

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/01/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255277	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/07/2019
NAME OF PROVIDER OR SUPPLIER GREENE RURAL HEALTH CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1017 JACKSON STREET LEAKESVILLE, MS 39451		
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F 000	INITIAL COMMENTS A Recertification survey was conducted from 3/4/19 through 3/7/19, by Healthcare Management Solutions, LLC on behalf of Mississippi State Department of Health. The facility was found not to be in substantial compliance with requirements of participation for Medicare and Medicaid and deficiencies were cited at F656, F657, F689, F697, F758, F761 and F880.	F 000			
F 656 SS=D	The facility's census during survey was 56, and the facility held a license for 60 beds. Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will	F 656		5/1/19	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

04/08/2019

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 656	Continued From page 1 provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv) In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on the facility policy, care plan review, and staff interviews the facility failed to develop and implement a comprehensive person-centered care plan for Resident (R)18. The resident's plan of care did not include person-specific, measurable objectives and a timeframe to evaluate the resident's progress to goals. Findings include: The following policies were reviewed: Care Planning- Interdisciplinary Team, Operational Policy and Procedure Manual, for Long Term Care, 2001 Med- Pass Inc., Revised May 2017; and Care Plans, Comprehensive Person-Centered, [same manual], Revised December 2016. According to the care plans comprehensive person centered policy, the care plan will include the following: measurable	F 656	1) The comprehensive care plan was revised for Resident #18 to be person-specific, have measurable goals and a time frame to evaluate resident's progress to goals by the Interdisciplinary Team on 04/03/2019. 2) All residents have been identified as having the potential to be affected by the same deficient practice. 3) All staff responsible for the development and implementation of care plans was inserviced on 03/22/2019 by the Director of Nursing and the Staff Development Nurse on the importance of developing a comprehensive care plan with regards to person-centered care, measurable goals and a time frame for		

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F 656	Continued From page 2 objectives and timeframe, a description of the services to be provided, include the resident's stated goals on admission, build on resident's strengths, have measurable outcomes, reflect current standards of practice, include interventions that address the underlying source of the problem, not just only symptoms or triggers, are ongoing in assessment, are interdisciplinary in approach, are reviewed and revised when the desired outcome is not achieved. Review of Resident #18's care plan reflected that many of the problems on the plan of care are dated from March 2016, and have not been revised. Problems address the resident's medical diagnoses rather than being person-centered. Goals are not specific nor measurable. Interventions are not time limited. On 03/07/19 at 10:19 AM, an interview of the MDS/Care Plan Nurses, LPN #38 and LPN #39, who are responsible for completing the nursing portions of the MDS, making decisions on proceeding with the "Care Assessment Areas (CAAs)", and then developing the care plans was conducted. LPN #38 and LPN #39 stated during the care conferences, the entire plan of care including the interventions are reviewed then reprinted and placed on chart. Both the LPNs stated that it is not often that revisions are made to the goals, or interventions. Each discipline is responsible for developing their plan of care and for evaluating their interventions for effectiveness. It is the expectation that the discipline would come to the meeting with any changes they wanted made on the care plan. Discussion with the "Minimum Data Set (MDS)/Care Plan Licensed Practical Nurses (LPN) regarding the	F 656	measuring the residents progress toward the goals. An audit of care plans for all residents was initiated on 04/03/2019 by the Activity Director and completed on 04/10/2019. The Quality Assurance Nurse, Activity Director, Director of Nursing and/or Administrator will audit random care plans to ensure accurate development and implementation of person-centered care plans weekly beginning 04/08/2019 and ending 04/29/2019, then monthly beginning 05/06/2019 and ending 07/06/2019 and quarterly thereafter. The Quality Assurance Nurse will maintain a log of findings and these will be reported to the Director of Nursing and/or Administrator for corrective action if necessary. 4)Logs with findings will be presented to the Quality Assurance Performance Improvement (QAPI)Committee by the Quality Assurance (QA) Nurse monthly and quarterly with the Medical Director for evaluation and review to determine if further action is necessary to ensure compliance is achieved and sustained.		

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F 656	Continued From page 3 activities goal that "the resident would make eye contact with each interaction" confirmed it was unrealistic since the resident is receiving end of life care and awareness varies over the day. Confirmed no identified measures included in the goal to determine progress or meeting a goal. Many of the interventions are assigned to one discipline; not promoting an interdisciplinary approach. Confirmed Hospice interventions for Resident #18 are not added to the plan of care except to say- contact Hospice if there are problems, but the problems were not identified. Continued interview of LPN #38 and LPN #39 on 03/07/19 at 10:19 AM, confirmed during care plan conference, the focus has not been on reviewing interventions for effectiveness and revising the plan of care, then revisiting the new interventions to see if they have had better results in achieving the goals. It was also discussed and confirmed that if the goal has not been achieved, then it may not have been realistic or was not stated in terms that were easily measurable. Further interview on 03/07/19 revealed LPN #38 and LPN #39 stated that they would expect the discipline to have documentation in the progress note as to whether the resident has made any progress, but they do not check to see if the documentation is present. Review of R #18's progress notes do not reflect documentation related to the resident progress toward goals.	F 656			
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be-	F 657		5/1/19	

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F 657	Continued From page 4 (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on record review, staff interview, and facility policy review, the facility failed to ensure that one (1) resident, Resident #7, out of 11 sampled residents, had their care plans updated and revised to reflect their current status and care needs. Findings include: A facility policy entitled, "Goals and Objectives, Care Plans" dated as revised 09/13, indicated, " . . . Care plans shall incorporate goals and objectives that lead to the resident's highest	F 657	1) The comprehensive care plan for Resident #7 was revised by the Social Services Director,(SSD) on 04/03/2019 to reflect target behaviors of psychosis related to Multi-Infarct Vascular Dementia to include: delusions and hallucinations with goals and approaches updated to reflect resident specific interventions to decrease symptoms. 2) All residents have been identified as having the potential to be affected by the		

