

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

PRINTED: 07/16/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255119		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/18/2019	
NAME OF PROVIDER OR SUPPLIER DIVERSICARE OF AMORY				STREET ADDRESS, CITY, STATE, ZIP CODE 1215 EARL FRYE DRIVE AMORY, MS 38821			
(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
F 000	INITIAL COMMENTS			F 000			
F 558 SS=D	A recertification survey was conducted by Healthcare Management Solutions, LLC on behalf of Mississippi State Department of Health, at the facility from 4/15/19 to 4/18/19. During the survey, the facility was found not to be in substantial compliance with the requirements of participation for Medicare and Medicaid. The facility was cited regulatory deficiencies at F558, F583, F656, F676, F677, F690, F755, and F758. The facility's census on 4/15/19 was 127 residents, and the facility held a license for 152 beds. Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on facility policy review, clinical record review, and interviews, the facility failed to ensure Resident #87 was provided accommodations for a shower, instead of a bed bath, for one (1) of a survey sample of 39 residents. Findings include: A facility policy entitled, "Your Resident Rights and Protections Under State and Federal Law", undated, documented, "You have the right to reside and receive services in the nursing home with reasonable accommodation of your needs			F 558	On 4/17/19, Resident #87 received a shower by his Certified Nursing Assistant and his shower sheet was updated by the Unit Manager according to residents/family preference. Showers were then given based on his preferences. Resident #87 has expired on 6/4/19. All resident have the potential to be affected by this deficient practice. All shower sheets were updated on		6/24/19

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

TITLE

(X6) DATE

Electronically Signed

06/20/2019

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 558	Continued From page 1 and preferences, except when your health or safety, or that of other residents, would be endangered" Resident #87 was admitted by the facility, on 09/07/18, per review of the "Admission Record" with a diagnosis of Generalized Muscle Weakness. The admission "Minimum Data Set (MDS)" with an Assessment Reference Date (ARD) of 09/14/18, noted Resident #87 had a Brief Interview for Mental Status with a score of four (4) of 15, which indicated the resident had severe cognitive impairment. Resident #87 required extensive assistance of two staff members for bed mobility and documented the resident was moved from his room to another location once or twice in the seven day look back period. The MDS identified the resident preferred showers instead of sponge/bed baths. A "Care Plan" dated 09/14/18, identified Resident #87 with a self-care deficit and was dependent on staff for personal hygiene. A document entitled "Showers" identified Resident #87 was to receive a shower every Monday, Wednesday, and Friday on the 3:00 PM to 11:00 PM shift. An interview was conducted with a family member on 04/15/19 at 2:46 PM. The family member stated Resident #87 has not been up, from bed, since his rehabilitation stopped. The family member said the resident needed assistance to get out of bed with a Hoyer lift. The family member said the resident has not had a shower since he was admitted to the facility, but confirmed the resident had bed baths instead. The family member said she would like to see	F 558	4/17/19 by the Unit Managers, Director of Nursing Services, and Assistant Director of Nursing Services to resident's/family's preference. Preferences are being honored, refusal documented and care plans updated as needed. Unit Managers and Assistant Director of Nursing Services will monitor all shower sheets Monday through Friday for four weeks and monthly thereafter to ensure that showers are being honored, refusals documented and care plans are updated. Monitoring began on 4/17/19. Results of the monitoring will be reviewed in Daily Clinical Start-up for follow up. An in-service was conducted by the Director of Clinical Services on 4/17/19 through 6/17/19 with all nursing staff concerning honoring shower preferences, giving showers and bed baths, documentation of refusals and updating care plans as needed. Findings from reviews will be brought to our monthly Quality Assurance Performance Improvement meeting by the Director of Nursing Services for root cause analysis, trending and follow up.		

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F 558	Continued From page 2 Resident #87 receive a shower instead, at least intermittently. An interview was conducted with a Certified Nursing Assistant (CNA) #77 on 04/17/19 at 3:10 PM. CNA #77 said she gives Resident #87 a bed bath instead of a shower because the shower gurney was broken. She also said the gurney was full of miscellaneous items stacked on the gurney for storage. CNA #77 then went to the shower room, located on A North hallway, and in the shower room was a gurney. On top of the gurney was a single, card board box. The pad on top of the gurney was lifted and was damp underneath, which was indicative of recent use. CNA #77 recanted, and said she was not sure if the gurney was broken or not. She then stated, "the resident tends to holler out, when we try to get him out of bed." On 04/17/19 at 3:30 PM, Licensed Practical Nurse (LPN) #164 was interviewed. LPN #164 said no one had shared with her Resident #87 was getting a bed bath instead of a shower. She said she has been told that all the residents on the A Unit were scheduled to receive showers. LPN #164 said the expectation for all the residents on the A Unit were to receive showers and not bed baths. The Maintenance Director was interviewed on 04/17/19 at 3:56 PM. The Maintenance Director stated the shower gurney was not broken. An interview was conducted with the Director of Nursing (DON) on 04/18/19 at 2:18 PM. The DON said she was not aware the shower gurney was broken, and it was her expectation that residents were offered a shower first, and then a bed bath	F 558			

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F 558	Continued From page 3 only if they wanted one.	F 558		
F 583 SS=D	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. This REQUIREMENT is not met as evidenced	F 583		6/24/19

