facility Administrator and Assistant Director of Nursing were asked to provide a list of residents who had been diagnosed with a scabies infection. The Assistant Director of Nursing stated the infections were discovered during the month of May 2023. The

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| F 657 | Continued From page 11 | F 657 | | |

Assistant Director of Nursing stated she was the Infection Preventionist at the facility and was responsible for reporting infections to the Health Department. A copy of the line listing was requested. A copy of the "Scabies Outbreak Line List Final" was received.

Review of the facility's documentation of its line listing of infections reported to the local health department revealed documentation of scabies infections in May 2023. Resident # 2's name was listed on 5/9/2023. The prescribed treatment was documented as "Permethrin Cream 5% t/x (treatment) on 5/9/2023."

Review of the clinical record for Resident # 2 was conducted on 10/11/2023-10/12/2023.

Review of the Physicians Progress Notes revealed documentation of a skin rash on 5/8/2023. There was documentation of an order for Permethrin Cream.

Review of the care plan revealed no documentation of a scabies infection. There were no notes regarding the need for Contact Precautions. There were no listed interventions to prevent the spread of infection.

On 10/16/2023 at 2:20 p.m., an interview was conducted with the Assistant Director of Nursing who stated the facility staff members knew who had scabies infection and needed contact precautions because signs were placed on the doors of the residents and Isolation carts were placed outside the door of the affected residents. When asked if there should have been documentation on the care plan, she stated "yes."

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During the end of day debriefing, the Assistant Director of Nursing, Unit Manager and Corporate Nurse Consultant were informed of the findings. The Corporate Nurse stated there should have been documentation on the care plan to reflect the Scabies infection.

No further information was provided.

3. For Resident # 3, the facility staff failed to revise the care plan to include a diagnosis of scabies and the use of contact precautions.

On 10/11/2023, the facility Administrator and Assistant Director of Nursing were asked to provide a list of residents who had been diagnosed with a scabies infection. The Assistant Director of Nursing stated the infections were discovered during the month of May 2023. The Assistant Director of Nursing stated she was the Infection Preventionist at the facility and was responsible for reporting infections to the Health Department. A copy of the line listing was requested. A copy of the "Scabies Outbreak Line List Final" was received.

Review of the facility's documentation of its line listing of infections reported to the local health department revealed documentation of scabies infections in May 2023. Residents # 3's name was listed on 5/10/2023. The prescribed treatment was documented as "Permethrin Cream 5% t/x (treatment) on 5/9/2023."

Review of the clinical record was conducted on 10/11/2023-10/12/2023. Review of the Physicians Progress Notes revealed documentation of a skin rash on 5/9/2023. There

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| F 657 | Continued From page 13<br>was documentation of an order for Permethicin Cream.<br><br>Review of the care plan revealed no documentation of a scabies infection. There were no notes regarding the need for contact precautions. There were no listed interventions to prevent the spread of infection.<br><br>On 10/16/2023 at 2:20 p.m., an interview was conducted with the Assistant Director of Nursing who stated the facility staff members knew who had scabies infection and needed contact precautions because signs were placed on the doors of the residents and Isolation carts were placed outside the door of the affected residents. When asked if there should have been documentation on the care plan, she stated "yes."<br><br>During the end of day debriefing, the Assistant Director of Nursing, Unit Manager and Corporate Nurse Consultant were informed of the findings. The Corporate Nurse stated there should have been documentation on the care plan to reflect the Scabies infection.<br><br>No further information was provided. | F 657 | | |
| F 658 SS=D | Services Provided Meet Professional Standards<br>CFR(s): 483.21(b)(3)(i)<br><br>§483.21(b)(3) Comprehensive Care Plans<br>The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-<br>(i) Meet professional standards of quality.<br>This REQUIREMENT is not met as evidenced by:<br>Based on staff interview, facility documentation | F 658 | 1. Resident #4 no longer resides at the | 12/19/23 |

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| F 658 | Continued From page 14<br>review, and clinical record review, the facility staff failed to ensure care and services met professional standards of quality for one Resident (Resident # 4) in a survey sample of 8 residents.<br><br>Findings included:<br><br>For Resident #4, the facility staff failed to assess and monitor for adverse reactions to the administration of several medications including antidepressants, antipsychotic medications, antihypertensives and a diuretic, resulting in dehydration, diminished Activities of Daily living functional abilities, and oversedation.<br><br>Resident # 4 was admitted to the facility with diagnoses including but not limited to: Dementia, Diabetes Mellitus-type 2, Chronic Kidney Disease Stage 3, Hypertension and history of a stroke in 2017,<br><br>The Admission MDS (Minimum Data Set) assessment tool with an ARD (Assessment Review Date) of 7/22/2023, coded Resident # 4 with a BIMS (Brief Interview for Mental Status) score of "00" out of 15, indicating severe cognitive impairment. It coded Resident # 4 as requiring extensive assistance of one staff person for ADLs (Activities of Daily Living) including toileting, hygiene and transferring and extensive assistance of two staff persons for dressing. Resident # 4 required total assistance of two staff persons for bathing. Resident # 4 was coded as frequently incontinent of bowel and occasionally incontinent of bladder. Resident # 4 required supervision of one staff member for walking in room and in corridor and mobility on and off the unit. There was no pressure wound noted. | F 658 | facility.<br><br>2. All residentss have the ability to be affected by the deficiency. Skin assessments were completed on current residents.<br><br>3. All licensed nursing staff will be educated on monitoring side effects of medications and completing skin assessments to identify skin impairment to ensure services are provided that meet professional standards.<br><br>4. The DON or designee will review 2 residents for two weeks and then 4 residents for two months that side effects have been monitored and skin assessments have been completed to identify skin impairments to meet professional standards. Results of these audits will be presented to the facility QAPI committee monthly for three months for review, and if warranted, further action. | |

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Review of the clinical record was conducted on 10/11/2023-10/13/2023 and 10/16/2023.

A review of the clinical record revealed that Resident # 4 was admitted to the Memory Care unit at the facility on 7/19/2023. Resident # 4 had a diagnosis of dementia and exhibited inappropriate behaviors.

Resident # 4 was evaluated in the Emergency Room on 8/1/2023 for behaviors. Review of the hospital Emergency Room notes revealed documentation that the facility staff reported feeling intimidated by Resident # 4. The facility staff initially refused to accept Resident # 4 when the Emergency Room staff called to report the status of discharge back to the facility. The ER staff contacted the facility's Administrator to authorize the return to the facility. Resident # 4 had been prescribed several medications that have black box warnings for the elderly. Resident # 4 became over sedated according to documentation.

Resident # 4 experienced a decline in Activities of Daily Living (ADLs) functional abilities. He was no longer able to ambulate, no longer able to feed himself and needed additional assistance for ADLs.

Resident # 4 did not consume meals for several days prior to discharge to the hospital on 8/28/2023. There was no documentation of monitoring of consumption of liquids or hydration status. There was no documentation about assessment of skin turgor or of urinary output color and amount.

Medications were administered daily as ordered

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by the physician. Resident # 4 was given scheduled medications despite that the side effect of "sedated" was documented in progress notes.

Review of the Treatment Administration record revealed the documentation of Antipsychotic side effects did not accurately utilize the letters according to the legend to denote side effects. There were check marks documented on each date. The legend was:

A= sedation
B= Drowsiness
C = Dry Mouth
D = Constipation
E = Blurred Vision
F = EPS
G = Weight Gain
H = Edema
I = Postural Hypotension
J = Sweating
K = Loss of Appetite
L = Urinary Retention
NA = none
Every Shift for Monitoring Antipsychotic Use

NA- if no side effects

Resident # 4 was a known Type 2 Diabetic. The records revealed Resident # 4 did not eat several meals toward the end of his stay at the facility. There was no documentation that Resident # 4 was monitored for signs and symptoms of hypoglycemia or hyperglycemia or that blood sugars had been checked to determine if the blood sugar was in normal limits.

On 8/28/2023 at 9:50 a.m., Resident # 4 was

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discharged to the hospital for being "unresponsive." Prior to discharge, Resident # 4's blood sugar was checked on 8/28/2023 at 9:24 a.m. and documented as 579. Review of the clinical record revealed 8/28/2023 was the only blood sugar documented during the 6 weeks Resident # 4 resided in the facility.

Resident # 4 had a diagnosis of Hypertension and was prescribed three antihypertensive medications:
Metoprolol Tartrate Tablet, Give 12.5 milligrams by mouth two times a day
Amlodipine Besylate, Amlodipine Besylate Oral Tablet 10 MG, Give 10 mg by mouth once a day.
Hydralazine HCl, Hydralazine HCl Oral Tablet 10 MG, Give 10 mg by mouth two times a day.