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F 657	Continued From page 5 obtainable level of independence with the resident's personal and cultural beliefs in the development of these goals . . .Goals and objectives are reviewed and/or revised . . .When there has been a significant change in the resident's condition . . .When the desired outcome has not been achieved . . . " Resident #7: A care plan dated as initiated 10/10/17, identified Resident #7 had a diagnosis of Dementia with behavioral disturbances, a Brief Interview for Mental Status (BIMS) score of 12, and had an Anxiety Disorder with disorganized thinking. The goal of the care plan was for the resident not to have a BIMS of less than 12 at the next review date. The date of this goal was 04/24/18. The approaches included medication as ordered, laboratory testing as related to the use of the antipsychotic Seroquel, to observe for adverse side effects, and to education the resident on pros and cons of the use of a psychotropic medication. Review of the "Face Sheet" documented Resident #7 was re-admitted to the facility on 10/10/17, with a diagnosis of Dementia with behavioral disturbances. Per review of the readmission "Physician Orders", dated 10/10/17, noted Resident #7 was ordered Seroquel (an antipsychotic) 100 milligrams (mg) to be administered at bedtime. Per review of a physician order, dated 01/30/18, it directed clinical staff to change the Seroquel diagnosis to Psychosis. The care plan was updated on 01/30/18, and the	F 657	same deficient practice. 3) An audit of mood and behavior care plans for all residents began on 04/03/2019 and was completed on 04/08/2019 by the Social Service Director(SSD) and Director of Nursing(DON). Care plans were reviewed and revised as necessary to include, targeted behaviors, updated measurable goals and person-centered approaches. Staff responsible for mood and behavior documentation and revision of care plans was inserviced on accurate documentation of mood and behavior symptoms and revision of care plans as symptoms change based on thorough assessment of the resident's condition by the Director of Nursing (DON), Staff Development Nurse and Social Service Director on 03/22/2019, 04/09/2019 and 04/10/2019. The Quality Assurance (QA) Nurse, Social Service Director (SSD), Director of Nursing (DON) and/or Administrator will audit random care plans for updated measurable goals and person centered approaches to reflect any changes in condition to ensure timely revision has been completed if necessary weekly for four (4) weeks beginning 04/08/2019 and ending 04/29/2019, monthly for three (3) months beginning 05/06/2019 and ending 07/06/2019 and quarterly thereafter. Any discrepancies will be immediately updated and a log of findings will be maintained. Findings will be reported to the Director of Nursing (DON) and/or Administrator for corrective action if necessary.		

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F 657	Continued From page 6 diagnosis for Seroquel was changed to Psychosis from Dementia with behavioral disturbances. The approaches were not updated at this time to reflect the new diagnosis, such as monitor for increase in behaviors related to Psychosis. In another care plan, the goal of Resident #7's BIMS score of less than 12 was reviewed with a new target date of 07/17/18. The care plan had an updated goal that Resident #7 would have a BIMS score of 8 or greater at the next review date of 04/02/19. A new goal was identified that Resident #7 would be able to recall the month by the next review date. The approaches remained the same. An interview was conducted with the former Director of Nursing (DON) on 03/07/19 at 7:21 AM. The former DON said her expectation for the revision of a care plan was to be done if there was a change in the resident's condition, quarterly, and annually.	F 657	4) Logs will be presented to the Quality Assurance Performance Improvement Committee (QAPI) by the Quality Assurance (QA) Nurse monthly and quarterly with the Medical Director to determine if further action is needed to ensure compliance is achieved and sustained.		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2) Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record and policy review, it was determined the facility failed to investigate an injury sustained by one (1) of 14 sampled residents, Resident #35. Failure to	F 689	1) An investigation of incident involving Resident #35 was completed on 03/05/2019 by the Director of Nursing (DON). Licensed Practical Nurse (LPN)		5/1/19

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F 689	Continued From page 7 investigate and determine how the injury occurred puts the resident at risk for repeated and additional injuries. Findings include: Review of the facility policy titled Accidents and Incidents-Investigating and Reporting, revised July 2017, revealed all accidents or incidents involving residents, employees, visitors, vendors, etc., occurring on our premises shall be investigated and reported to the Administrator. The policy also included a template for recording the incident, titled Report of Incident/Accident, and a template of a form titled, Accident, Incident, or Abuse Description by Witness, with a lined section for recording the name of the resident, date and time of the incident, the working shift, a description of the incident, and the name of the employee who would complete the form ...incident/accident reports will be reviewed by the Safety Committee/interdisciplinary Team for trends related to accident or safety hazards in the facility and to analyze any individual resident vulnerabilities. Review of Resident #35's clinical record on the "Weekly Body Audit (flow sheet)," dated 02/15/19 at 9:00 AM, revealed a licensed nurse discovered and assessed a skin tear on Resident #35's right upper arm and initiated the facility's standard protocol for treatment of a skin tear. However, the nurse did not complete an incident report for review by the management staff. Interviews with direct care staff revealed they thought the injury might have been the result of the resident's skin contact with a lift pad used when transferring the resident from his bed to a chair, but staff interviewed could not definitively identify the	F 689	#83 was inserviced on 03/12/2019 by the Medical Records Clerk regarding completion of incident reports on skin tears at the time of occurrence so an immediate investigation is initiated and interventions are implemented to ensure residents remain as free of accidents as possible. 2) All residents have been identified as having the potential to be affected by the same deficient practice. 3) All Nurses were inserviced on 03/22/2019, 04/09/2019 and 04/10/2019 by the Director of Nursing (DON) and the Staff Development Nurse regarding completing incident reports and investigating accidents involving residents. Staff Development Nurse will educate all nursing staff upon new hire and quarterly thereafter. Treatment Administration Records (TAR) audits were initiated to ensure an incident report was completed on each treatment order if necessary by the Quality Assurance (QA) Nurse, Medical Records Clerk, and/or the Director of Nursing (DON) weekly x four (4) weeks beginning 04/08/2019 and ending 04/29/2019. Treatment Administration Records (TAR) will be audited at random monthly thereafter. Findings will be reported to the Administrator and/or the Director of Nursing (DON) for corrective action if necessary. 4) The Quality Assurance (QA) Nurse will report the findings to the Quality		

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F 689	Continued From page 8 source of the injury. The facility's management staff did not review an incident report nor initiate an investigation of Resident #35's injury of unknown source, even though nurses documented treatment of the injury from 02/15/19 to 03/05/19. Review of Resident #35's "Face Sheet" in the clinical record, revealed the facility admitted the resident on 08/10/16, with diagnoses to include Parkinson's Disease, generalized muscle weakness, and other abnormalities of gait and mobility. Review of the Quarterly Minimum Data Set (MDS) assessment dated 02/05/19, revealed the resident scored a 9 on a scale of zero (0) to 15, on the Brief Interview for Mental Status (BIMS) assessment for cognition, indicating the resident could be interviewed. An attempt was made to ask Resident #35 about the bandaged area on his right arm, on 03/05/19 at 9:10 AM, the resident made eye contact with the surveyor, but did not provide an answer. Observation, on 03/05/19 at 9:19 AM, revealed Resident #35 was seated in a reclining chair near the nurses' station. The resident was wearing geriatric (Geri) sleeves on both arms which covered the resident's arms up to his elbows. The resident had a white bandage on his right arm above his elbow. Interview, on 03/05/19 at 9:30 AM, with Licensed Practical Nurse (LPN) #80, revealed she knew Resident #35 received a skin treatment to the site on his right upper arm, but she was not sure how he obtained the injury. She reviewed the nurses'	F 689	Assurance Performance Improvement Committee monthly and quarterly with the Medical Director to determine if further action is necessary to ensure compliance is achieved and sustained.		