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F 583	Continued From page 4 by: Based on facility policy review, observations, and interviews, the facility failed to ensure privacy for Residents #24, #115, and #40, out of a census of 127 residents, prior to, and during personal care. Specifically, staff provided personal care with Resident #24's room door open to hallway traffic, and failed to knock on residents' doors and wait for permission, before entering Resident #115 and #40's room. Findings include: According to the facility's policy titled, "Privacy", with an effective date of June 2017, "Residents have the right to personal privacy, including privacy in treatment, written accommodations, medical and telephone communications, visits, and meetings of family resident groups." On 04/16/19 3:01 PM, Certified Nurse Assistant (CNA) #46 was observed in Resident #24's room with the door ajar. With the door ajar, CNA #46 was observed adjusting the resident's bed linens and exposing the resident's left thigh and brief. This left the resident exposed to anyone in the hallway, passing by the resident's room at the time. No attempts were made to cover the resident or close the door for privacy. After exiting the room with dirty linen, the aide reported that the resident had spilled urine from his urinal and she was assisting to change the resident and his bed linens. On 04/16/19, during medication pass with Licensed Practical Nurse (LPN) #30, at 12:45 PM, the nurse entered Resident #40's room. Continued observation revealed at 12:47 PM, she entered Resident #115's room. The nurse failed	F 583	Upon notification, Resident #24 was covered up to provide privacy. Focus rounds on Resident #24 was started on 4/17/19 and will be conducted daily by Unit Managers, Director of Nursing Services, Assistant Director of Nursing Services and Department Heads to ensure that privacy is being provided. The Director of Clinical Services provided one on one education on 4/16/19 to Nurse #30, Certified Nursing Assistant #46 and all Certified Nursing Assistants present on hall to include but not limited to privacy, dignity, resident rights, exposure of residents during resident care, knocking on residents door before entering, announcing self and waiting for permission to enter. Upon notification, that Nurse #30 did not knock on Resident #115 and Resident #40 door before entering nor announce her self and wait for permission to enter the Director of Clinical Services provided one on one education on 4/16/19 to Nurse #30 and all Certified Nursing Assistants present on hall to include but not limited to privacy, dignity, resident rights, exposure of residents during resident care, knocking on residents door before entering, announcing self and waiting for permission to enter. All resident have the potential to be affected by this deficient practice. Focus rounds were done on 4/24/19 on all		

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F 583	Continued From page 5 to knock, announce herself, and wait for permission, before entering both rooms to administer medications. Residents were randomly observed for privacy throughout the survey. An interview with the Director of Nursing (DON) was conducted to determine the facility's expectation for residents' privacy during resident care. During the interview with the DON, on 04/18/19 at 1:40 PM, she revealed her expectations were for staff to knock on doors before entering the residents' rooms, and to pull privacy curtains and blinds before providing care. She said staff should cover areas of the resident's body not being cared for and that she expected the door to be closed during care.	F 583	residents to observe that all team members are adhering to our standard of practice of providing privacy to our residents, to include but not limited to privacy, dignity, resident rights, exposure of residents during resident care, knocking on resident's door before entering, announcing self and waiting for permission to enter by Unit Managers, Director of Nursing Services, Assistant Director of Nursing Services, and Department Heads. Focus Rounds were started on 4/24/19 on all residents to observe that all team members are adhering to our standard of practice of providing privacy to our residents, to include but not limited to privacy, dignity, resident rights, exposure of residents during resident care, knocking on resident's door before entering, announcing self and waiting for permission to enter by Unit Managers, Director of Nursing Services, Assistant Director of Nursing Services, and Department Heads and will be conducted three times a week for four weeks and monthly thereafter. An in-service was conducted by the Director of Clinical Services on 4/22/19 through 6/17/19 with all staff on privacy, dignity, resident rights, exposure of residents during resident care, knocking on resident's door before entering, announcing self and waiting for permission to enter by unit. Results of focus rounds will be reviewed in Daily Clinical Start-up for follow up. Findings from the reviews will be brought		

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F 583	Continued From page 6	F 583			
F 656 SS=E	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 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	F 656	to our monthly Quality Assurance Performance Improvement meeting by the Director of Nursing Services for root cause analysis, trending and follow up.	6/24/19	

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F 656	Continued From page 7 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 facility policy review, observations, record reviews, and resident, family, and staff interviews, the facility failed to ensure care plans were implemented for four (4) of 25 sampled residents, (Resident #1, #24, #87, and #105). Specifically, the facility failed to follow the resident's care plan related to personal hygiene for Resident #1 and Resident #24; failed to include and implement resident (or resident representative/family) preferences related to care for Resident #87; and failed to follow the care plan for restorative services for Resident #105. Findings include: Review of the facility's policy titled, "Care Plans", with an effective date of June 2017, revealed, "Care plans will be developed and implemented by teams for all patients based upon the RAI [Resident Assessment Instrument] manual guidelines." Care plans are developed by the interdisciplinary team (IDT) and revised as needed according to resident status, goals and preferences. 1. Review of Resident #1's "Care Plan," revised 01/16/19, located in the electronic record under the "Care Plan" tab, revealed the resident	F 656	Resident #1 fingernails were cleaned and trimmed according to resident's/families preference by his Certified Nursing Assistant on 4/17/19. Resident's care plan was reviewed and all care was provided according to care plan. Resident #24 was shaved on 4/15/19 by his Certified Nursing Assistant. Resident's care plan was reviewed and all care was provided according to care plan. Resident #87 was bathed 4/17/19 by his Certified Nursing Assistant. Resident's care plan was reviewed and all care was provided according to care plan. Resident #87 expired on 6/4/19. Resident #105 received restorative care on 4/17/19 by the Certified Restorative Aide. Resident's care plan was reviewed and all care was provided according to care plan. All residents have the potential to be affected by this deficient practice of. On 4/22/19, a review of all care plans was initiated. All care plans were reviewed and revised as needed in Daily Clinical Startup to reflect all Resident care and		