Metoprolol-
Metoprolol is a beta blocker which increases the Potassium level in the blood. (Also called a Potassium sparing drug.)

Side effects of Metoprolol include confusion, dizziness, shortness of breath, slow or irregular heartbeat, sweating and unusual tiredness or weakness.

Amlodipine-
Side effects of Amlodipine include dizziness or lightheadedness, swelling of ankles or feet, confusion, sweating and unusual tiredness or weakness.

Hydralazine-
Side effects of Hydralazine include dizziness or lightheadedness.

Resident # 4 was prescribed Spironolactone 100

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milligrams by mouth one time a day for inappropriate behaviors on 7/20/2023- side effects include high potassium level, kidney injury, decrease in the amount of urine, increased thirst, drowsiness, lightheadedness, nausea, vomiting and diarrhea. Spironolactone is a potassium sparing diuretic.

Very high potassium levels can be fatal. Nursing staff should assess and monitor for signs and symptoms of high potassium levels.

There was no documentation of the facility staff closely monitoring Resident # 4 for the potential side effects related to the medications ordered and administered as scheduled.

There was no documentation of monitoring intake and output when Resident # 4 was sedated and unable to eat or refused a meal.

There was no documentation of monitoring of Resident # 4's weight. The initial orders on admission were Weights for 3 days. There was no order to weigh the resident after changes in condition. There was no nursing intervention to weigh the resident.

There was no documentation of lab work being obtained to monitor electrolytes.

Review of the progress notes revealed Resident # 4 was transported to the hospital Emergency Room on 8/28/2023 at 9:50 a.m.

Review of the hospital records revealed the results of the Comprehensive Metabolic Profile blood work collected on 8/28/2023 at 10:17 a.m. The critical values included:

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Sodium = 166 (normal 135-145)
Blood glucose (sugar) =600 (normal 65-100)
Potassium =7.8 (normal 3.5-5.1)
Chloride= 126 (normal 97-108)
BUN= >225 (normal 6-20)
Creatinine 11.8 (normal .7 - 1.3)

On 8/28/23 Resident # 4 was transferred from the local hospital's Emergency Room to a larger hospital into the Intensive Care Unit and admitted with the diagnoses that included but were not limited to:

Severe volume depletion
Hypernatremia
Acute kidney injury related to volume depletion
Metabolic acidosis-now normal gap
Hyperglycemia on admission which has responded rapidly to volume administration
Hyperkalemia which is responded to volume restriction
Leukocytosis with sepsis syndrome
Thrombocytopenia secondary to sepsis
Hypoalbuminemia

According to the National Institutes of Health, the term "dehydration" is used interchangeably with "volume depletion." It specifically stated: "dehydration- loss of total body water producing hypertonicity. Often used interchangeably with volume depletion ...." www.ncbi.nim.nih.gov accessed 10/25/2023

Resident # 4 was admitted to the hospital with diagnosis of dehydration.

Resident # 4 had been prescribed several medications with rapid changes in orders related

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to behaviors exhibited.

The standard of practice was that residents would have time to adjust to the new medications prior to changes to adjust the dosages and number of medications.

The Consultant Pharmacist wrote recommendations to the physician that cautioned about the order for three antidepressant medications. Review of the Pharmacy Recommendations for July 1. 2023-July 31. 2023 revealed documentation of "3 (three) antidepressants, Sertraline, Paroxidine and Trazodone. Use of 2 or more antidepressants simultaneously may increase the risk of side effects."

There were no documented diagnoses to support the orders. The physician discontinued one medication and documented a diagnosis of dementing disorder with behavioral symptoms. There was a handwritten note of reply "Sertraline was already discontinued." There was no documentation to support the plan to continue with two remaining medications when the recommendation stated two or more may increase the risk of side effects.

On 10/16/2023 at approximately 1:00 PM, an interview with the ADON Assistant Director of Nursing, Corporate Nurse Consultant and the Unit Manager was conducted. They were asked if it was the expectation of the facility that nurses follow physician orders and or clarify any orders they do not understand. They all indicated that it was the facility's expectation of all nurses to administer medications as ordered by the physician, to document the administration of the

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medication and to monitor for side effects.

Review of the Medication Administration Records revealed documentation that psychotropic medications were administered when the resident exhibited signs of being sedated. Documentation revealed that Resident # 4 did not exhibit any behaviors during the times the medications were administered.

There was no evidence of monitoring for over sedation or dehydration.

According to Lippincott Nursing 2023 - "Assessing for dehydration in adults"-Nursing-39 (4): p 14, April 2009", excerpts written were: nurses should assess patients for the risk of dehydration, assess skin turgor, carefully measure and record intake and output from all sources, assess mental status, assess capillary refill and measure and record weights daily at the same time each day, wearing the same amount of clothing.

Further Guidance stated:
"Complete a thorough head to toe assessment, assess intake and output, assess vital signs, assess laboratory values, assess skin turgor, assess urine color and concentration, auscultate cardiac sounds, assess cardiac rhythm and assess mental status."

Review of the Facility's Medication Administration Policy, entitled Administering Medications, 2001 Med Pass Revised April 2019 stated: Medications are administered in a safe and timely manner and as prescribed.
"4. Medications are administered in accordance with the prescriber's orders, including any time

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frame.
5. Medication administration times are determined by resident need and benefit, not staff convenience. Factors that are considered include a. enhancing optimal therapeutic effect of the medication"
"8. If a dosage is believed to be inappropriate or excessive for a resident, or a medication has been identified as having potential adverse consequences for the resident or is associated with adverse consequences, the person preparing or administering the medication will contact the prescriber, the resident's attending physician or the facility's medical director to discuss the concerns."

There was documentation of a Physician's visit after the 8/2/2023 care plan meeting. Excerpts included:

8/3/2023 Follow up Physician Progress Notes-
"He was last seen by this provider on 7/26/23 and at that time, Depakote and Trazodone were added to his medication regimen. This is a consultation at the request of staff related to patient's increased physical aggression and a report that he had touched another female resident inappropriately. Police was called due to his destructive behaviors and he was sent to the ER but returned to the facility without any changes in his psychotropic meds. Patient has also been reported to be resistant to care and treatment, thus, it is unknown whether how much of the psychotropics he has taken since his admission. He has a large body structure. Patient is seen in his room today, with guarded affect, fair eye contact. He has a sitter. There is no evidence that he responds to internal stimuli. Based on his symptomatology, no changes will be made to his

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psychotropics rather ensure that he is compliant in taking them."

Under Plan was written"
Care Plan Recommendations: Discontinue Seroquel PRN dose. Discontinue sertraline - patient already on Paxil. All other psychotropic medications as is. Ensure medication compliance. Psychotropic medication will need additional time to see beneficial effects. Therefore, dose reduction of psychotropic medications is clinically contraindicated at this time. Continue redirection strategies and sitter until patient adjusts to new environment. Monitor for changes in mood or behaviors and notify/page___ (name of healthcare provider redacted).

Physicians Progress Note dated 8/14/2023 included reason for visit "is being assessed today for skilled services related to physical deconditioning and drowsiness per staff. The plan included the excerpt :Plan: Physical deconditioning slow position changes education and redirection keep shoes tied tight to prevent falls fall precautions keep the bed in the lowest position vital signs per facility protocol Drowsiness D/C (Discontinue) Ativan"

Review of the Pharmacy Recommendations for July 1. 2023-July 31. 2023 revealed documentation of "3 (three) antidepressants, Sertraline, Paroxidine and Trazodone. Use of 2 or more antidepressants simultaneously may increase the risk of side effects." There was a handwritten note of reply "Sertraline was already discontinued."

Review of the Interim Medication Review Report

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dated 8/2/2023 10:19 p.m. revealed the following: "Please consider the following Pharmacist recommendations in assessing this Resident's drug regimen. the prescriber and/or nursing staff should respond appropriately. Recommendations marked URGENT should be resolved by midnight the next calendar day, copied to the MDS Coordinator and placed in the Resident chart appropriately.
Under "Consultant Pharmacist Recommendations to the Physician", the following excerpts were included:
Evaluated resident r/t (related to) changes in behavior and sexual aggression. Resident has a medical history of Alzheimer's disease. Resident is receiving Sertraline 50 mg QD, Paroxetene 20 mg QD, Lorazepam 0.5 mg BID, buspirone 5 mg BID, trazodone 50 mg QHS, depakote 250 mg TID, Seroquel 50 mg QD and 75 mg BID, Seroquel 25 mg Q 12h PRN and donepezil 10 mg QD.