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F 689	Continued From page 9 progress notes within the resident's chart, but she did not find documentation that explained what happened. She said the Director of Nursing (DON) should have an incident report. Review of the Treatment Administration Record (TAR) for the month of February 2019 and March 2019, revealed a treatment to the resident's right upper arm was initiated on 02/15/19, and was to be administered on each shift at 7:00 AM and again at 7:00 PM. The treatment orders were changed on 02/21/19, and all treatment to the area at the right arm was discontinued on 03/05/19. Interview on 03/05/19 at 10:00 AM, with the DON, revealed she could not find any documentation that explained the reason for the injury in the nurses' progress notes, but that she should have an incident report on file that documented the injury on Resident #35's right upper arm. Continued interview, on 03/05/19 at 10:30 AM with the DON, revealed she could not locate an incident report for Resident #35's right upper arm injury. The DON said LPN #83 was on duty that day, and she would contact her to find out what happened to Resident #35's right upper arm. Review of a brief type written note, dated 03/05/19, provided to the surveyor, revealed the DON spoke with LPN #83. Further review of the note revealed LPN #83 was called to Resident #35's room on 02/15/19, by Certified Nursing Assistant (CNA) #60, because the resident had blood on his shirt sleeve. In the note the DON provided to the surveyor, the LPN described the injury on the resident's right upper arm as an abrasion. The note revealed that LPN #83 and	F 689			

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F 689	Continued From page 10 CNA #60 agreed the lift's sling caused the injury when the resident was transferred from his bed to the Geri-chair. The note also indicated LPN #83 educated both CNAs by telling them to be sure the sling was not squeezing the resident's arm. Observation, on 03/05/19 at 2:15 PM, revealed Resident 35 was in bed in his room, but the bandage was no longer on the resident's right arm. The DON lifted the resident's right arm for the surveyor to view the site where the bandage had been earlier in the day. The area was light pink in color and there was not an open wound. She said the incident likely occurred early in the morning of 02/15/19, when the resident was transferred to the Geri-chair in preparation for a breakfast meal, because LPN #83 told her she observed dried blood on the resident's shirt when she first assessed the wound. Again, the DON confirmed LPN #83 did not complete an incident report. Continued interview, on 03/05/19 at 2:25 PM, with the DON, revealed the facility would normally complete an incident report for the type of injury Resident #35 had. She said if it had been an abrasion, the facility did not expect the staff to complete an incident report. She said LPN #83 described the area as only an abrasion. The DON said she thought that may have been why the nurse did not complete an incident report. However, she said on 02/15/19, LPN #83 initiated the treatment protocol the facility typically used to treat a skin tear. She said the treatment protocol was not in writing, so she could not provide it to the surveyor, but that the steps in the treatment were listed on Resident #35's Treatment Administration Record (TAR).	F 689			

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F 689	Continued From page 11 Interview on 03/06/19 at 9:45 AM, with CNA #53, revealed she was not exactly sure of the date, but she observed a skin tear on Resident #35's right upper arm. She said she and CNA #60 reported it to LPN #83. She said she thought the lift pad may have caused the injury, but not when she assisted with the resident's transfer, because the blood on his shirt was not fresh but was older looking, dried blood. She said the injury could have occurred on the night shift (early morning) when staff transferred the resident from his bed to a chair for breakfast. Interview, on 03/06/19 at 10:00 AM, with CNA #60 revealed just after breakfast on 02/15/19, she and CNA #53 were transporting Resident #35 to his room to change his brief when she noticed dried blood on his right shirt sleeve. She said the injury looked like an area that could have been caused by the lift pad while staff transferred the resident from bed to chair. She said this was her best guess, but she did not know exactly how the resident's injury happened. She said she did not observe any blood on the lift pad used to transfer the resident from the chair to his bed. Interview on 03/06/19 at 10:15 AM, with LPN #83, revealed she was the treatment nurse on duty when CNA #53 and CNA #60 called her to Resident #35's room as they were putting the resident back to bed. The LPN said she observed the resident's right upper arm and saw blood on his sleeve. She further described the skin at the area as "rolled back and hard, so not movable." The LPN said the resident had very fragile skin and the injury could have been caused by the lift pad used for transferring the resident, but she added this was only a guess on her part, and she didn't know for certain how the injury occurred.	F 689			

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F 689	Continued From page 12 She said she did not complete an incident report because she thought the injury looked like an abrasion, but she also stated there was a moderate amount of blood on the resident's shirt sleeve. She said she was not sure if the resident was wearing his Geri-sleeves when she assessed him. The LPN said she did not notify the resident's physician, but if she had completed an incident report, she would have notified the doctor. She said she initiated treatment to the injury, per the facility's skin tear protocol. Interview, on 03/07/19 at 7:37 AM, with the DON, revealed if an incident report had been completed, it would have been reviewed at the next staff "stand up" meeting. Therefore, all staff who attended the meeting would have been aware of the injury. She said upon review of the incident report, the administrative staff would have determined if the facility needed to initiate an investigation of the incident/injury. The DON said, for Resident #35's case, LPN #83 should have completed an incident report for the Interdisciplinary Team (IDT) to review. She said in addition to that review, the facility's medical records personnel would have reviewed the incident report to ensure policies and procedures were followed, that the MD was notified, and that the episode was correctly documented. Interview, on 03/07/19 at 8:15 AM, with the Administrator, revealed it was not the facility's practice to complete an incident report for an abrasion, and it was her understanding the nurse identified Resident #35's injury as an abrasion. She said if the nurse assessed the skin as being "rolled back and hard," she would consider that a skin tear, and an incident report should have been completed. The Administrator said it was	F 689			

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F 689	Continued From page 13 important for the facility to determine the source of an injury so that care could be provided in a safe and proper manner. She said completion of an incident report was the first step in a process that would have provided the administrative staff the opportunity to investigate the situation and implement any necessary changes in the resident's care.	F 689			
F 697 SS=D	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews, policy and record review, it was determined that the facility failed to ensure that pain management was provided to one (1) resident reviewed for pain management out of 14 sampled residents, Resident #18, who required pain management services. Findings include: Review of the "Pain Assessment and Management Policy, 2001 Med-Pass, Inc. (Revised March 2015)" the resident is to be assessed at least each shift for acute pain or significant changes in levels of pain. Pain management is defined in the policy as the process of alleviating the resident's pain to "a level that is acceptable to the resident based on the resident's clinical condition and established	F 697	1) Resident #18 was assessed for pain by the Registered Nurse (RN) Supervisor on 03/05/2019 with results documented in the nurses notes. Nurses were inserviced on 03/22/2019 by the Director of Nursing (DON) and Staff Development Nurse regarding assessment and documentation of pain each shift and proper use of the Pain Flow Sheet per policy. 2) All residents have been identified as having the potential to be affected by the same deficient practice. 3) An inservice for all nurses was conducted on 04/09/2019 and 04/10/2019 by the Director of Nursing (DON) regarding assessing and documenting the level of pain each shift and using the Pain	5/1/19	