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F 656	Continued From page 8 required extensive assistance with personal care, due to the resident's diagnoses of Hemiparesis and Chronic Obstructive Pulmonary Disease. On 04/15/19 at 1:52 PM, 04/16/19 at 9:56 AM, and 04/17/19 at 2:34 PM, Resident #1 was observed in his room with his fingernails approximately .25 centimeters (cm) long and containing a dark substance underneath them. On 04/17/19 at 2:34 PM, during an interview with Certified Nurse Assistant (CNA) #65, the aide revealed residents' nails are cleaned with their baths or as needed. On 04/17/19 2:47 PM, during an interview with Registered Nurse (RN) #10, who was assigned to Resident #1's unit, it was revealed Resident #1 was scheduled for baths on Monday, Wednesday, and Friday, on the 3 PM to 11 PM shift, and nail care should be provided then. 2. Review of Resident #24's Admission Minimum Data Set assessment (MDS), with an Assessment Reference Date (ARD) of 01/18/19, revealed the resident's Brief Interview for Mental Status (BIMS) was 11 of 15, which indicated moderate cognitive impairment. The assessment also revealed Resident #24 required extensive staff assistance with Activities of Daily Living (ADLs). Review of Resident #24's "Care Plan", dated 01/24/19, located in the electronic record under the "Care Plan" tab, revealed that the resident needed extensive assistance with personal hygiene and dressing, related to his mobility impairment and self-care impairment.	F 656	Doctors orders by Director of Nursing Services, Assistant Director of Nursing Services and Unit Managers. The Director of Nursing Services, Assistant Director of Nursing Services and Unit Managers will review care plans daily for four weeks and then weekly thereafter. An in-service was conducted by the Director of Clinical Services on care plans with all nursing staff to reflect Resident care and Doctors orders. On 4/22/17, an in-service was held by the Director of Clinical Services with the Work Force Manager, On Call nurses, Payroll supervisor, Director of Nursing Services, and Assistant Director of Nursing Services to discuss the Certified Restorative Aide's schedule informing them that the Director of Nursing Services, Assistant Director of Nursing Services and Administrator is to be notified of all restorative staffing issues to find another solution. On 4/22/19, an in-service was held with the Certified Restorative Aides and Restorative Nurse by the Director of Clinical Services informing them that if they were pulled to the floor they were to notify their Supervisor/Director of Nursing Services/Assistant Director of Nursing Services/Administrator so other arrangements can be made. An in-service was held with all nursing staff by the Director of Clinical Services on cleaning and trimming Residents finger nails, assuring showers are completed and that all Residents are shaved as needed. This in-service was held on 4/22/19 through 6/17/19. The Director of Nursing Services,		

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F 656	Continued From page 9 Resident #24 was observed to be unshaven with facial hairs on 04/15/19 at 12:15 PM, on 04/17/19 at 12:42 PM, and on 04/18/19 at 8:40 AM. Each time the resident was asked about shaving, he stated he wanted to be shaved. On 04/18/19 9:08 AM, during an interview with CNA #74, who was assigned to Resident #24's hall, the aide shared a copy of the "Care Giver Information Sheet," for the C Hall where Resident #24 resided. According to the sheet, Resident #24 was scheduled for showers on the 3 PM to 11 PM shift. The CNA said residents are shaved on their shower days. 3. Resident #87 was admitted by the facility on 09/07/18. Review of the admission "Minimum Data Set (MDS)", with an Assessment Reference Date (ARD) of 02/27/19, noted Resident #87 had a Brief Interview for Mental Status with a score of four out of 15, which indicated the resident had severe cognitive impairment. Resident #87 required extensive assistance of two staff members for bed mobility, and was moved from his room to another location only once or twice in the seven day look back period. Review of Resident #87's "Care Plan", dated 09/14/18, noted Resident #87 had functional deficit related to an impairment from a hemorrhagic cardiovascular accident. The interventions documented the resident was a two person lift, and was dependent on staff for hygiene. There was no mention of the resident and/or his family member's request for a shower instead of a bed-bath. An interview was conducted with a family member on 04/15/19 at 2:46 PM. family member	F 656	Assistant Director of Nursing Services, and Administrator will review the staffing schedule during the morning Clinical Meeting with the Work Force Manager and On Call Nurses to ensure that if Restorative Aides are pulled other arrangements will be made for Restorative Services. Finding from reviews will be brought to our monthly Quality Assurance Performance Improvement meeting by the Director of Nursing Services for root cause analysis, trending and follow up.		

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F 656	Continued From page 10 stated she would like to see Resident #97 receive a shower instead of a bed-bath. On 04/17/19 at 3:30 PM, a Licensed Practical Nurse (LPN) #164 was interviewed. She said she had been told that all the residents on the A Unit were scheduled to receive showers and was unaware Resident #87 had not been offered showers instead of bed baths. 4. Resident 105's electronic record revealed the resident was admitted by the facility, on 12/27/18, with the diagnoses of Hemiplegia and Hemiparesis following Cerebral Infarction. A quarterly MDS (Minimum Data Set) assessment (a comprehensive assessment of each resident's functional capabilities and helps nursing home staff identify health problems), dated 3/27/19, indicated Resident #105 scored 15 of 15 on the BIMS (Brief Interview for Mental Status), an extensive one staff assist for ambulation, was only able to steady himself when ambulating with staff assistance, had impairment of one side and used a cane and a wheelchair. The resident was coded as being on a Restorative Program for walking. Review of Resident #105's Care Plan for ambulation, dated 3/21/19, indicated the resident had "difficulty with walking due to generalized weakness and CVA (Cerebral Vascular Accident)." The interventions for the care plan were as followed: "Allow rest as needed, Encourage independence with minimal assistance, Give instructions, cueing, and assistance to aid in improving self-performance, observe for pain/stiffness/SOB (shortness of breath) and notify nurse if present, Observe for	F 656			