There does not appear to be a diagnosis listed on the Physicians Order/MAR that indicates the need for this type of drug therapy (dementia related psychosis not approved).

Next was a list of "Appropriate diagnosis to support antipsychotic use" documented. include schizophrenia, schizo-affectove disorder, psychotic mood disorders (including mania and depression with psychotic features....."

Amongst the list of appropriate diagnoses, there was a line drawn in black ink under the listed diagnosis "dementing disorder with behavioral symptoms".

The recommendations further stated "If no benefit

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noted in 4 weeks to 12 weeks, recommend tapering use of antidepressant and antipsychotic with the goal of discontinuation. I do not recommend the use of benzodiazepines since they may contribute to apathy and increase fall risk."
There was no documented initials written in either of the boxes to "Agree or Disagree" with the recommendations. There was a handwritten reply written in the section underneath the Physician Summary " Please indicate the appropriate action was taken on the aforementioned recommendations"
"Spoke to _____[name redacted] (Pharmacist) on 8/9/2023. Sertraline and Seroquel PRN already DCd (discontinued). Diagnosis for Seroquel is Unspecified Dementia, Unspecified Severity with Behavioral Disturbance (F03.91)
Do not discontinue Seroquel-patient will most likely increase risk for psychiatric decompensation.
It was signed by the Psychiatric Nurse Practitioner.

Review of the Nurses Notes revealed documentation several times that Resident # 4 was "sleeping." There was documentation on an EMAR (Electronic Medication Administration Record)- Administration Note dated 8/10/2023 at 12:06 p.m. that indicate Resident # 4 was "sedated." The choices listed for side effects were: Note Text: Side Effects - Antidepressant: Indicate letter if observed: A= Sedation; B= Drowsiness; C= Dry Mouth; D=Blurred Vision; E= Urinary Retention; F= Tachycardia; G=Muscle Tremor; H= Agitation; I= Headache; J= Skin Rash; K=Photosensitivity; L= Weight Gain; NA= None every shift for Monitoring Antidepressant Use A" The letter A was chosen and indicated

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"sedation."

Subsequent documentation included notes that Resident # 4 exhibited no behaviors, was resting quietly with the television on and

8/13/2023 : Resident noted to be drowsy this morning. Total assistance needed during feeding. Transfer x2. VS wnl(vital signs within normal limits) will continue with monitoring and POC (plan of care)

Review of the Transfer form dated 8/28/2023 (the day of discharge to the hospital) revealed documentation about Resident # 4's usual status prior to the acute change in condition. Documentation on the Transfer Interact Form denoted that prior to the acute change in condition, Resident # 4's usual mental status/cognitive function was not alert, not ambulatory and was dependent in all activities of daily living.

On 10/12/2023 at 4:08 p.m., an interview was conducted with the Director of Nursing who stated on admission, medications were sent by the Pharmacy as ordered by the Physician. The Director of Nursing stated "the Pharmacist reviews the meds (medications) and sends the report for review of recommendations for the Nurse Practitioner to review." The Director of Nursing stated "the Supervising Physician for the Nurse Practitioners comes at least once a week, usually on Wednesdays. The Nurse Practitioners come Monday through Friday." The Director of Nursing stated recommendations by the Pharmacist are "usually acted upon by the next day. They either Agree or Disagree with the recommendations."

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On 10/13/2023 at 1:22 p.m., an interview was conducted with the Physician who comes to the facility once a week. The Physician stated he comes to facility every Wednesday. When asked about Resident # 4, The Physician stated he "vaguely" remembered him. Stated he thought "this is the resident who balled his fists" at him when he tried to talk to him. The surveyor requested a follow up interterview with teh Physician when he had access to the resident's record. The Physician agreed to call on Monday, 10/16/2023, which did not occur prior to the survey exit.

On 10/13/2023 at 1:55 p.m., an interview was conducted with the ADON (Assistant Director of Nursing) who stated she was in the care planning meeting and remembered that the daughter "did not want him to be overly sedated." The ADON stated "the family wanted him to be comfortable." When asked if she noticed any signs of Resident # 4 being overly medicated and when she last saw Resident # 4 prior to his discharge, the ADON stated personally could not remember when she last saw him but it was during that last week of his residing there. The ADON stated she "only saw him resting" when she looked in the room. She stated "the Unit Manager was back there and would have more contact with the resident."

On 10/16/2023 at approximately 12:30 p.m., an interview was conducted by Surveyor B and Surveyor C with the Unit Manager who stated she remembered Resident # 4. The Unit Manager stated she had conversations with the family members and was aware that the family did not want him to be overly medicated. She stated he

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often sat on the side of the bed or in his recliner. The Unit Manager stated she noticed that Resident # 4 was a little drowsy and we had them discontinue some of his medication. The Unit Manager stated that on the day Resident # 4 went to the hospital, the nurse asked her to assess the resident. The Unit Manager stated she observed that Resident # 4 would not open his eyes and would not respond to verbal stimuli (questions or jokes about the military to which he normally would respond) or a sternal rub. The Unit Manager stated she "knew he needed to be sent to the ER (Emergency Room) because he might be septic." He was sent to the Emergency Room.

Review of the Progress Notes revealed that Resident # 4 was admitted to the facility on 7/19/2023. There was no documentation of any skin issues upon admission. There was no documentation of skin issues on any of the weekly skin assessment sheets.

Review of the clinical record revealed no documentation of the implementation of interventions to prevent the risk of developing a pressure ulcer. There was no documentation of turning and repositioning every two hours, or use of an air mattress. The weekly skin checks at the facility documented no skin issues.

Interviews were conducted on 10/12/2023 at 11:10 a.m. with the Administrator and the Assistant Director of Nursing. Both were asked if Resident # 4 had a pressure ulcer or wound while at the facility. The Administrator stated she did not know but the Assistant Director of Nursing stated Resident # 4 did not have any pressure ulcers (bed sores). A copy of the Wound Report

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was requested.

Review of the Facility's documentation of Wound Reports for July, August and September 2023 revealed no documentation of Resident # 4 having any type of Pressure wound. Resident # 4's name was not listed on the report for any of the months reviewed.

On 10/12/2023 at 2:42 p.m., an interview was conducted with RN (Registered Nurse)- B who stated she was a new employee of 3 weeks at the time of the survey. She was not employed at the facility at the time Resident # 4 resided there. RN-B stated the facility nurses perform weekly skin checks during skin sweeps. RN-B stated the "CNAs are really good. They usually come and grab me. They let us know and patients let us know too. They will tell us. Upon admission, we check everyone." RN-B stated the nurse would notify the Nurse Practitioner of any new skin issues, receive any orders and notify the family.

On 10/12/2023 at 2:44 p.m., Certified Nursing Assistant B was interviewed about providing care to residents to prevent pressure injuries. CNA-B stated residents "should be turned every 2 hours, if sitting in a chair, they should stand every 2 hours, float heels and move pressure off any bony part of the body."

During the end of day debriefing on 10/16/2023, the facility's Corporate Nurse Consultant, Assistant Director of Nursing and Unit Manager were informed that the hospital records had been requested and would be reviewed when obtained. They were informed that the family of Resident # 4 stated they were unaware of the changes in condition and unaware of a sacral pressure

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wound. They stated they were sure there was no sacral pressure wound based on the documentation.

No further information was received by the facility.

Records from the Hospital Emergency Room and the larger hospital in another city were requested. None of the records were received prior to exit from the survey.

**On 10/23/2023 at 12:50 p.m., the records from the hospital were received. Review of the hospital records from 8/28/2023 revealed Resident # 4 was admitted to the hospital with diagnoses that included severe dehydration and electrolyte imbalances. Further review revealed that resident # 4 had a Stage 2 pressure ulcer on the sacrum that was infected with Pseudomonas Aeruginosa as per the culture results.

The facility staff stated Resident # 4 did not have a pressure ulcer on the sacrum. They stated he had no skin issues.
However, upon admission to the hospital on 8/28/2023, Resident # 4 had a pressure ulcer on the sacrum that was described as a stage 2 Pressure ulcer. The culture report noted the wound was infected with Pseudomonas Aeruginosa. Resident # 4 had a fever and sepsis according to the hospital admission notes on 8/28/2023. Further review revealed a diagnosis of Sepsis related to to buttock wound infection." Resident # 4's prognosis was listed as guarded and in other documents listed as "poor prognosis."