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F 697	Continued From page 14 treatment goals." The policy documented that a "pain assessment tool, as indicated by facility protocol, will be necessary when performing pain assessment." The policy identifies "behavioral signs of pain such as verbal expressions such as groaning, crying, and screaming as well as facial expressions that can indicate pain as well as physiological signs." Per policy, "pain is to be assessed using a consistent approach and a standardized pain assessment instrument appropriate to the resident's cognitive status. The nurse is to document the resident's level of pain. The Wong-Baker scale is available for use on the Pain Flow Sheet." Per interview of the Registered Nurse (RN) Supervisor and the Quality Assurance and Performance Improvement (QAPI) RN Nurse on 03/05/19 at 10:15 AM, the Pain Flow Sheet is only for documenting pain scores if the resident receives an as needed "prn" medication. A discussion of the facility policy with the RN Supervisor and the QAPI RN and the failure to follow the "Pain Assessment and Management Policy," which instructs staff to use a standardized pain assessment tool to ensure a consistent approach in assessment of pain. Per the facility policy, the use of "a standardized pain assessment instrument appropriate to the resident's cognitive status" is to be used and the facility failed to follow the policy and do not use the standardized tool. Per policy, the resident is to be assessed at least each shift for acute pain or significant changes in levels of pain. Review of the Physician orders written 03/17/19, indicate that Resident #18 was placed on Hospice 05/26/17, for extensive pain management. The Resident's responsiveness to			F 697	Flow Sheet. Medication Administration Records (MAR's) have been revised by the Medical Records Clerk to include: Monitor for pain every shift with documented results beginning 04/01/2019. MAR's and Pain Flow Sheets will be audited weekly for four (4) weeks beginning 04/08/2019 and ending 04/29/2019 by the Quality Assurance (QA) Nurse, RN Supervisor and or Director of Nursing (DON) to ensure that pain management is provided to all residents. Any problems identified will be brought to the Administrator and/or Director of Nursing (DON) for corrective action if necessary. 4) The Quality Assurance (QA) Nurse will report the findings to the Quality Assurance Performance Improvement Committee monthly and quarterly with the Medical Director for evaluation and review to determine if further action is necessary to ensure compliance is achieved and sustained.		

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F 697	Continued From page 15 verbal and tactile stimuli varied making it difficult to assess pain levels. Resident #18's annual History and Physical dated 12/12/18, indicates that the resident has the following diagnoses: Alzheimer's disease, Malignant Melanoma of unspecified lower limb including hip, Osteoarthritis of both knees, chronic back and neck pain, and Dementia with Psychosis. The physician's annual History and Physical dated 12/12/18, states that the resident's acute problem was persistent pain and the Fentanyl patch dosage was increased from 75 milligrams (mg) to 100 mg. On 01/17/19, the physician's progress note indicated that the resident has chronic intractable pain and does open eyes to verbal and tactile stimuli and mumbles incoherently. Aggressive palliative terminal comfort care is needed with narcotic analgesia. On 02/21/19, physician notes documented resident has chronic intractable pain adequately controlled at this time. The resident has an order dated 06/15/17, for Morphine Sulfate 20 milligram/milliliter, give one (1) milliliter sublingual every one (1) hour as needed for pain or shortness of breath. There was no documentation that the as needed pain medication was given. According to the RN Supervisor and QAPI RN, interviewed on 03/05/19 at 10:15 AM, the Pain Flow Sheet is only for documenting pain scores if the resident receives an as needed "prn" medication. Pain is assessed each shift and placed in the nurse's notes. Review of the nurses notes from January 2019 to March 5, 2019, reflect notations that the resident has no signs or symptoms of pain, no shortness of breath, and	F 697			

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F 697	Continued From page 16 the resident's level of alertness as appropriate but there is no pain score obtained from the use of a standardized pain scale documented. The DON verified the "Wong-Baker" scale is available for use on the "Pain Flow Sheet" but the nurses just document and do not use the standardized pain assessment tool. The Hospice document, "Updated Plan of Care Comprehensive Assessment and Plan of Care" dated 02/20/19, does not contain documentation related to pain scores. The resident's facility and Hospice plan of care related to pain relief does not identify an acceptable level of pain or any non-pharmacological or pharmacological interventions that should be used for various levels of pain.	F 697			
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented	F 758		5/1/19	

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F 758	Continued From page 17 in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on observation, clinical record review, staff and resident interviews, facility policy review, and review of the Food and Drug Administration (FDA) Medication Guide, the facility failed to ensure that one (1) resident, Resident #7, out of a survey sample of five (5) residents reviewed for unnecessary medications, was provided adequate indications for use of an antipsychotic medication Seroquel. Resident #7 had	F 758	1) Attending physician reviewed Resident #46 medications and assessed condition on 03/14/2019. New order was received to discontinue Nuedexta. Attending physician assessed and reviewed medication for Resident #7 with no medication changes indicated. Resident # 7 plan of care was revised to indicate the monitored target symptoms for psychosis		

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F 758	Continued From page 18 inadequate monitoring for the use of this antipsychotic medication; and the facility failed to ensure that one (1) resident, Resident #46, who was prescribed Nuedexta (a medication for Pseudobulbar Affect (PBA) for symptoms of excessive crying and laughing), had adequate indications for use and monitoring. Findings include: Review of the facility's policy, undated, noted, " . . . Antipsychotic medication therapy shall be used only when it is necessary to treat a specific condition . . . Residents will only receive antipsychotic medications when necessary to treat specific conditions for which they are indicated and effective . . . The Attending Physician and other staff will gather and document information to clarify a resident's behavior, mood, function, medical condition, symptoms, and risks . . . Nursing staff will document in detail an individual's target symptoms(s) . . . The Attending Physician and facility staff will identify acute psychiatric episodes, and will differentiate them from enduring psychiatric conditions . . . " Resident #7: Per review of the readmission "Physician Orders" dated 10/10/17, noted Resident #7 was ordered Seroquel (an antipsychotic) 100 milligrams (mg) to be administered at bedtime. Per review of the Food and Drug Administration (FDA) Medication Guide documented, " . . . SEROQUEL may cause serious side effects, including: 1. risk of death in the elderly with dementia. Medicines like SEROQUEL can increase the risk of death in elderly people who	F 758	related to Multi-Infarct Vascular Dementia. 2) All Residents receiving psychotropic medications have been identified as having the potential to be affected by the same deficient practice. 3) An Audit of all Residents with mental health diagnosis and receiving psychoactive medications, which totaled forty three (43), was completed on 04/08/2019 by Social Service Director (SSD) to ensure accurate behavior monitoring and will be done monthly by Social Service Director (SSD), Quality Assurance (QA) Nurse, and/or Director of Nurses (DON) x 3 months beginning 05/08/2019 and ending 07/08/2019. Audits will be done quarterly thereafter by the Interdisciplinary Team. A list of each Residents targeted symptoms was placed on the Medication Administration Record (MAR) on 04/08/2019 with the mood and behavior flow sheet for easier identification of diagnosis specific behaviors by the Social Service Director. Pharmacy Consultant reviewed all residents receiving antipsychotic medications and their diagnosis on 03/26/2019 and made recommendations to physicians as necessary. Any problems identified during audits will be brought to the DON and /or Administrator for corrective actions as necessary. 4) The Quality Assurance (QA) Nurse will report the findings to the Quality Assurance Performance Improvement Committee monthly and quarterly with the		