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F 656	Continued From page 11 safety precautions, Praise when goal is met, Resident to participate in restorative therapy 6 days/week with rest breaks as requested per resident, Walk distance tolerated using quad cane and limited assistance and rest breaks as requested." Review of a "Therapy to Restorative Nursing Recommendations," dated 3/1/19, indicated Resident #105 was to ambulate with contact guard and wheelchair. During an interview, on 4/15/19 at 12:19 PM, Resident #105 stated, "I won't get my restorative today. My restorative CNA (Certified Nurse Assistant) is on the floor working." During an interview, on 4/15/19 at 12:22 PM, CNA #86 indicated, "the restorative CNA is working the floor today. We are short staffed, and they had to pull her to the floor. We had a call off." During an interview, on 4/15/19 at 3:02 PM, Restorative CNA #93 indicated, "When I am pulled to the floor, no one does restorative. They were short staffed on A Hall." Review of a "POC Legend Report," documented by the Restorative CNA, indicated Resident #105 did not receive his ROM (Range of Motion) or walking for 4/13, 4/14, and 4/15/19. Review of a penciled actual work schedule provided by the Director of Nursing Services, from 4/3/19 through 4/15/19, indicated the facility did not have Restorative CNAs working for the days of 4/13, 4/14 and 4/15/19. During an interview, on 4/17/19 at 12:37 PM, the	F 656			

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F 656	Continued From page 12 Director of Nursing indicated Resident #105 did not receive his Restorative Program for walking and Range of Motion for 4/13, 4/14 and 4/15/19. When asked if Resident #105's care plan was being followed, the Director of Nursing Services response was "no."	F 656			
F 676 SS=D	Activities Daily Living (ADLs)/Mntn Abilities CFR(s): 483.24(a)(1)(b)(1)-(5)(i)-(iii) §483.24(a) Based on the comprehensive assessment of a resident and consistent with the resident's needs and choices, the facility must 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: §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 ... §483.24(b) Activities of daily living. The facility must provide care and services in accordance with paragraph (a) for the following activities of daily living: §483.24(b)(1) Hygiene -bathing, dressing, grooming, and oral care, §483.24(b)(2) Mobility-transfer and ambulation, including walking, §483.24(b)(3) Elimination-toileting,	F 676		6/24/19	

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F 676	Continued From page 13 §483.24(b)(4) Dining-eating, including meals and snacks, §483.24(b)(5) Communication, including (i) Speech, (ii) Language, (iii) Other functional communication systems. This REQUIREMENT is not met as evidenced by: Based on facility policy review, record reviews, and interviews the facility failed to ensure restorative services were provided for one (1) of 44 sampled residents (Resident #105). Specifically, the facility failed to provide consistent restorative services as ordered, for Resident #105 to maintain and/or improve the resident's ability to ambulate. Findings include: Review of an undated facility policy titled, "Restorative Program", provided by the Administrator revealed, "Restorative services refers to nursing interventions that promote the resident's ability to adapt and adjust to living as independently and safely as possible ...if the resident has been participating in therapy, therapy may suggest a restorative program that will continue to achieve the resident's functional goal" Resident #105's electronic record revealed the resident was admitted to the facility, on 12/27/18, with the diagnoses of Hemiplegia and Hemiparesis following Cerebral Infarction. A quarterly "Minimum Data Set (MDS)" assessment, dated 3/27/19, revealed Resident #105 scored 15 of 15 on the Basic Interview for	F 676	Resident #105 did receive his restorative services for 4/17/19 by the Certified Restorative Aide. Resident continued on Restorative services until 6/4/19. All Residents who are on the restorative case load have the potential to be affected by the deficient practice. The Director of Nursing Services, Assistant Director of Nursing Services, and Administrator is to be notified of all restorative staffing issues to find another solution. The Director of Nursing Services, Assistant Director of Nursing Services, and Administrator will review the staffing schedule daily during the morning Clinical Meeting with the Work Force Manager and On Call nurses to ensure that if Restorative Aides are pulled other arrangements will be made for Restorative Services. On 4/22/19, an in-service was held by the Director of Clinical Education with the Work Force Manager, On Call Nurses, Payroll Supervisor, and Assistant Director of Nursing Services to discuss the Restorative Aide's schedule informing them that if Restorative Aides are pulled		

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F 676	Continued From page 14 Mental Status (BIMS), which indicated the resident was cognitively intact. Resident #105 required extensive staff assist for ambulation, and was only able to steady himself when ambulating with staff assistance. Resident #105 had an impairment of one side following a stroke, and used a cane and a wheelchair. The resident was coded as receiving Restorative Program services for walking. Review of Resident #105's "Care Plan" for ambulation, dated 3/21/19, indicated the resident was: "participate in restorative therapy 6 (six) days/week with rest breaks as requested per resident. Walk distance tolerated, using quad cane and limited assistance and rest breaks as requested." Review of a "Therapy to Restorative Nursing Recommendations", dated 3/21/19, indicated Resident #105 was to ambulate with contact guard and wheelchair. During an interview, on 4/15/19 at 12:19 PM, Resident #105 stated, "I won't get my restorative today. My restorative CNA (Certified Nurse Assistant) is on the floor working." During an interview, on 4/15/19 at 12:22 PM, CNA #86 indicated, "the restorative CNA is working the floor today. We are short and they had to pull her to the floor. We had a call off." During an interview, on 4/15/19 at 3:02 PM, Restorative CNA #93 indicated, "When I am pulled to the floor, no one does restorative. They were short staffed on A Hall. Review of a "POC Legend Report," documented	F 676	other arrangements will be made for Restorative Services. On 4/22/19, an in-service was held by the Director of Clinical Education with the Restorative Aides and Restorative Nurse informing them that if they were pulled to the floor they were to notify their Supervisor, Director of Nursing Services, Assistant Director of Nursing Services, and Administrator so other arrangements can be made. Finding from reviews will be brought to our monthly Quality Assurance Performance Improvement meeting by the Director of Nursing Services for root cause analysis, trending and follow up.		