Resident # 4 was transferred to the hospital's Emergency Room with "hyperglycemia and

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| F 658 | Continued From page 31<br>altered mental status", then transferred to the Intensive Care Unit. He was described as Obtunded and diagnosed with many serious conditions to include but not limited to: dehydration, had several critical lab values, kidney injury, urinary tract infection, sepsis and an infected sacral pressure wound infected with Pseudomonas Aeruginosa.<br><br>The hospital notes stated Resident # 4 was found to be in renal failure and hyperkalemic (high potassium). The notes also stated he "is severely dehydrated and treated with IV (intravenous fluids). The Emergency Room Physicians initially ordered dialysis for Resident # 4. However, the nephrologist ordered to delay dialysis until attempts to increase hydration. His prognosis was listed as "guarded."<br><br>Resident # 4 remained in ICU for several days. Resident # 4 had a Percutaneous Endoscopic Gastrostomy tube inserted while in the hospital. He was discharged from the hospital to another nursing home facility on 9/13/2023.<br><br>The facility staff failed to assess and monitor for side effects of medications, failed to identify a sacral pressure wound (ulcer) and failed to prevent a decline in functional abilities. The staff also failed to assess and monitor for dehydration and electrolyte imbalances. Resident # 4 also had critical lab values. | F 658 | | |
| F 676 SS=D | Activities Daily Living (ADLs)/Mntn Abilities<br>CFR(s): 483.24(a)(1)(b)(1)-(5)(i)-(iii)<br><br>§483.24(a) Based on the comprehensive assessment of a resident and consistent with the resident's needs and choices, the facility must | F 676 | | 12/19/23 |

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| F 676 | Continued From page 32<br>provide the necessary care and services to ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that such diminution was unavoidable. This includes the facility ensuring that:<br><br>§483.24(a)(1) A resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living, including those specified in paragraph (b) of this section ...<br><br>§483.24(b) Activities of daily living.<br>The facility must provide care and services in accordance with paragraph (a) for the following activities of daily living:<br><br>§483.24(b)(1) Hygiene -bathing, dressing, grooming, and oral care,<br><br>§483.24(b)(2) Mobility-transfer and ambulation, including walking,<br><br>§483.24(b)(3) Elimination-toileting,<br><br>§483.24(b)(4) Dining-eating, including meals and snacks,<br><br>§483.24(b)(5) Communication, including<br>(i) Speech,<br>(ii) Language,<br>(iii) Other functional communication systems.<br>This REQUIREMENT is not met as evidenced by:<br>Based on staff interview, and clinical record review, the facility failed to provide care and services to ensure one Resident (Resident # 4) in a survey sample of 8 residents received care and | F 676 | 1. Resident #4 no longer resides at the facility.<br><br>2. All residents have the ability to be | |

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| F 676 | Continued From page 33<br>services for Activities of Daily Living. (ADLs).<br><br>Findings included:<br><br>For Resident # 4, the facility staff failed to provide care and services for ADLs. Staff failed to document the provision of care for activities of daily living (ADLs) care on numerous dates and times.<br><br>Resident # 4 was a 74-year-old with diagnoses including but not limited to: Dementia, Diabetes Mellitus-type 2, Chronic Kidney Disease Stage 3, Hypertension and history of a stroke in 2017.<br><br>The Admission MDS (Minimum Data Set) assessment tool with an ARD (Assessment Review Date) of 7/22/2023, coded Resident # 4 with a BIMS (Brief Interview for Mental Status) score of "00" out of 15, indicating severe cognitive impairment. It coded Resident # 4 as requiring extensive assistance of one staff person for ADLs (Activities of Daily Living) including toileting, hygiene and transferring and extensive assistance of two staff persons for dressing. Resident # 4 required total assistance of two staff persons for bathing. Resident # 4 was coded as frequently incontinent of bowel and occasionally incontinent of bladder. He required supervision of one staff member for walking in room and in corridor and mobility on and off the unit.<br><br>Review of the clinical record was conducted on 10/11/2023 -10/13/2023 and 10/16/2023.<br><br>Review of the Progress Notes revealed that Resident # 4 was admitted to the facility on 7/19/2023 and discharged to the hospital on 8/28/2023. | F 676 | affected by the deficiency. An audit was completed to ensure that residents have services in place to prevent ADL decline.<br><br>3. All licensed nursing staff and the Interdisciplinary team will be reeducated to ensure services are in place to prevent ADL decline.<br><br>4. The DON or designee will review weekly two residents weekly for 2 weeks and 4 residents monthly for two months that residents at risk for ADL decline have interventions in place to prevent ADL decline. Results of these audits will be presented to the facility QAPI Committee monthly for three months for review, and if warranted, further action. | |

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Review of the Transfer form dated 8/28/2023 (on the day of discharge to the hospital) revealed documentation about Resident # 4's "usual status prior to the acute change in condition." Documentation on the Transfer Interact Form denoted that prior to the acute change in condition, Resident # 4's usual mental status/cognitive function was not alert, not ambulatory and dependent in all activities of daily living.

Review of the ADL documentation report for July 2023 and August 2023 revealed numerous dates that there was no documentation of Activities of daily living care being provided for Resident # 4. The dates included but were not limited to:
7/22/2023-day shift
7/24/2023-evening shift
8/3/2023-night shift
8/5/2023-night shift
8/8/2023-day and night shift
8/10/2023- day and night shift
8/11/2023- night shift

There was documentation of urinary continence with occasional episodes of incontinence and bowel continence with occasional episodes of incontinence.

There was no bowel continence documentation on the following dates: 8/8-day shift and night shift, 8/10-day shift, 8/11-night shift, 8/18-night shift, 8/24-night shift, 8/27-evening shift. There was no documentation of the reasons for the missing documentation.

On 10/12/2023 at 4:33 p.m., an interview was conducted with CNA-B who stated the facility

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expected residents to be cared for.

On 10/12/2023 at 4:45 p.m., an interview was conducted with LPN-B who stated the expectation was for staff members to provide care to the residents to help maintain their abilities.

On 10/16/2023 at 2:30 p.m., an interview was conducted with the Assistant Director of Nursing, Unit Manager and Corporate Nurse Consultant. They were asked about the facility's expectation regarding providing care and documentation of that care. They all stated that care should be provided and documented. When asked what blanks in the documentation meant, they stated that "in nursing, if it's not documented, it's not done." The Corporate Nurse Consultant stated she could not say if the care was provided or not if it was not documented. She stated the expectation is for all care to be provided and documented in the clinical record.

The Unit Manager stated she was very familiar with Resident # 4 and noted that upon admission, he was ambulating with supervision and was occasionally incontinent of urine. The Unit Manager stated that when she returned to work after being off for a few days, Resident # 4 was no longer ambulating with supervision but instead, required extensive to total assistance of staff to ambulate and needed assistance with eating his meals. She also stated Resident # 4 was wearing incontinence briefs.

The Unit Manager stated she instructed the staff to make frequent rounds and provide assistance as needed. She also stated it was important for staff to provide the necessary care for residents to maintain their level of abilities to participate in

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| F 676 | Continued From page 36<br>Activities of Daily Living. She stated that the staff should document the care provided and notify the nurses of any changes.<br><br>On 10/16/2023 during the end of day meeting, the Assistant Director of Nursing, Corporate Nurse Consultant were informed of the findings.<br><br>No further information was provided. | F 676 | | |
| F 686 SS=D | Treatment/Svcs to Prevent/Heal Pressure Ulcer<br>CFR(s): 483.25(b)(1)(i)(ii)<br><br>§483.25(b) Skin Integrity<br>§483.25(b)(1) Pressure ulcers.<br>Based on the comprehensive assessment of a resident, the facility must ensure that-<br>(i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and<br>(ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing.<br>This REQUIREMENT is not met as evidenced by:<br>Based on staff interview, facility documentation review and clinical record review, the facility staff failed to ensure one Resident (Resident # 4) in a survey sample of 8 residents, received care and services to prevent and identify an infected pressure ulcer.<br><br>Findings included: | F 686 | 1. Resident #4 no longer resides at the facility.<br><br>2. All residents have the ability to be affected by the deficiency. An audit was completed to ensure interventions are in place to prevent pressure ulcers.<br><br>3. All licensed nursing staff will be | 12/19/23 |

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| F 686 | Continued From page 37<br>For Resident # 4, the facility staff failed to prevent and identify a Stage 2 pressure ulcer (1) that was found when emergently discharged to the hospital on 8/28/2023. The pressure ulcer was cultured at the hospital and revealed a Pseudomonas Aeruginosa infection, resulting in harm.<br><br>Resident # 4 was admitted on 7/19/2023 with diagnoses including but not limited to: Dementia, Diabetes Mellitus-type 2, Chronic Kidney Disease Stage 3, Hypertension and history of a stroke in 2017.<br><br>The Admission MDS (Minimum Data Set) assessment tool with an ARD (Assessment Review Date) of 7/22/2023, coded Resident # 4 with a BIMS (Brief Interview for Mental Status) score of "00" out of 15, indicating severe cognitive impairment. It coded Resident # 4 as requiring extensive assistance of one staff person for ADLs (Activities of Daily Living). There was no pressure wound noted.<br><br>Review of the clinical record was conducted on 10/11/2023 -10/13/2023 and 10/16/2023.<br><br>Review of the Progress Notes revealed that Resident # 4 was admitted to the facility on 7/19/2023. There was no documentation of any skin issues upon admission.<br><br>Review of the clinical record revealed no documentation of interventions known to prevent the risk of developing a pressure ulcer. There was no documentation of turning and repositioning every two hours, or use of an air mattress.<br><br>The weekly skin checks at the facility | F 686 | reeducated to ensure interventions are in place to prevent pressure ulcers.<br><br>4. The DON or designee will review 2 residents weekly for 2 weeks and 4 residents monthly for two months to ensure that residents have interventions in place to prevent pressure ulcers. Results of these audits will be presented to the facility QAPI committee monthly for three months for review, and if warranted, further action. | |

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| F 686 | Continued From page 38 | F 686 | | |

documented no skin issues.