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F 758	Continued From page 19 have memory loss (dementia). SEROQUEL is not for treating psychosis in the elderly with dementia." Review of the "Face Sheet" documented Resident #7 was re-admitted to the facility on 10/10/17, with a diagnosis of Dementia with behavioral disturbances. A care plan for Resident #7 was dated as initiated on 10/10/17, and the identified problem was the resident had a diagnosis of Dementia with behavioral disturbances and required the use of a psychotropic medication related to Psychosis. A physician's note dated 10/18/18, documented Resident #7 was doing well. The physician noted the resident would continue on the current dose of Seroquel. There was no documentation that showed the resident was delusional, hallucinated, or was a risk to self or to others. The Medication Administration Record (MAR) for 10/18, noted Resident #7 received Seroquel 50 mg at bedtime, daily for Psychosis. A "Nursing Observation Record" for the month of 10/18, identified Resident #7 yelled out on the 7:00 PM to 7:00 AM shifts, 23 times and was verbally inappropriate 22 times. It noted the resident was redirected, given food or a drink, or was provided a diversional activity. A document with no title dated for the month of 10/18, identified a column on the left side and was entitled "Mood." There were multiple moods identified under this column. At the bottom of the document was "ALL BEHAVIOR MUST BE EXPLAINED." Under the section, "... Delusions	F 758	Medical Director for evaluation and review to determine if further action is necessary to ensure compliance is achieved and sustained.		

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F 758	Continued From page 20 (misconceptions or beliefs that are firmly held contrary to reality) . . ." It was documented Resident #7 would yell out "Peanut" and believed her roommate was "Peanut." It was noted the resident did this type of behavior 10 times during this month. Under the section ". . . Physical behavioral symptoms directed toward others. . ." it was documented Resident #7 would yell out "Peanut." It was noted the resident did this type of behavior 10 times for the month of 10/18. Review of the "Nurse's Notes" for the month of 10/18. noted no behaviors exhibited by Resident #7. The MAR for 11/18, noted Resident #7 received Seroquel 50 mg at bedtime, daily for Psychosis. A "Nursing Observation Record" for 11/18, identified Resident #7 yelled out on the 7:00 PM to 7:00 AM shifts 25 times and was verbally inappropriate 24 times. It noted the resident was redirected or was given food or a drink. A document with no title dated for the month of 11/18, identified a column on the left side and was entitled "Mood." There were multiple moods identified under this column. At the bottom of the document was "ALL BEHAVIOR MUST BE EXPLAINED." Under the section, ". . .Being short-tempered, easily annoyed . . ." It was documented Resident #7 was upset at her roommate and was crying. It was noted the resident did this type of behavior 10 times during this month. Under the section Delusions . . ." It was documented Resident #7 would yell out "Peanut" and believed her roommate was "Peanut." It was noted the resident did this type of behavior 10 times. Under the section ". . .	F 758			

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F 758	Continued From page 21 Physical behavioral symptoms directed toward others. . . " it was documented Resident #7 would yell out "Peanut" and would yell at her roommate to "shut up." It was noted the resident did this type of behavior 10 times for the month of 11/18. Review of the "Nurse's Notes" for the month of 11/18, noted no behaviors exhibited by Resident #7. A physician's note dated 11/14/18, documented Resident #7 voiced no complaints on this date. The physician ordered to continue the use of the Seroquel. There was no mention if Resident #7 was delusional, hallucinated, or was a risk to self or to others. It was noted on a document entitled "Encounter - Nursing Home Visit", Resident #7 was seen by the Mental Health Nurse Practitioner (MHNP) on 11/29/18. It was noted the resident was identified with depression, anxiety, and cognitive change. There was no evidence to show Resident #7 had any inappropriate behaviors, had delusions, hallucinated, or was identified as harmful to self or to others. There was no documented evidence to show the resident had past psychiatric history of Schizophrenia or Bi-polar disorder. On 12/06/18, the "Nurse's Notes" documented Resident #7 said ". . . I'm coming to make you some biscuits . . ." Resident #7's quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 12/11/18, identified Resident #7 had a Brief Interview for Mental Status (BIMS) score of 8 out of 15, which indicated moderate cognitive impairment. Resident #7 did not exhibit any	F 758			

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F 758	Continued From page 22 behavioral symptoms, such as hallucination or delusions or was a risk to self or to others. The MDS said the resident did have other behavioral symptoms that were not directed to others, and noted this type of behavior occurred four to six (6) days, but happened less than daily. The MDS assessment did not identify Resident #7 had a diagnosis of Schizophrenia or Bi-polar with mania. The diagnoses listed on the MDS were Dementia, Anxiety Disorder, Depression, and Psychotic disorder. The "Social Service Progress Notes" dated 12/11/18, showed Social Services met with Resident #7 for the quarterly assessment, and interviewed the resident for changes in her mood. It was at this time the resident voiced that she would be better off dead and ". . . If I could get my hands on a gun I would blow my brains out and end my life. . ." It was noted on a document entitled "Encounter - Nursing Home Visit" Resident #7 was seen by the MHNP on 12/11/18. It was noted the resident was identified with depression, anxiety, and cognitive change. The MHNP noted Resident #7 made a statement to harm herself and the MHNP was asked by staff to evaluate the resident. The MHNP noted the resident said she wanted to shoot herself, but did not have access to guns. The MHNP documented the resident voiced she was depressed about her condition and her roommate makes too much noise. The MHNP recommended an increase in the resident's antidepressant and recommended the antipsychotic Seroquel back to 100 mg at bedtime, daily. The MHNP documented the resident's depression needed to be addressed and monitored and said that her current suicidal	F 758			

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F 758	Continued From page 23 plan was not viable since the resident did not have access to a gun. There was no evidence to show Resident #7 had any inappropriate behaviors, had delusions, hallucinated, or was identified as harmful to self or to others. There was no documented evidence to show the resident had a past psychiatric history of Schizophrenia or Bi-polar disorder. A physician's note dated 12/12/18, documented Resident #7 was seen by a psychiatric consult, and the MHNP had recommended to increase the Seroquel back to 100 mg at bedtime, daily. The physician wrote the resident experienced an increase in complaints of depression, suicidal thoughts and an increase in acting out and disruptive behavior. A physician's order to administer Resident #7 Seroquel 100 milligrams (mg) to increase the dose due to diagnosis of Psychosis and failed gradual dose reduction (GDR). The date of the physician order was 12/12/18. The MAR for 12/18, noted Resident #7 received an increase of Seroquel 100 mg at bedtime, daily for Psychosis. A "Nursing Observation Record" for 12/18, identified Resident #7 yelled out on the 7:00 PM to 7:00 AM shifts 27 times and was verbally inappropriate 27 times. It noted the resident was redirected, given food or a drink, or was provided a diversional activity. A document with no title dated for the month of 12/18, identified a column on the left side and was entitled "Mood." There were multiple moods	F 758			