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F 676	Continued From page 15 by the Restorative CNA, indicated Resident #105 did not receive his ROM (Range of Motion) or ambulation assistance on 4/13/19, 4/14/19, or on 4/15/19. Review of a penciled actual work schedule, provided by the Director of Nursing, from 4/03/19 through 4/15/19, indicated the facility did not have Restorative CNAs working for the days of 4/13/19 through 4/15/19. During an interview, on 4/17/19 at 12:37 PM, the Director of Nursing confirmed Resident #105 did not receive his Restorative services as ordered, for walking and Range of Motion on 4/13/19, 4/14/19 or on 4/15/19.	F 676		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on facility policy review, observations, record reviews, and interviews, the facility failed to ensure the dependent residents that are unable to carry out activities of daily living, receive the necessary services to maintain good personal hygiene for three (3) of 25 sampled residents (Residents #1, #24, and #26). Findings include: A facility policy entitled, "ADL (Activities for Daily Living) Care", dated 06/17, documented, "All residents will receive assistance as needed with	F 677	Resident #1 fingernails were cleaned by Certified Nursing Assistant on 4/17/19 and trimmed according to Resident's/Families preference. Resident #24 was shaved by Certified Nursing Assistant on 4/15/19. Resident #26 fingernails were cleaned by Certified Nursing Assistant on 4/18/19 but he would not allow the staff to trim his nails. All care was provided per care plan. All dependent Residents have the potential to be affected by the deficient	6/24/19

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F 677	Continued From page 16 their daily personal care" 1. Record review of Resident #1's undated Face Sheet, found in front of his clinical record, revealed the resident's most recent admission by the facility was 09/26/11, with diagnoses to include Hemiplegia and Hemiparesis (paralysis affecting one side of the body) following Cerebral Infarction (stroke) affecting left non-dominant side. Review of Resident #1's Quarterly Review MDS, with an Assessment Reference Date (ARD) of 04/01/19, found in the electronic record under the "MDS" tab, revealed the resident required extensive assistance for personal hygiene. On 04/15/19 at 1:52 PM, Resident #1 was observed upright in his bed with his lunch tray. At that time, it was noted that the resident's fingernails were approximately .25 centimeter (cm) long with a dark substance underneath several of his nails. Additional observations of Resident #1 on 04/16/19 at 9:56 AM, and 04/17/19 at 2:34 PM, revealed his fingernails continued to be long and with the dark substance under them. Resident #1's Care Plan, found in the electronic record under the "Care Plan" tab, with a Focus on his physical functioning deficit related to his diagnosis of Hemiparesis and Chronic Obstructive Pulmonary Disease revealed an intervention that was revised on 01/16/19, that indicated the resident required extensive assistance with personal care. On 04/17/19 at 2:34 PM, Resident #1 was noted	F 677	practice of. On 4/24/19, focus rounds were conducted on all residents by Unit Managers, Director of Nursing Services, Assistant Director of Nursing Services and Department Heads to observe that all Residents had been shaved and fingernails were clean and trimmed. Focus rounds began on 4/24/19 by Unit Manager, Director of Nursing Services, Assistant Director of Nursing, on Ten residents Three times a week for four weeks, then Ten Residents weekly thereafter, to ensure that the Resident's finger nails are clean and trimmed and Resident's have been shaved. Results of focus rounds will be reviewed in Daily Clinical Start-up for follow up and any refusals will be addressed with the Resident/Family and care planned. An in-service was conducted by Director of Clinical Education with all nursing staff on cleaning and trimming Residents finger nails and making sure that all Residents are shaved when needed. The in-service was held on 4/22/19 through 6/17/19. Findings from the review will be brought to monthly Quality Assurance Performance Improvement meeting by the Assistant Director of Nursing for root cause analysis, trending and follow up.		

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F 677	Continued From page 17 in bed, and his fingernails continued to need care. The dark substance remained under his nails and the nails remained long. During an interview with Certified Nursing Assistant (CNA) #65 on the same day directly after the observation, the aide revealed residents' nails are cleaned with their baths or as needed. On 04/17/19 at 2:47 PM, during an interview with Registered Nurse (RN) #10, who was assigned to Resident #1's unit, it was revealed Resident #1 was scheduled for baths on Monday, Wednesday, and Friday, on the 3 PM to 11 PM shift. Review of a report from Resident #1's electronic record of his activities of daily living/care, provided by the Assistant Director of Nursing (ADON), revealed Resident #1 was last showered on 04/09/19, and received a bed bath on 04/15/19. There was no notation any nail care had been provided. 2. Record review of Resident #24's Face Sheet, found in the front of the resident's clinical record, revealed the resident was last admitted to the facility on 01/11/19, with diagnoses to include Muscle Weakness (Generalized), Unspecified abnormalities of gait and mobility, and Tremor, unspecified. During observations of Resident #24, on 04/15/19 around 12:15 PM, it was noted the resident had facial hair that was approximately .25 cm in length. When asked the last time the resident had been shaved, he stated that he needed one. On 04/17 at 12:42 PM, and again on 04/18/19 at	F 677			

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F 677	Continued From page 18 8:40 AM, in the resident's room, Resident #24 was observed with a growth of whiskers to his face and confirmed he had not been shaved. Resident #24 replied when asked about his shave, "I sure need it." He stated he had a shower the day before. Record review of Resident #24's admission MDS, with an ARD date of 01/18/19, found in the electronic record under the "MDS" tab, revealed the resident required extensive assistance for personal hygiene and was totally dependent on staff for bathing. Resident #24's Care Plan, dated 01/24/19, with a Focus on his physical functioning deficit related to his mobility impairment and self-care impairment, found in the clinical record under the "Care Plan" tab, noted an intervention that he usually needs extensive assistance with personal hygiene and dressing. On 04/18/19 9:08 AM, with CNA #74, who was assigned to Resident #24's hall, revealed staff try to shave residents when their facial hairs grow back and if the resident gets a shower on the later shift they are shaved on the day shift. The aide shared a copy of the "Care Giver Information Sheet," for the C Hall where Resident #24 resided. According to the sheet, Resident #24 was scheduled for showers on the 3 PM to 11 PM shift. 3. Observation on 04/15/19 10:55 AM, revealed Resident #26's fingernails were very long with dirt under them. His right thumb has a nail which came to a point and was approximately half an inch in length. Resident #26 has a diagnosis of Hemiplegia to his right dominant side after a	F 677			