Interviews were conducted on 10/12/2023 at 11:10 a.m. with the Administrator and the Assistant Director of Nursing. Both were asked if Resident # 4 had a pressure ulcer or wound while at the facility. The Administrator stated she did not know but the Assistant Director of Nursing stated Resident # 4 did not have any pressure ulcers (bed sores). A copy of the Wound Report was requested.

The Assistant Director of Nursing provided a copy of the Wound report on 10/12/2023 at 1:20 p.m.

Review of the Facility's documentation of Wound Reports for July, August and September 2023 revealed no documentation of Resident # 4 having any type of pressure wound. Resident # 4's name was not listed on the report for any of the months reviewed.

On 10/12/2023 at 2:42 p.m., an interview was conducted with RN (Registered Nurse)- B who stated she was a new employee at the time of the survey. She was not employed at the facility at the time Resident # 4 resided there. RN-B stated the facility nurses perform weekly skin checks during skin sweeps. RN-B stated the "CNAs are really good. They usually come and grab me. They let us know and patients let us know too. They will tell us. Upon admission, we check everyone." RN-B stated the nurse would notify the Nurse Practitioner of any new skin issues, receive any orders and notify the family.

On 10/12/2023 at 2:44 p.m., Certified Nursing Assistant B was interviewed about providing care to residents to prevent pressure injuries. CNA-B

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| F 686 | Continued From page 39 | F 686 | | |

stated residents "should be turned every 2 hours, if sitting in a chair, they should stand every 2 hours, float heels and move pressure off any bony part of the body."

On 10/16/2023 at approximately 12:30 p.m., an interview was conducted by Surveyor B and Surveyor C with the Unit Manager who stated she remembered Resident # 4. The Unit Manager stated if residents were not getting out of bed, the nurses should do more than weekly skin assessment. She stated she instructed the nursing staff to do skin assessments twice a week on residents who did not get out of bed. The Unit Manager stated she was not informed that Resident # 4 had a pressure wound. She stated that according to the documentation, Resident # 4 did not have a pressure wound (ulcer).

During the end of day debriefing on 10/16/2023, the facility's Corporate Nurse Consultant, Assistant Director of Nursing and Unit Manager were informed that the hospital records had been requested and would be reviewed when obtained. They stated they were sure there was no sacral pressure wound based on the documentation.

No further information was received by the facility.

**On 10/23/2023 at 12:50 p.m., the records from the hospital were received. Review of the hospital records revealed that upon admission to the hospital on 8/28/2023,Resident # 4 had a pressure ulcer on the sacrum that was described as a stage 2 pressure ulcer. The culture report noted the wound was infected with Pseudomonas Aeruginosa. Resident # 4 had a fever and sepsis according to the hospital admission notes

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| F 686 | Continued From page 40<br>on 8/28/2023. Further review revealed a diagnosis of Sepsis related to to buttock wound infection. Resident # 4's prognosis was listed as guarded and in other documents listed as "poor prognosis."<br><br>Reference:<br>(1) Stage 2: Partial thickness loss of dermis presenting as a shallow open ulcer with a red or pink wound bed, without slough or bruising. May also present as an intact or open/ruptured blister. https://www.cms.gov/files/document/pocket-guide pressure-ulcers-and-injuries-stages-and-definitions.pdf | F 686 | | |
| F 742 SS=D | Treatment/Srvcs Mental/Psychoscial Concerns CFR(s): 483.40(b)(1)<br><br>§483.40(b) Based on the comprehensive assessment of a resident, the facility must ensure that-<br>§483.40(b)(1)<br>A resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder, receives appropriate treatment and services to correct the assessed problem or to attain the highest practicable mental and psychosocial well-being;<br>This REQUIREMENT is not met as evidenced by:<br>Based on staff interview, clinical record review, and facility documentation, the facility staff failed to provide appropriate treatment and services for Residents who display or are diagnosed with mental disorder or psychosocial adjustment difficulty for one Resident (Resident #4) in a survey sample of 8 Residents. | F 742 | 1. Resident #4 no longer resides at the facility.<br><br>2. All residents with mental disorders have the ability to be affected by the deficiency. An audit was completed to ensure residents with mental disorders have psychiatric services in place. | 12/19/23 |

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| F 742 | Continued From page 41<br>The findings included:<br><br>For Resident #4 the facility staff failed to ensure that the Resident was seen by psychiatric (psych) services in order to provide a continuity of care after being discharged from the hospital where he was receiving psych services.<br><br>Resident #4 was admitted to the facility on 7/19/23 with diagnoses that included but were not limited to dementia to Alzheimer's Disease and Vascular Dementia, with psychotic disturbance. He has a history of Agitation and sexual behavior disturbance. His BIMS score of 00/15 indicates severe cognitive impairment. Prior to admission to this facility, he was followed by Psych while a patient at the Veterans Hospital.<br><br>Excerpts from Resident #4's discharge summary from the (Name of Hospital) are as follows:<br><br>"Key Findings: We consulted psychiatry and adjusted your medications to help alleviate some behavioral symptoms of dementia. You will be discharged to a long-term care center to better help your needs.<br><br>Discharge summary from the hospital included the following psychotropic medications.<br><br>Sertraline 100 mg (an anti-depressant)<br>Seroquel (an anti-psychotic) 50 mg by mouth daily at 8:00 AM<br>Seroquel 75 mg by mouth daily at 2:00 PM<br>Seroquel 75 mg by mouth daily at bedtime<br>Seroquel 25 mg by mouth BID (twice daily) PRN (as needed) for agitation.<br>Haloperidol (an anti-psychotic) inj 2 mg BID PRN if unable or unwilling to tolerate by mouth | F 742 | 3. Interdisciplinary team members will be reeducated to ensure psychiatric services are provided that meet the needs of residents with mental disorders.<br><br>4. The DON or designee will review 2 residents weekly for two weeks and 4 residents monthly for two months to ensure that residents that have mental disorders have psychiatric services in place. | |

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| F 742 | Continued From page 42 | F 742 | | |

Seroquel.

Upon admission to the facility the psychotropic medications were changed as follows:

Paroxetine HCL 10 Mg (Also known as Paxil an anti-depressant SSRI -Selective Serotonin Reuptake Inhibitor) Date ordered:7/20/23.
Sertraline 100 mg (Also known as Zoloft an anti-depressant SSRI -Selective Serotonin Reuptake Inhibitor) Date ordered 7/19/23.
Melatonin 5 mg give 10 mg at bedtime for sleep. Date Ordered 7/20/23.
Seroquel 50 mg. one time a day for Vascular dementia with psychotic disturbance Date ordered 7/19/23.
Seroquel 75mg by mouth two times a day for dementia Date ordered 7/19/23.
Spironolactone 100 mg. by mouth one time per day for inappropriate behavior. Date Ordered 7/20/23.
Seroquel 25 mg every 12 hrs. PRN for agitation

On 10/16/23 a review of the clinical record revealed that Resident #4 only had one visit from Psych services and that was on 7/26/23. The following is an excerpt from the note.