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F 758	Continued From page 24 identified under this column. At the bottom of the document was "ALL BEHAVIOR MUST BE EXPLAINED." Under the section Delusions . . ." It was documented Resident #7 would yell out "Peanut" and yelled out a family member's name." It was noted the resident did this type of behavior 12 times during the month of 12/18. Review of the "Nurse's Notes" for the month of 01/19, noted no behaviors exhibited by Resident #7. A "Nursing Observation Record" for 01/19, identified Resident #7 yelled out on the 7:00 PM to 7:00 AM shifts 30 times and was verbally inappropriate 30 times. It noted the resident was redirected, given food or a drink, or was provided a diversional activity. This was an increase in yelling and verbally inappropriate behavior from the previous month made by the resident. A document with no title dated for the month of 01/19, identified a column on the left side and was entitled "Mood." There were multiple moods identified under this column. At the bottom of the document was "ALL BEHAVIOR MUST BE EXPLAINED." The month was document as follows: little or no interest or pleasure in doing things, it was documented Resident #7 exhibited this behavior, on the day shifts, seven times; trouble falling or staying asleep, it was documented Resident #7 exhibited this behavior, on the day shifts, seven times; feeling tired or having little energy, it was documented Resident #7 exhibited this behavior, on the day shifts, seven times; trouble concentrating on things, it was documented Resident #7 exhibited this behavior, on the day shifts, seven times; being short tempered, easily annoyed, it was	F 758			

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F 758	Continued From page 25 documented Resident #7 exhibited this behavior on the day shift three times and on the night shift two times. There were no details of Resident #7's behavior noted for this month. Review of the "Nurse's Notes" for the month of 01/19, noted no behaviors exhibited by Resident #7. The MAR for 01/19, noted Resident #7 received Seroquel 100 mg at bedtime, daily for Psychosis. The MHNP noted he saw Resident #7 on 01/11/19, and the chief complaint identified was Depression, Anxiety, and cognitive change. There was no evidence to show Resident #7 had any inappropriate behaviors, had delusions, hallucinated, or was identified as harmful to self or to others. There was no documented evidence to show the resident had a past psychiatric history of Schizophrenia or Bi-polar disorder. A physician's note dated 01/17/19, documented Resident #7 voiced no complaints on this date. There was no mention if Resident #7 was delusional, hallucinated, or was a risk to self or to others. The Consultant Pharmacist noted to the physician on 01/25/18, through a monthly medication review, ". . . This resident is receiving the antipsychotic agent, Seroquel, but lacks an allowable diagnosis to support its use. . . Because the atypical antipsychotic do not have an approved indication for Behavioral and Psychological Symptoms of Dementia, any use of these meds would be considered off-label and the potential benefits must outweigh the risks. May wish to add/re-enforce diagnosis or add	F 758			

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F 758	Continued From page 26 appropriate documentation to this resident's chart and/or evaluations and documentation of the effectiveness in achieving therapy goal. . . " On this review, the physician agreed with the Consultant Pharmacist and added the diagnosis of psychosis to Resident #7's medical record. A document with no title dated for the month of 02/19, identified a column on the left side and was entitled "Mood." There were multiple moods identified under this column. At the bottom of the document was "ALL BEHAVIOR MUST BE EXPLAINED." There were no behaviors identified for this month. A physician's note dated 02/21/19, documented Resident #7 voiced no complaints on this date. There was no mention if Resident #7 was delusional, hallucinated, or was a risk to self or to others. An interview was conducted with Resident #7 on 03/06/19 at 9:06 AM. The resident said she did not have a history of mental health issues prior to her admission to the facility. She stated that she did not have Schizophrenia. On 03/06/19 at 10:05 AM, a Certified Nursing Assistant (CNA), CNA #40, was interviewed. CNA #40 said she has been employed at the facility for the past 2.5 years. The staff member said Resident #7 would see things occasionally, such as the resident's family member. She said the resident was "very sweet." CNA #40 said she was not afraid of her and there were no other residents who were afraid of Resident #7. She said the resident will yell out occasionally and would state, "Be quiet Peanut" often referring this nickname to her family member. The staff			F 758			

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F 758	Continued From page 27 member said the resident did not hit her or other staff or residents. She said if the resident had a behavior she would inform the nurse on duty. Another interview was conducted with CNA #80 at 10:31 AM. The staff member said she has not heard Resident #7 state that she wants to die or to take her own life. An interview was conducted with Licensed Practical Nurse (LPN) LPN #80 on 03/06/19 at 10:55 AM. LPN #80 said Resident #7 sees the resident at least one time per week to conduct a total body audit. LPN #80 said she was not afraid of the resident, the resident did not yell out constantly to be an annoyance, no other residents were afraid of her, and the resident has made no threats to harm herself to LPN #80. An interview was conducted on 03/06/19 at 1:09 PM, with Social Services (SS) SS #36. SS #36 said Resident #7 did make a comment one time about wanting to take her life and mental health was called in immediately after this comment was made. Per SS #36, the resident was determined not able to physically harm herself. A telephone interview was conducted with the Consultant Pharmacist (CP) on 03/06/19 at 2:48 PM. The CP said that she comes out to the facility once a month to review all residents' medications. The CP said she reviews the progress notes and will speak with nursing regarding behaviors of a resident. The CP said she did look for a diagnosis when a resident was on an antipsychotic medication. The CP said indications for use of Seroquel was Schizophrenia, Depression or Major Depression. She went onto say that if a resident was psychotic this could be a symptom of Schizophrenia.	F 758			

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F 758	Continued From page 28 A telephone interview was conducted with the MHNP on 03/06/19 at 3:30 PM. The MHNP stated the indications for the use of Seroquel was for Schizophrenia or Bi-polar disorder. The MHNP said to use the term Psychotic or Dementia Psychosis was not specific enough. The Director of Nursing (DON) was interviewed on 03/07/19 at 6:55 AM. The DON said Resident #7 was Psychotic and said Seroquel was appropriate for the resident. The DON said the resident did yell but did not know the resident well enough to say if the resident yelled constantly. An interview was conducted with a night CNA #54 on 03/07/19 at 6:59 AM. CNA #54 said Resident #7 was not a threat to herself or to others and she had no behaviors and specifically stated "she is a happy resident." The staff member said she was not afraid of the resident. The Medical Director (MD) was interviewed by telephone on 03/07/19 at 10:30 AM. The MD said he has known Resident #7 for 20 years. He said the resident was not at her normal baseline and the psychosis was an associated psych feature and her hallucinations, were upsetting to her. He said that he was not using Seroquel off label. He confirmed the resident did not have a history of Schizophrenia or Bi-polar prior to her admission to the facility. Resident #46: Review of "Physician Orders," dated March 2019, revealed Resident #46 was ordered Nuedexta 20 MG BID (twice a day) for PBA. The physician's order for the medication was written on 03/21/18.			F 758			