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F 677	Continued From page 19 stroke. His right arm was flaccid, and he often wears a sling. Another observation, on 04/18/19 at 1:42 PM, revealed the right thumb nail in the same condition as previously observed, uncut and dirty. Review of the Minimum Data Set (MDS) assessment, dated 04/12/19, revealed that Resident #26 requires extensive assistance of one person to carry out personal hygiene tasks such brushing teeth, combing hair and cutting finger and toe nails. The resident had a BIMS score of 4 (of 15), which indicated severe cognitive impairment. The resident had a "Care Plan", dated 04/12/19, with an intervention to: "improve his level of physical functioning including improving his physical hygiene." Interview with Registered Nurse (RN) #4, on 04/18/19 at 1:55 PM, revealed staff are to look at the finger nails during the resident's bath and cut the nails when needed. In an interview with Certified Nurse Assistant (CNA) #50, on 04/18/19 at 2:05 PM, CNA #50 stated, "he can tell you what he wants, and has not told us he wants his nails cut."	F 677			
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical	F 690		6/24/19	

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F 690	Continued From page 20 condition is or becomes such that continence is not possible to maintain. §483.25(e)(2) For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on facility policy review, observations, record reviews, and interviews, the facility failed to ensure appropriate catheter care, to prevent potential infections, for one (1) of nine (9) residents (Resident #56) reviewed with indwelling urinary catheters. Findings include:	F 690	Upon notification on 4/18/19, a hook was placed on Resident "#56's" wheelchair at the correct height so the drainage bag was at a level below the bladder at all times in order to maintain a free flow of urine by the Maintenance Supervisor. All resident's who have catheters have the		

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F 690	Continued From page 21 The facility's undated policy titled, "900 Chapter 34 Urinary Elimination", which was a copy of a page from an unidentified source and stamped with the facility's name and address, revealed staff were instructed to "keep drainage bag below the level of the bladder at all times." The policy further noted that the rationale for this procedure was to "maintain free flow of urine, thus decreasing risk for CAUTI [Catheter Associated Urinary Tract Infection] (Gould et al., 2010)." Record review of Resident #56's undated "Face Sheet" (demographic and limited medical information) from the clinical record revealed the resident's most recent admission was 11/19/18. According to the resident's diagnoses listed on the Face Sheet, he had diagnoses to include "Neuromuscular Dysfunction of the Bladder, unspecified" and "Urinary Tract Infection, site not specified." Record review of Resident #56's "Care Plan" revised on 03/21/19, with a Focus on the "potential for alteration in elimination of bladder due to 24 Fr [French] Suprapubic Urinary Catheter". The care plan included an intervention to "Keep drainage bag of catheter below the level of the bladder at all times and off floor, encourage me to do so even when I am non-compliant." The intervention was revised 02/06/17. During the initial screening, on 04/15/19 at 9:00 AM, Resident #56 was observed in his room sitting in a motorized wheel chair. It was noted that the resident had an indwelling catheter with the collection bag attached to the arm of the wheel chair. The tubing of the catheter, which contained yellow urine with a cloudy sediment,	F 690	potential to be affected by this deficient practice. On 4/22/19, an audit was conducted by the Unit Managers, Director of Nursing Services, Assistant Director of Nursing, on all residents to ensure that the drainage bags are at a level below the bladder at all times in order to maintain a free flow of urine. An audit will be done on all Residents, by the Unit Managers, Director of Nursing Services and Assistant Director of Nursing, three times a week for four weeks, and weekly thereafter, who have catheters to ensure that the drainage bags are at a level below the bladder at all times in order to maintain a free flow of urine. Results from this audit will be reviewed in Daily Clinical Start up for follow up. An in-service was conducted on 4/18/19, by Director of Clinical Education, with all nursing staff on the proper placement of all catheter bags to ensure that they are at the correct height so the drainage bag is at a level below the bladder at all times in order to maintain a free flow of urine. Findings from the audits will be brought to monthly Quality Assurance Performance Improvement by the Assistant Director of Nursing, for root cause analysis, trending and follow up.		

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F 690	Continued From page 22 was coiled and resting between the resident's left side, near the hip, and the left side of the wheel chair. Resident #56 was observed with his indwelling catheter positioned in the previously mentioned manner again on 04/16/19 at 11:52 AM. The catheter tubing was again hanging near the left waist, above or at bladder level, with sediment in the tubing, and on 04/17/19 at 11:33 AM in the front lobby. During an observation and an interview with the facility's Director of Nursing (DON), on 04/18/19 at 12:48 PM, in Resident #56's room, she confirmed the tubing should have been positioned below the bladder to allow the urine to drain. The catheter bag was again hooked to the arm of the wheelchair and the tubing coiled and resting between the residents' right side and the side of the wheel chair. The DON said she felt that the design and size of the resident's wheelchair presented a problem [in positioning the tubing]. She confirmed she understood why the current positioning was a concern.	F 690			
F 755 SS=E	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services 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. §483.45(a) Procedures. A facility must provide	F 755			6/24/19