"7/26/23 Recommendations: Depakote Sprinkles 250 mg PO TID - give with each meal related to unspecified dementia unspecified severity with mood disturbance. Trazodone 50 mg 1 tablet p.o. nightly related to depression and insomnia.
Discontinue Sertraline - patient already on Paxil. Continue Seroquel, melatonin, Paxil and memantine. Patient benefits from these medications without any adverse effects.
Redirection strategies. Supportive care. Offer opportunities for socialization and participation in

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| F 742 | Continued From page 43<br>activities as they adjust to new routine and to avoid social isolation.<br>Monitor for changes in mood or behaviors and notify/page Team Health as needed. Will continue to follow and provide consultation.<br>Follow-up: Will continue to follow in 3-4 weeks to evaluate status and to provide support. Supportive interactions can help reduce the possibility of an exacerbation of symptoms."<br><br>The following medications were added by the facility Nurse Practitioner (NP) after the psych NP had been consulted.<br><br>Buspirone HCL [an anti-anxiety] 5 mg 1 tab by mouth twice a day Date ordered 7/29/23.<br>Lorazepam (Ativan) [an anti-anxiety] 0.5 mg twice a day for agitation / anxiety / aggression for 30 days give first dose now. Date ordered 7/31/23.<br><br>On 10/16/23 during the end of day meeting the Administrator was made aware of the concerns and no further information was provided. | F 742 | | |
| F 744 SS=D | Treatment/Service for Dementia<br>CFR(s): 483.40(b)(3)<br><br>§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.<br>This REQUIREMENT is not met as evidenced by:<br>Based on staff interview, clinical record review and facility documentation, the facility staff failed to provide appropriate treatment and services for Residents who display or are diagnosed with dementia for one Resident (Resident #4) in a | F 744 | 1. Resident #4 no longer resides at the facility.<br><br>2. All residents with dementia have the ability to be affected by the deficiency. An | 12/19/23 |

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| F 744 | Continued From page 44<br>survey sample of 8 Residents.<br><br>The findings included.<br><br>For Resident # 4 the facility staff failed to consult with a psychiatrist (psych) adding several psychotropic medications to his medication regimen.<br><br>Resident #4 was admitted to the facility on 7/19/23 with diagnoses that included but were not limited to dementia to Alzheimer's Disease and Vascular Dementia, with psychotic disturbance. He has a history of Agitation and sexual behavior disturbance. His BIMS score of 00/15 indicates severe cognitive impairment. Prior to admission to this facility, he was followed by Psych while a patient at the Veterans Hospital.<br><br>Excerpts from Resident #4's discharge summary from the (Name of Hospital) are as follows:<br><br>"Key Findings: We consulted psychiatry and adjusted your medications to help alleviate some behavioral symptoms of dementia. You will be discharged to a long-term care center to better help your needs."<br><br>Discharge summary from the hospital included the following psychotropic medications.<br><br>Sertraline 100 mg (an anti-depressant)<br>Seroquel (an anti-psychotic) 50 mg by mouth daily at 8:00 AM<br>Seroquel 75 mg by mouth daily at 2:00 PM<br>Seroquel 75 mg by mouth daily at bedtime<br>Seroquel 25 mg by mouth BID (twice daily) PRN (as needed) for agitation.<br>Haloperidol (an anti-psychotic) in 2 mg BID PRN | F 744 | audit of residents the the diagnosis of dementia was completed to ensure interventions are in place.<br><br>3. Interdisciplinary team members will be reeducated to ensure interventions are in place for residents with dementia.<br><br>4. The DON or designee will review 2 residents weekly for two weeks and 4 residents monthly for 2 months to ensure interventions are in place for residents with dementia. Results of these audits will be presented to the facility QAPI committee monthly for 3 months for review, and if warranted, further action. | |

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| F 744 | Continued From page 45 | F 744 | | |

if unable or unwilling to tolerate by mouth Seroquel.

Upon admission to the facility the psychotropic medications were changed as follows:

Paroxetine HCL 10 Mg (Also known as Paxil an anti-depressant SSRI -Selective Serotonin Reuptake Inhibitor) Date ordered:7/20/23.
Sertraline 100 mg (Also known as Zoloft an anti-depressant SSRI -Selective Serotonin Reuptake Inhibitor) Date ordered 7/19/23.
Melatonin 5 mg give 10 mg at bedtime for sleep. Date Ordered 7/20/23.
Seroquel 50 mg. one time a day for Vascular dementia with psychotic disturbance Date ordered 7/19/23.
Seroquel 75 mg by mouth two times a day for dementia Date ordered 7/19/23.
Spironolactone 100 mg. by mouth one time per day for inappropriate behavior. Date Ordered 7/20/23.
Seroquel 25 mg every 12 hrs. PRN for agitation

According to the NIH (National Institutes of Health) Library of Medicine:
"The administration of 2 or more serotonergic drugs or an overdose of 1 agent can cause the serotonin syndrome, a potentially life-threatening disorder characterized by myoclonus, hyperreflexia, sweating, shivering, incoordination, and mental status changes.11 The serotonin syndrome can be distinguished from other SSRI-induced side effects by the clustering of clinical features, their severity, and duration.10 The coadministration of serotonergic drugs (e.g., 2 SSRIs or an SSRI plus an MAOI) should be avoided. "

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| F 744 | Continued From page 46 | F 744 | | |

After admission the following medications were added:

Depakote (Anti-convulsant) sprinkles 250 mg three times per day Date ordered 7/26/23 [NOTE: This Resident does not have a seizure disorder. This drug is being used Off label use for depression or anxiety]
Trazodone 50 mg by mouth at bedtime for Vascular dementia with psychotic disturbance Date ordered 7/26/23.
Buspirone HCL 5 mg 1 tab by mouth twice a day Date ordered 7/29/23.
Lorazepam (Ativan) 0.5 mg twice a day for agitation / anxiety / aggression for 30 days give first dose now. Date ordered 7/31/23.

The pharmacy recommendations dated 8/2/23 read as follows:

"The following medications are best administered with these guidelines (time, with or without food crushing etc.)
Evaluated resident r/t [related to] changes in sexual aggression. Resident has a medical history of Alzheimer's disease. Resident is receiving Sertraline 100 mg, Paroxetine 20 mg Lorazepam 0.5 mg BID, Buspirone 5 mg BID Trazodone 50 mg hs [at bedtime] Depakote 250 mg TID (3x daily) Seroquel 50 mg daily and 75 BID [2x daily] Seroquel 25mg PRN and donepezil 10 mg."

"There does not appear to be a diagnosis listed on the Physician Order that indicates the need for this type of drug therapy (dementia related psychosis is NOT approved)."

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| F 744 | Continued From page 47<br>"Appropriate diagnosis to support antipsychotic use include schizophrenia, schizo-affective, psychotic mood disorder, acute psychotic episodes, brief reactive disorder, schizophreniform disorder, atypical psychosis, delusional disorder dementing disorder with behavioral symptoms, Tourette's disorder."<br><br>The response from the medical director was as follows:<br><br>"Spoke to [name redacted] (pharmacist) on 8/9/23 Sertraline and PRN Seroquel DC'd [discontinued] Diagnosis for Seroquel is Unspecified Dementia, unspecified severity with behavior disturbance (F03.91). Do not discontinue Seroquel - patient will most likely increase risk for psychiatric decompensation."<br><br>On 10/16/23 during the end of day meeting the Administrator was made aware of the concerns and no further information was provided. | F 744 | | |
| F 755 SS=D | Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3)<br><br>§483.45 Pharmacy Services<br>The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.<br><br>§483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and | F 755 | | 12/19/23 |

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| F 755 | Continued From page 48<br>biologicals) to meet the needs of each resident.<br><br>§483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-<br><br>§483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility.<br><br>§483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and<br><br>§483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.<br>This REQUIREMENT is not met as evidenced by:<br>Based on staff interview, facility documentation review, and clinical record review, the facility staff failed to ensure medications were available for administration for two Residents (Residents # 6 and # 3 ) in a survey sample of 8 residents.<br><br>Findings included:<br><br>1. For Resident # 6, the facility failed to ensure medications were available for administration several times as ordered by the physician.<br><br>Review of the clinical record was conducted 10/11/2023-10/13/2023.<br><br>Review of the Progress Notes revealed the following documentation regarding medications being unavailable: | F 755 | 1. Resident #6 no longer resides at the facility.<br><br>2. All residents that receive medications have the ability to be affected by the deficiency. An audit was completed to ensure medications were availalbe to be administered.<br><br>3. All licensed nursing staff will be reeducated on ensuring medications are available to be administered to the residents.<br><br>4. The DON or designee will review 2 residents weekly for two weeks and 4 residents monthly for two months to ensure that residents have medications available for administration. Results of | |

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| F 755 | Continued From page 49<br>Torsemide Oral Tablet 60 MG (milligrams) (Torsemide) Give 1 tablet by mouth one time a day for Edema -Order Date-08/25/2023 1640. The medication was unavailable 9/1/23, 9/5/23 and 9/6/23.<br><br>Effective Date: 08/30/2023 20:03 Type: EMAR(Electronic Medication Administration Record) - Administration Note Text : Gabapentin Capsule 100 MG (milligrams)<br>Give 1 capsule by mouth three times a day for Neuropathy "awaiting medication."<br><br>Review of the August 2023 and September 2023 Medical Administration Records revealed several medications were documented as "not available" for administration or "on order."<br><br>Review of Physicians Orders revealed valid orders for the medications not available for administration.<br><br>On 10/16/2023 at 3:05 p.m., an interview was conducted with the Unit Manager who stated the Pharmacy delivered medications once a day on the night shift. The Unit Manager stated when medications were delivered to the facility, some nurses left the medications sitting at the desk. She stated, "The medications did arrive from the pharmacy but have not been scanned in the system." The Unit manager stated if a medication was not available at the time of scheduled administration, the nurses should go to the (name of on-site stat box) to see if the medication was available in that stock.<br><br>Review of the Stat Box contents revealed the medication, Gabapentin 100 mg tablet quantity of 7 tablets, was on hand. | F 755 | these audits will be presented to the facility QAPI committee monthly for three months for review, and if warranted, further action. | |

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| F 755 | Continued From page 50 | F 755 | | |

During the end of day debriefing on 10/16/2023, the Corporate Nurse Consultant, Unit Manager and Assistant Director of Nursing were informed of the findings. They stated medications should be available for administration.