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F 758	Continued From page 29 Review of Resident #46's "Face Sheet," revealed the facility admitted the resident on 08/01/17, with diagnoses which included Huntington's disease and Major Depressive Disorder. Review of "Coastal Neurological Institute Progress Note," dated 03/21/18, revealed during a consultation visit, Resident #46 was diagnosed this date with PBA; however, there was no documented evidence to support the diagnosis. Observation, on 03/04/29 at 10:52 AM, revealed Resident #46 lying on the floor on a mat. Continued observation and attempted interview revealed no response from the resident. Further observation, on 03/04/19 at 1:56 PM, revealed resident sitting in his wheelchair watching television (TV.) Observation, on 03/05/19 at 8:51 AM, revealed Resident #46 in his room, sitting in his wheelchair, with the radio on. Observation, on 03/05/19 at 10:10 AM, revealed the resident in his room sitting in his wheelchair, with his eyes closed. Interview, on 03/06/19 at 1:52 PM, with the facility's Administrator in Training (AIT), revealed she took Resident #46 to his consultation appointment at (name of institution). Continued interview with the AIT revealed the resident was being seen by a Neurologist because of increased behaviors. Further interview revealed she presented the Neurologist that the resident would be calm one minute and then combative the next minute. The AIT stated the Neurologist reviewed the resident's medication regimen and made the recommendation for the medication of Nuedexta. The AIT further stated she did not tell the Neurologist the resident had been laughing or crying uncontrollably and she assumed the	F 758			

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F 758	Continued From page 30 resident was prescribed the Nuedexta for his increased behaviors of verbal aggression, physical aggression, and other inappropriate behaviors. Interview, on 03/06/19 at 2:48 PM, with the facility's consulting pharmacist revealed the medication Nuedexta was only used to treat PBA. Continued interview revealed she did not pick that medication up during the monthly medication regimen review (MRR) because the resident was seen by the Neurologist and the resident was diagnosed with PBA. The consultant pharmacist stated if the medication was being used to treat behaviors, it may need to be looked at as a psychotropic medication during the review. Interview, on 03/07/19 at 9:07 AM, with Certified Nursing Assistant (CNA) #66, revealed she had been employed at the facility for one (1) year and being regularly assigned to Resident #46, she was familiar with him. Continued interview revealed she has witnessed Resident #46 acting out with physical aggression and verbal aggression; however, she has never witnessed him exhibit uncontrollable laughter or crying. Interview, on 03/07/19 at 9:21 AM, with CNA #55 revealed she had been employed at the facility for two (2) years and Resident #46 had calmed down a lot since he was admitted. The CNA stated since she had been employed by the facility, she has never seen or heard him laughing or crying uncontrollably. Interview, on 03/07/19 at 9:38 AM, with Licensed Practical Nurse (LPN) #82, revealed she had been employed at the facility for three (3) years. Continued interview revealed when Resident #46			F 758			

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F 758	Continued From page 31 was first admitted to the facility, his behaviors were really bad; however, the physicians have been able to regulate his medications and his behaviors are better and they are few and far in between now. When asked had she ever witnessed the resident laugh or cry uncontrollably, the LPN stated she had only seen the resident cry on occasion after his family had visited him. The LPN further stated, being a nurse and having experienced a patient with PBA, Resident #46 has not had the uncontrollable laughing and crying. Interview, on 03/07/19 at 10:18 AM, with the Director of Nursing (DON) revealed she believed Resident #46 was on the appropriate medication regimen because she has seen the resident go from one extreme to another. Continued interview revealed she did not think the resident could control the behaviors he did such as hitting and laughing inappropriately. Interview, on 03/07/19 at 10:27 AM, with the Administrator, revealed it was her expectation the facility would comply with regulations related to medication and appropriate use of medications. The administrator stated it was important to ensure the proper needs of the resident were met.	F 758			
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when	F 761			5/1/19

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F 761	Continued From page 32 applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, policy, and staff interviews, the facility failed to ensure that multi-dose medication vials were labeled in accordance with currently accepted professional principles indicating when a multi-dose vial is first opened and needs to be discarded for four (4) medication vials on the medication cart for Hallway C and D; one (1) of two (2) medication carts. Findings include: The Administering Medications policy statement dated 2001, Med Pass, Inc. (Revised December 2012) documented: "The expiration/ beyond use date on the medication must be checked prior to administering. When opening a multi-dose vial, the date opened shall be recorded on the vial."	F 761	1) Vial of Lidocaine HCL, Infed, Lidocaine for Resident #33, and the vial of insulin found on medication cart for C&D hall was discarded on 03/08/2019 by the Quality Assurance (QA) Nurse. Licensed Practical Nurse #78 was inserviced regarding open vials of medications must be discarded past 28 days by the Quality Assurance (QA) Nurse. A complete audit of all multi dose vials on both medication carts was done on 03/08/2019 by the QA Nurse. All opened multi dose vials were found to have date recorded on vial and none were found to be open past 28 days. 2) All residents have been identified as having the potential to be affected by the same deficient practice.		

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NAME OF PROVIDER OR SUPPLIER GREENE RURAL HEALTH CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1017 JACKSON STREET LEAKESVILLE, MS 39451		
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F 761	Continued From page 33 On 03/5/19 at 02:29 PM, the medication cart for Hallway C and D was inspected with Licensed Practical Nurse (LPN) #78, the Director of Nursing (DON) and the Quality Assurance and Performance Improvement Registered Nurse (QAPI RN). A vial of Lidocaine HCL was not sealed and the rubber top appeared to have been accessed by a needle. The notation "10/29" and unreadable initials appeared on the bottom of the vial which had an expiration date of 08/01/19. LPN #78 stated that she thinks the date on bottom of the vial is when it was open but is not sure. When asked how long an open vial of medication can be kept, LPN #78 stated that she is new and unsure. A vial of Infed 100 mg 2 ml/vial for Resident #9 was open and the date first accessed was not identified. Expiration date of 12/19, was indicated. The DON verified the vial was not dated when opened. Observation of an open multi-dose vial of Lidocaine for Resident #33 was not dated as to when it was opened. The DON verified no date when the vial was accessed. A vial of insulin was found in the medication cart for Hallway C and D, open, with the date it was open not identified. The QAPI RN verified that the vial should have been dated as to when it was opened. The QAPI RN and the DON verified that multi-dose vials are to be discarded in 28 days after opening and if not dated they would be unable to determine when 28 days had passed.	F 761	3) Medication carts will be checked nightly by night shift nurses to ensure all opened multi dose vials have open dates recorded on vial and vials are discarded after 28 days beginning 03/18/2019. Medication storage areas will be audited weekly x four (4) weeks by the QA Nurse and/or Director of Nurses (DON) beginning 04/08/2019 and ending 05/06/2019 and monthly thereafter to ensure open multi dose vials are dated when opened and discarded after 28 days. Findings will be reported to the Administrator and/or DON for corrective action as necessary. 4) The Quality Assurance (QA) Nurse will report the findings to the Quality Assurance Performance Improvement Committee monthly and quarterly with the Medical Director for evaluation and review to determine if further action is necessary to ensure compliance is achieved and sustained.		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an	F 880			5/1/19