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F 755	Continued From page 23 pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §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 §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on facility policy review, observations, record reviews, and interviews, the facility failed to ensure that discontinued controlled medications were properly secured for pharmacy return for credit and/or for destruction, for four (4) of 39 sampled residents, (Resident #121, #22, #5, and #58). Findings include: A facility policy entitled, "8.2 Disposal/Destruction of Expired or Discontinued Medication", dated as revised 03/28/19, noted, "Facility should place all discontinued or out-dated [sic] medications in a designated, secured location which is solely for discontinued medications or marked to identify	F 755	On 4/16/19, the narcotic cabinet was secured to the floor and a second lock was placed on the cabinet by the Maintenance Supervisor. On 4/17/19 all Narcotics that were in the Narcotic cabinet were reconciled and account for by the Director of Nursing Services and Assistant of Director Nursing Services. All residents who have an order for narcotics have the potential to be affected by this deficient practice. On 4/17/19, the Assistant Director of Nursing and Administrator began monitoring the narcotics cabinet five		

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F 755	Continued From page 24 the medications are discontinued and subject to destruction. Before destruction Facility should secure controlled substances under Double Lock at all times. "Double Lock" can mean a locked cabinet in a locked room or a double locked cabinet. Double Locked can also mean a sealed container in a locked cabinet or locked room until the sealed container is picked up by a licensed waste disposal company " An interview was conducted with Registered Nurse (RN) #31 on 04/16/19 at 12:47 PM. When asked how discontinued medications were returned/credited or destroyed, RN #31 stated, "all discontinued narcotics are given to the Director of Nursing (DON) for disposal." On 04/16/19 at 1:07 PM, the DON was interviewed in her office. During the interview the DON stated the pharmacist comes into the facility once a month and assists her with the destruction of the narcotics. While in the DON's office, there was a small metal box attached to a large file cabinet. The DON said the keys to the discontinued narcotics were in this box, and unlabeled. She reached into the box and pulled out a key and said it opened the smaller, two-drawer file cabinet with a lock. An observation on 04/16/19 at 1:25 PM, revealed the door to the DON's office was open. An interview was conducted with the DON at 1:27 PM, and confirmed the office door was open, and the narcotics were not secured by "double locks" as required. The DON stated her office was usually locked and the Assistant Director of Nursing (ADON) was in the office next door. During this interview, the DON opened the two-drawer cabinet, to check the medications,	F 755	times a week for four weeks then weekly thereafter to ensure that it is always double locked. An in-service was conducted on 4/22/19 by the Director of Clinical Services with the Director of Nursing Services and the Assistant Director of Nursing Services on the importance of the narcotic cabinet being double locked at all times. Findings from reviews will be brought to our monthly Quality Assurance Performance Improvement meeting by the Administrator for root cause analysis, trending and follow up.		

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F 755	Continued From page 25 and the following controlled medications were observed to be present: 1. Resident #121 was admitted to the facility on 08/22/07 per review of the "Admission Record." Resident #121 had on bubble pack of Tramadol (schedule IV drug/low rate of addiction) 50 milligrams (mg). The pack contained three pills out of 10. The date documented as received was 04/03/19. There was a second bubble pack for Tramadol and it contained 30 pills out of 30. The date documented as received was 04/06/19. There was also a 30 milliliter (ml) of liquid Ativan (an antianxiety). There was 29 ml remaining. There was no documented date of when this medication was received by the facility. 2. Resident #22 was admitted to the facility on 07/25/12 per review of the "Admission Record." Resident #22 had two bubble packs of Hydrocodone 7.5/325 mg (schedule II drug/highly addictive). The first bubble pack contained seven out of 30. The second bubble pack had 30 out of 30 pills remaining. The date of each bubble pack was 11/21/18. 3. Resident #5 was admitted to the facility on 08/31/16 per review of the "Admission Record." Resident #5 had Lyrica (schedule V drug/lowest rate of addiction) 50 mg. The first bubble pack contained 14 out of 14 capsules. A second bubble pack contained 14 out of 14 capsules. The date of each bubble pack was 03/20/19. 4. Resident #58 was admitted to the facility on 05/04/11 per review of the "Admission Record." Resident #58 had three bubble packs of Hydrocodone 7.5/325 mg. The first bubble pack contained 16 out of 30 pills remaining. The	F 755			

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F 755	Continued From page 26 second bubble pack had 30 out of 30 pills remaining. The third bubble pack had 16 out of 30 pills remaining. There was no date documented on when the facility received these medications. She was asked about the four residents, and confirmed all four had been discharged. Additional discharge information for each resident, (Resident #121, Resident #22, Resident #5, and Resident #58) was requested at this time, but it was not provided by the DON prior to the survey exit.	F 755			
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 in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and	F 758		6/24/19	

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F 758	Continued From page 27 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 facility policy review, observations, record reviews, and interviews, the facility failed to ensure that one (1) of five (5) residents reviewed for unnecessary medications had adequate indications for use of an antipsychotic medication, Seroquel (Resident #92). The resident did not have adequate behavior monitoring or indications for appropriate use. Findings include: Review of an undated facility policy titled, "Antipsychotic Alternatives", provided by the	F 758	A Gradual Dose Reduction was initiated on 4/19/19 by the Nurse Practitioner for Resident #92 for Seroquel 12.5mg. On 4/22/19 the resident was started on Melatonin 5mg. Resident's last dose of Seroquel was on 5/6/19. No negative side effects were noted. All residents who have orders for psychotropic drugs have a potential to be affected by this deficient practice. All resident who had orders for		