No further information was provided.

2. For Resident # 3, the facility staff failed to ensure the medications were available for administration on several scheduled dates of administration as ordered by the physician.

Review of the clinical record was conducted 10/11/2023-10/13/2023.

Review of the Progress Notes revealed the following documentation regarding medications being unavailable:

Effective Date: 09/13/2023 09:05 Type: EMAR - Administration Note: Scopolamine Transdermal Patch 72 Hour
Apply 1 mg (milligram) transdermally one time a day every 3 day(s) for increase secretions
"on order"

Effective Date: 09/07/2023 21:38 Type: EMAR - Administration Note
Note Text : Scopolamine Transdermal Patch 72 Hour
Apply 1 mg transdermally one time a day every 3 day(s) for increase secretions
"Patches unavailable; unable to reorder"

Effective Date: 09/01/2023 16:26 Type: EMAR - Administration Note

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| F 755 | Continued From page 51 | F 755 | | |

Note Text : Scopolamine Transdermal Patch 72 Hour
Apply 1 mg transdermally one time a day every 3 day(s) for increase secretions
"Medication on order"

10/10/2023-Scopolamine Transdermal Patch 72 Hour
Apply 1 mg transdermally one time a day every 3 day(s) for increase secretions
"on order"

10/13/2023- Scopolamine Transdermal Patch 72 Hour
Apply 1 mg transdermally one time a day every 3 day(s) for increase secretions
"on order"
Risperidone Give 3 milliliters by mouth three times per day-"On order"
Glucerna with each meal three times a day-not available on 9/22/023 and 9/17/2023

Review of the September 2023 and October 2023 Medical Administration Records revealed several medications were documented as "not available" for administration or "on order."

Review of Physicians Orders revealed valid orders for the medications not available for administration.

On 10/12/2023 at 11:48 a.m., an interview was conducted with LPN (Licensed Practical Nurse) D who stated "the staff should notify the Pharmacy when medications are not available for administration, check the (Name of STAT box), notify the MD (Medical Doctor) and make sure the Pharmacy sends the medication STAT."

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| F 755 | Continued From page 52 | F 755 | | |

On 10/13/2023 at 11:55 a.m., an interview was conducted with the Administrator who stated the Pharmacy should have medications available for administration as per Physicians Orders. The Administrator was asked to present a copy of the Stat Box medications list to determine if the missing medications were available in that supply. The Administrator stated medications should be given as ordered by the physician.

On 10/13/2023 at 2:42 p.m., an interview was conducted with the Assistant Director of Nursing who stated the expectation was for the Pharmacy to make sure medications were available for administration as per physicians orders. The Assistant Director of Nursing also stated the facility staff should check the "(Name) of STAT box for medications to see if the missing medication is available in that supply. The Director of Nursing stated the pharmacy should deliver the missing medication on the next run if it was not available in the (Name of STAT box).

On 10/16/2023 at 3:05 p.m., an interview was conducted with the Unit Manager who stated the pharmacy delivered medications once a day on the night shift. The Unit Manager stated when medications were delivered to the facility, some nurses left the medications sitting at the desk. She stated "the medications did arrive from the pharmacy but have not been scanned in the system." The Unit Manager stated if a medication was not available at the time of scheduled administration, the nurses should go to the (on-site Stat box) to see if the medication was available in that stock.

During the end of day debriefing on 10/16/2023, the Corporate Nurse Consultant, Unit Manager

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| F 755 | Continued From page 53<br>and Assistant Director of Nursing were informed of the findings. They stated medications should be available for administration.<br><br>No further information was provided. | F 755 | | |
| F 757 SS=D | Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6)<br><br>§483.45(d) Unnecessary Drugs-General.<br>Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used-<br><br>§483.45(d)(1) In excessive dose (including duplicate drug therapy); or<br><br>§483.45(d)(2) For excessive duration; or<br><br>§483.45(d)(3) Without adequate monitoring; or<br><br>§483.45(d)(4) Without adequate indications for its use; or<br><br>§483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or<br><br>§483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section.<br>This REQUIREMENT is not met as evidenced by:<br>Based on interview, clinical record review and facility documentation, the facility staff failed to ensure that a Resident was free from unnecessary medications to include duplicate drug therapy for one Resident (Resident #4) in a survey sample of 8 Residents. | F 757 | 1. Resident #4 no longer resides at the facility.<br><br>2. All residents that receive duplicate therapy have the ability to be affected by the deficiency. A drug regimen review | 12/19/23 |

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| F 757 | Continued From page 54<br><br>The findings included:<br><br>For Resident #4 the facility staff failed to ensure the Resident was free from duplicate drug therapy to include 2 SSRI's (Selective Serotonin Reuptake Inhibitors),<br><br>Resident #4 was admitted to the facility on 7/19/23 with diagnoses that included but were not limited to dementia to Alzheimer's Disease and Vascular Dementia, with psychotic disturbance. He has a history of Agitation and sexual behavior disturbance. His BIMS score of 00/15 indicates severe cognitive impairment. Prior to admission to this facility, he was followed by a psychiatrist (psych) while a patient at the (Name of) Hospital.<br><br>Excerpts from Resident #4's discharge summary from the hospital are as follows:<br><br>"Key Findings: We consulted psychiatry and adjusted your medications to help alleviate some behavioral symptoms of dementia. You will be discharged to a long-term care center to better help your needs."<br><br>Discharge summary from the hospital included the following psychotropic medications.<br><br>Sertraline 100 mg (an anti-depressant)<br>Seroquel (an anti-psychotic) 50 mg by mouth daily at 8:00 AM<br>Seroquel 75 mg by mouth daily at 2:00 PM<br>Seroquel 75 mg by mouth daily at bedtime<br>Seroquel 25 mg by mouth BID (twice daily) PRN (as needed) for agitation.<br>Haloperidol (an anti-psychotic) in 2 mg BID PRN if unable or unwilling to tolerate by mouth | F 757 | was completed on current residents.<br><br>3. All licensed nursing staff will be reeducated to ensure each resident receives a drug regimen review.<br><br>4. The DON or designee will review weekly 2 residents weekly for two weeks and 4 residents montly for two months to ensure that residents have had a drug regimen review. Results of these audits will be presented to the facility QAPI committee monthly for three months for review, and if warranted, further action. | |

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| F 757 | Continued From page 55 | F 757 | | |

Seroquel.

Upon admission to the facility the psychotropic medications were changed as follows:

Paroxetine HCL 10 Mg (Also known as Paxil an anti-depressant SSRI -Selective Serotonin Reuptake Inhibitor) Date ordered:7/20/23.
Sertraline 100 mg (Also known as Zoloft an anti-depressant SSRI -Selective Serotonin Reuptake Inhibitor) Date ordered 7/19/23.
Melatonin 5 mg give 10 mg at bedtime for sleep. Date Ordered 7/20/23.
Seroquel 50 mg. one time a day for Vascular dementia with psychotic disturbance Date ordered 7/19/23.
Seroquel 75mg by mouth two times a day for dementia Date ordered 7/19/23.
Spironolactone 100 mg. by mouth one time per day for inappropriate behavior. Date Ordered 7/20/23.
Seroquel 25 mg every 12 hrs. PRN for agitation

On 7/26/23 Resident #4 was seen by the psychiatric nurse practitioner and excerpts from her notes read:

"Discontinue Sertraline - patient already on Paxil. Continue Seroquel, melatonin, Paxil and memantine. Patient benefits from these medications without any adverse effects."