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F 880	Continued From page 34 infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv) When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and	F 880			

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F 880	Continued From page 35 (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi) The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, policy review and staff interviews, the facility failed to ensure that resident care equipment shared among residents in Point- of-care testing (blood glucose monitoring) were properly cleaned/disinfected after each use according to manufacturer's instructions for multi-patient use for one (1) of 14 sampled residents, Resident #1. This deficient practice had the potential to affect any resident with diabetes (undetermined number present) who require point-of-care blood glucose monitoring. Findings include:	F 880	1) Licensed Practical Nurse (LPN) #84 and Licensed Practical Nurse (LPN) #82 were inserviced on 03/11/2019 by Quality Assurance (QA) Nurse with regards to infection control, prevention and cleaning of equipment, including surface of glucometer to be wet x two (2) minutes, observing that it remains wet for the full two (2) minutes and return demonstration provided. 2) All twenty (20) residents receiving glucose monitoring have been identified as having the potential to be affected by		

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F 880	Continued From page 36 The Blood Sampling-Capillary (Finger Sticks) policy provided by the DON from the Nursing Services Policy and Procedure Manual, 2001 Med-Pass Inc, revised April 2012 indicates that an EPA registered disinfectant for cleaning of the sampling device should be used to clean and disinfect the device following manufacturer's directions. Survey tag referenced is F 441 and the CDC Clinical Reminder-Use of Fingerstick Devices on One or More Person Poses Risk for Transmitting Bloodborne Pathogens (undated reference). CDC guidelines recommend that whenever possible glucometers should not be shared among residents in Long Term Care settings but if necessary EPA approved disinfectants need to be used according to the manufacturer's directions. Observation on 03/06/19 at 12:15 PM, revealed Licensed Practical Nurse #(LPN) 84, who was the medication nurse for Hallway C and D, prepared to obtain a blood glucose level on Resident #1. She retrieved the glucometer from the medication cart drawer where it is stored along with other medication administration articles. She stated that the facility has two (2) glucometers (one for each hallway) that are stored in the medication carts and used for all residents requiring blood glucose monitoring. LPN #84 described the process while cleaning the glucometer as the following: "PDI Super Sani-Cloth Disinfecting and Sanitizing Germicidal disposable wipes (purple top) are used to wipe all areas of the glucometer vigorously for 15-20 seconds." After cleansing, the glucometer was placed on a clean paper towel used as a barrier and taken into Resident #1's room. After she obtained the blood sugar reading and administered the correct dosage of	F 880	the same deficient practice. 3) An inservice was held on 03/18/2019, 03/22/2019, and 04/04/2019, 04/09/2019 and 04/10/2019, by the Director of Nursing and Quality Assurance (QA) Nurse to ensure all nurses are trained regarding infection control and prevention and cleaning of glucometer per manufacturer recommendations of wipes used with a wet contact time of two (2) minutes prior to returning to its designated storage area. LPN #84 and LPN#82 were observed by the QA Nurse weekly x four (4) weeks beginning 03/11/2019 and ending 04/04/2019 to ensure measures were used to prevent the spread of infection and equipment was properly cleaned prior to returning to designated storage area. Random nurses will be observed monthly by the Quality Assurance (QA) Nurse and a log of findings will be maintained. Findings will be reported to the Director of Nursing (DON) and/or Administrator for corrective action if necessary. 4) The Quality Assurance (QA) Nurse will present the log of findings to the Quality Assurance Performance Improvement Committee monthly and quarterly with the Medical Director for evaluation and review to determine if further action is necessary to ensure compliance is achieved and sustained.				

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F 880	Continued From page 37 Insulin, LPN #84 returned the glucometer to the medication cart and began to clean it with the PDI Super Sani-Cloth Disinfecting and Sanitizing Germicidal wipes wiping it thoroughly for 10-15 seconds then placed the glucometer in the drawer where it is stored. When asked if she knew the term "wet contact" time, she stated she had heard of it and explained that it was the time that the glucometer should dry. She was not able to state that the wet contact time for the Super Sani-Cloth Germicidal wipes to be effective nor was she aware that wet contact time referred to the amount of time that the surface one was cleaning, and disinfecting, needed to remain wet with the cleaning agent. LPN #84 was shown the large emblem on the front of the container that indicates that Super Sani-Cloth Germicidal wipe disinfects and is an effective bactericidal, tuberculocidal, and viricidal with a wet contact of two (2) minutes. Directions for use listed on the container states the following: "To disinfect nonfood contact surfaces only: Unfold a clean wipe and thoroughly wet surface. Allow treated surface to remain wet for a full two minutes. Let air dry." LPN #84 stated that she was not aware that the glucometer must remain thoroughly wet for two (2) full minutes then allowed to air dry before using it with another resident. At 12:45 PM on 03/06/19, interview of LPN #82, who is the medication nurse for Hallway A and B, was asked to describe the process she uses to clean the glucometer before and after resident use. She stated that she uses a Super Sani-Cloth Wipe to wipe the glucometer for 10-15 seconds. LPN #82 was unaware of the wet contact time of two (2) minutes and that the	F 880			

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F 880	Continued From page 38 glucometer needed to remain thoroughly wet for two (2) full minutes and allowed to air dry. At 3:00 PM on 03/06/19, the Director of Nurses (DON) provided a copy as requested on the PDI Super Sani-Wipe directions which indicates a two (2) minute wet contact time. On 03/07/19 at 9:15 AM, the DON provided technical information on the PDI Disinfecting Cleaning Wipes (wrong product) pointing out that the cleansing wipes have a one (1) to two (2) minute wet contact time. The primary chemical in these wipes is alcohol and they are listed as having no efficacy as indicated on the technical specifications. These wipes are not the product used on the facility glucometers.	F 880					

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K 000	INITIAL COMMENTS 42 CFR 483.70(a) The facility meets the applicable provisions of the 2012 (existing) Edition of the Life Safety Code (LSC) of the National Fire Protection Association (NFPA). There were no LSC deficiencies cited during this survey.	K 000			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

04/02/2019

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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E 000	Initial Comments *EMERGENCY PREPAREDNESS* Survey conducted on 3/8/19 reveals the above facility meets all applicable Federal, State and local emergency preparedness requirements. No deficiencies were identified.			E 000			

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