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F 758	Continued From page 28 Administrator, revealed "A carefully monitored use of the alternatives with frequent reassessments is suggested. Always start by assessing the resident for pain. General Principles: Start with a pain assessment. Provide for a sense of security, Apply the 5 magic tools (knowing what the resident likes to see, smell, touch, taste, hear). Involve the resident's family by giving them a task to support the resident. Use a validated pain assessment to assure non-verbal pain is addressed. Screen for depression and possible interventions. Reduce noise (paging, alarms, TVs, etc.). Evaluate the resident's sleep patterns. Place the resident in bed when he or she is fatigued. Be calm and self-assured. Therapeutic Interventions; Begin with medical evaluation to rule out physical or medication problems. Evaluate the resident for acute medical conditions such as a urinary tract infection, upper respiratory infection, ear infection or other infections. Evaluate the resident for pain, comfort and/or other physical needs such as hunger, thirst, position changes, bowel and bladder urges. Attempt to identify triggering events or issues that stimulate behavior." Resident #92's electronic record revealed the resident was admitted to the facility, on 3/7/19 with the diagnoses of Fractured Pubis, Hypertension, Hypothyroidism, Insomnia, and Confusion Arousal. An admission Minimum Data Set (MDS) assessment, dated 3/14/19, revealed Resident #92 scored a six (of 15) on the BIMS, which indicated the resident had severe cognitive impairment. Resident #92's assessment documented no delirium, no delusions or hallucinations, and no trouble falling or staying	F 758	Psychotropic drugs was audited on 4/30/19 by the Unit Managers, Assistant Director of Nursing Services and Medical Records to ensure that they had gradual dose reductions if applicable, proper diagnoses and behavior monitor sheets are in place. On 5/3/19 Medical Records began auditing all residents that are currently receiving psychotropic drug to ensure that gradual doses reductions, if applicable are being done, that all residents who have orders for psychotropic drugs have the proper diagnoses and that behavior monitoring sheets are in place for all psychotropic one time a week for four weeks then monthly thereafter. Medical Records will audit new admits upon admission. Findings will be reviewed during Clinical Start up. An in-service was conducted on 4/22/19 through 6/17/19 by the Director of Clinical Services with all nursing staff on ensuring that gradual doses reductions if applicable are in place, all psychotropic drugs have the proper diagnoses and that behavior sheets are in place for all resident who receive psychotropic. Findings from the reviews will be brought to our monthly Quality Assurance Performance Improvement meeting by the Director of Nursing Services for root cause analysis, trending and follow up.		

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F 758	Continued From page 29 asleep. Review of a "Care Plan" for behaviors, dated 3/20/19, revealed Resident #92 had potential for behaviors related to a diagnosis of Dementia with behavior disturbance. The interventions for Resident #92 were: "attempt to engage resident in activity throughout the day. If behavior occurs: Calmly approach resident and call their name to gain their attention. Smile, do not ask questions. Do not argue or provoke resident." Review of a "Care Plan" for insomnia, dated 3/8/19, indicated the interventions for Resident #92 were; "Administer sleep medications as ordered by MD. Assess for adverse side effects. Assist resident in establishing a daily routine with periods of rest and activity. Maintain environment conducive to sleep (quiet, comfortable temperatures, dimmed lights. Review medications that resident is receiving for interference with sleep." Review of a "Nurse Practitioner Progress Note", dated 03/21/19, documented, "She presented with insomnia. It is described as chronic. This visit is for problem follow-up. The problem reported by nursing staff. The symptom is ongoing. The complaint is moderate. Len addition, she presented with dementia. This is exacerbation. Evaluation requested and history reported by nursing staff. It is described as ongoing. The complaint is mild. The symptom is worsening at night. Started on Restoril for sleep but it isn't helping, she and family are requesting to restart her Seroquel. She is not sleeping and has increasing behavior at night". Review of a "Physician's Order," dated 3/20/19,	F 758			

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F 758	Continued From page 30 indicated "Seroquel 12.5 MG (milligrams) at HS (hour of sleep) D/C (discontinue) Restoril 7.5 mg HS." Seroquel is an antipsychotic medication used in the treatment of schizophrenia. Seroquel has the potential for serious side effects such as seizures, high blood sugar, drop in blood pressure upon standing, and increased drowsiness. Antipsychotic use in the elderly should be avoided except for treating schizophrenia or bipolar disorder (manic depression). There is an increased risk of cognitive decline (problems with memory, language, thinking and judgement), morbidity (disease), and mortality (death) in elderly patients treated with antipsychotics for dementia-related psychosis (hallucinations and/or delusions) (PDR.net). Review of the "Nurses' Progress Notes", from 3/8/19 through 3/20/19 lacked documentation of the resident not sleeping or exhibiting behaviors. A "Nurses' Progress Note", dated 3/17/19, indicated, "says she sleeps well. She has no behaviors" During an interview, on 4/17/18 at 12:37 PM, the Director of Nursing confirmed insomnia was not an appropriate diagnosis for the use of Seroquel. During a telephone interview, on 4/18/19 at 11:40 PM, the Nurse Practitioner indicated the resident did not come from the hospital on the Seroquel. She indicated the family said she had been taking the Seroquel at home. The Nurse practitioner indicated the family had wanted the Seroquel. She indicated she had discontinued the Restoril and restarted the Seroquel. The Nurse practitioner indicated she would be at the facility tomorrow and would stop the Seroquel, try a different medication and talk with the family.	F 758			

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F 758	Continued From page 31 During a telephone interview, on 4/18/19 at 12:30 PM, the Pharmacist stated that insomnia was not an appropriate diagnosis for the Seroquel, but dementia with behavior disturbance was. When asked about the resident's behaviors and behavior monitoring prior to starting an antipsychotic the Pharmacist responded, "you want me to monitor the behaviors?"			F 758			

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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

06/20/2019

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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CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255119	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/18/2019
NAME OF PROVIDER OR SUPPLIER DIVERSICARE OF AMORY			STREET ADDRESS, CITY, STATE, ZIP CODE 1215 EARL FRYE DRIVE AMORY, MS 38821	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments *EMERGENCY PREPAREDNESS* Survey conducted on 4/18/19 reveals the above facility meets all applicable Federal, State and local emergency preparedness requirements. No deficiencies were identified.	E 000		

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

TITLE

(X6) DATE

Electronically Signed

06/20/2019

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.