A review of the clinical record revealed that Resident #4's Sertraline was not discontinued until 8/2/23.

According to the NIH (National Institutes of Health) Library of Medicine:

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| F 757 | Continued From page 56<br>"The administration of 2 or more serotonergic drugs or an overdose of 1 agent can cause the serotonin syndrome, a potentially life-threatening disorder characterized by myoclonus, hyperreflexia, sweating, shivering, incoordination, and mental status changes.11 The serotonin syndrome can be distinguished from other SSRI-induced side effects by the clustering of clinical features, their severity, and duration.10 The coadministration of serotonergic drugs (e.g., 2 SSRIs or an SSRI plus an MAOI) should be avoided. " | F 757 | | |
| F 758 SS=D | Free from Unnec Psychotropic Meds/PRN Use<br>CFR(s): 483.45(c)(3)(e)(1)-(5)<br><br>§483.45(e) Psychotropic Drugs.<br>§483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories:<br>(i) Anti-psychotic;<br>(ii) Anti-depressant;<br>(iii) Anti-anxiety; and<br>(iv) Hypnotic<br><br>Based on a comprehensive assessment of a resident, the facility must ensure that---<br><br>§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;<br><br>§483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically | F 758 | | 12/19/23 |

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| F 758 | Continued From page 57<br>contraindicated, in an effort to discontinue these drugs;<br><br>§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<br><br>§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.<br><br>§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.<br>This REQUIREMENT is not met as evidenced by:<br>Based on interview, clinical record review and facility documentation the facility staff failed to ensure Resident was free from unnecessary psychotropic drug use for one Resident (Resident #4) in a survey sample of 8 Residents.<br><br>The findings included:<br><br>For Resident #4 the facility staff failed to prevent duplication of drugs, and failed to ensure PRN (as needed) anti-psychotic medication were limited to 14 days.<br><br>Resident #4 was admitted to the facility on | F 758 | 1. Resident #4 no longer resides at the facility.<br><br>2. All residents who receive psychotropic medications have the ability to be affected by the deficiency. An audit was completed to ensure residents that receive psychotropic medications have a drug regimen review.<br><br>3. All licensed nursing staff will be reeducated to ensure residents who receive psychotropic medications receive medications appropriately. | |

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| F 758 | Continued From page 58<br>7/19/23 with diagnoses that included but were not limited to dementia to Alzheimer's Disease and Vascular Dementia, with psychotic disturbance. He has a history of Agitation and sexual behavior disturbance.<br><br>Excerpts from Resident #4's discharge summary from the hospital are as follows:<br><br>"Key Findings: We consulted psychiatry and adjusted your medications to help alleviate some behavioral symptoms of dementia. You will be discharged to a long-term care center to better help your needs."<br><br>Discharge summary from the hospital included the following psychotropic medications.<br><br>Sertraline 100 mg (an anti-depressant)<br>Seroquel (an anti-psychotic) 50 mg by mouth daily at 8:00 AM<br>Seroquel 75 mg by mouth daily at 2:00 PM<br>Seroquel 75 mg by mouth daily at bedtime<br>Seroquel 25 mg by mouth BID (twice daily) PRN (as needed) for agitation.<br>Haloperidol (an anti-psychotic) in 2 mg BID PRN if unable or unwilling to tolerate by mouth Seroquel.<br><br>Upon admission to the facility the psychotropic medications were changed as follows:<br><br>Paroxetine HCL 10 Mg (Also known as Paxil an anti-depressant SSRI -Selective Serotonin Reuptake Inhibitor) Date ordered:7/20/23.<br>Sertraline 100 mg (Also known as Zoloft an anti-depressant SSRI -Selective Serotonin Reuptake Inhibitor) Date ordered 7/19/23. | F 758 | 4. The DON or designee will review 2 residents weekly for 2 weeks and 4 residents monthly for two months to ensure that residents receiving psychotropic medications have had a drug regimen review. Results of these audits will be presented to the facility QAPI committee monthly for three months for review, and if warranted, further action. | |

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| F 758 | Continued From page 59 | F 758 | | |

Melatonin 5 mg give 10 mg at bedtime for sleep. Date Ordered 7/20/23.
Seroquel 50 mg. one time a day for Vascular dementia with psychotic disturbance Date ordered 7/19/23.
Seroquel 75 mg by mouth two times a day for dementia Date ordered 7/19/23.
Spironolactone 100 mg. by mouth one time per day for inappropriate behavior. Date Ordered 7/20/23.
Seroquel 25 mg every 12 hrs. PRN for agitation

According to the NIH (National Institutes of Health) Library of Medicine:
"The administration of 2 or more serotonergic drugs or an overdose of 1 agent can cause the serotonin syndrome, a potentially life-threatening disorder characterized by myoclonus, hyperreflexia, sweating, shivering, incoordination, and mental status changes.11 The serotonin syndrome can be distinguished from other SSRI-induced side effects by the clustering of clinical features, their severity, and duration.10 The coadministration of serotonergic drugs (e.g., 2 SSRIs or an SSRI plus an MAOI) should be avoided. "

On 7/26/23 Resident #4 was seen by the psychiatric nurse practitioner one time during his stay. The following are excerpts from the notes.

"Recommendations: Depakote Sprinkles 250 mg PO TID - give with each meal related to unspecified dementia unspecified severity with mood disturbance. Trazodone 50 mg 1 tablet p.o. nightly related to depression and insomnia. Discontinue Sertraline - patient already on Paxil. Continue Seroquel, melatonin, Paxil and memantine. Patient benefits from these

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| EMPORIA REHABILITATION AND HEALTHCARE CENTER | 200 WEAVER AVENUE EMPORIA, VA 23847 |

| (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 |
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medications without any adverse effects."
"Follow-up: Will continue to follow in 3-4 weeks to evaluate status and to provide support. Supportive interactions can help reduce the possibility of an exacerbation of symptoms."

A review of the clinical record revealed pharmacy recommendations dated 8/2/23, excerpts are as follows:

"The following medications are best administered with these guidelines (time, with or without food crushing etc.)
Evaluated resident r/t [related to] changes in sexual aggression. Resident has a medical history of Alzheimer's disease. Resident is receiving Sertraline 100 mg, Paroxetine 20 mg Lorazepam 0.5 mg BID, Buspirone 5 mg BID Trazodone 50 mg hs [at bedtime] Depakote 250 mg TID (3x daily) Seroquel 50 mg daily and 75 BID [2x daily] Seroquel 25mg PRN and donepezil 10 mg."

"There does not appear to be a diagnosis listed on the Physician Order that indicates the need for this type of drug therapy (dementia related psychosis is NOT approved)."

"I do not recommend the use of benzodiazepines since they contribute to apathy and increase fall risk."

"Appropriate diagnosis to support antipsychotic use include schizophrenia, schizo-affective, psychotic mood disorder, acute psychotic episodes, brief reactive disorder, schizophreniform disorder, atypical psychosis, delusional disorder dementing disorder with behavioral symptoms, Tourette's disorder."

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495375 | A. BUILDING _____ B. WING _____ | C 10/16/2023 |

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The response from the medical director was as follows:

"Spoke to [name redacted] (pharmacist) on 8/9/23 Sertraline and PRN Seroquel DC'd [discontinued] Diagnosis for Seroquel is Unspecified Dementia, unspecified severity with behavior disturbance (F03.91). Do not discontinue Seroquel - patient will most likely increase risk for psychiatric decompensation."

On 10/16/23 at approximately 5:00 PM an interview was conducted with LPN C who was asked if it was expected that physician orders be carried out in a timely fashion, she stated that it was. When asked if a medication was going to be changed and the physician ordered the change how long should it take to get that carried over to the orders, she stated not more than 24 hours if the medication is not STAT. When asked if a medication was to be discontinued how long should that process take, she stated that should just take a few minutes. We put the order in to discontinue the medication and that is it. When asked if it should take a week to get a medication stopped LPN C said, "That is far too long, depending on the reason for stopping the medication you could do harm by continuing to give it."

A review of the MAR (Medication Administration Record) revealed that Resident #4 had orders to receive PRN Seroquel from time of Admission 7/19/23 until 8/2/23 and received both SSRI's (Sertraline and Paxil) until 8/2/23, and the benzodiazepine (Ativan) was stopped on 8/2/23 as well.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495375 | A. BUILDING _____ B. WING _____ | C 10/16/2023 |

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|---|---|---|---|---|
| F 758 | Continued From page 62<br>On 10/16/23 during the end of day meeting the Administrator was made aware of the concerns and no further information was provided. | F 758 | | |