STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355080	A. BUILDING _____ B. WING _____	02/07/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DUNSEITH COM NURSING HOME	15 1ST ST NE DUNSEITH, ND 58329

(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 The standard Medicare/Medicaid survey started on 02/04/19 and concluded on 02/07/19.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility.	F 550		3/6/19

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

Electronically Signed | 02/27/2019

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F 550	Continued From page 1 §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, review of facility policy, and staff interview, the facility failed to ensure each resident is treated with dignity and respect during dining for 2 of 3 residents (#6 and #16) observed being fed by staff. Failure to sit while feeding a resident does not preserve the residents' dignity or enhance their quality of life. Findings include: Review of the facility policy, "Feeding Residents in the Dining Room Services" occurred on 02/07/19. This policy, dated April 2001, failed to address the inappropriateness of standing while feeding residents. Observation during the evening meal on 02/04/18 showed a staff member (#4) stood and fed Resident #6 the entire meal. The staff member (#4) then stood again and fed Resident #16. During an interview on the morning of 02/07/19, a supervisory nurse (#1) confirmed staff should not stand over residents while feeding them.	F 550	1.The facility failed to ensure each resident is treated with dignity and respect during dining for 2 of 3 residents (#6 and #16) observed being fed by staff. Failure to sit while feeding a resident does not preserve the resident's dignity or enhance their quality of life. On resident #6 and #16 the facility will ensure staff to be properly trained on the proper ways of feeding a resident to preserve residents dignity or enhance their quality of life. A new policy has been implemented on Promoting/Maintaining Resident Dignity During Mealtimes. 2.All residents have the potential to be affected by these deficient practices. 3.All facility Nursing staff will be in-serviced by DON/Designee on the proper procedure to enhance dignity during meal times and new policy of promoting/maintaining resident dignity during meal times. 4.DON/Designee will do a quality monitor on nursing staff on proper ways of feeding a resident during meal times to ensure all nursing staff are following the facility policy. Quality monitor will be done weekly x4 weeks, then bi weekly x 4, followed by monthly for a total of 1 year.	

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F 550	Continued From page 2	F 550	The above monitoring will be initiated starting 3/04/19. Results of the monitoring will be reviewed at the Quality Assurance Meeting. 5. 03/06/19	
F 644 SS=D	Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2) §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. This REQUIREMENT is not met as evidenced by: THIS IS A REPEAT CITATION FROM THE SURVEY COMPLETED ON 01/31/18. Based on record review, review of the North Dakota Provider Manual for Preadmission Screening and Resident Review (PASRR) & Level of Care Screening Procedures for Long Term Care Services, and staff interview, the facility failed to update/complete a new	F 644	1.The facility failed to update/complete a new preadmission screening and resident review on resident #2. Failure to complete the PASARR screening based on the residents known psychiatric diagnosis may result in the resident not receiving psychiatric services. Resident #2 will have a Pre-admission screening and PASARR completed by 03/07/19.	3/8/19

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F 644	Continued From page 3 pre-admission screening and resident review (PASRR) for 1 of 1 sampled resident (Resident #2). Failure to update/complete a new PASRR screening based on the resident's known psychiatric diagnosis may result in the resident not receiving necessary psychiatric services. Findings include: The North Dakota PASRR Provider Manual, page 13, states, ". . . Change in Status Process . . . Whenever the following events occur, nursing facility staff must contact Ascend to update the Level I screen for determination of whether a first time or updated Level II evaluation must be performed. These situations suggest that a significant change in status has occurred: . . . If an individual with MI, ID, and/or RC (mental illness, intellectual disability, and conditions related to intellectual disability [referred to in regulatory language as related conditions or RC]) was not identified at the Level I screen process, and that condition later emerged or was discovered. . . ." - Review of Resident #2's medical record occurred on all days of survey. Resident #2's medical diagnoses included unspecified psychosis not due to a substance or known physiological condition and mood disorder due to known physiological condition. A current Physician's progress note, dated 12/18/18, stated, ". . . Chronic psychiatric and behavioral issues are stable. . . ." The medical record identified a PASRR Level I for Resident #2, dated 09/05/13, completed	F 644	2.All Resident have the potential to be affected by this deficient practice. 3. The Social Service Director Designee will complete the PASAR screening on resident #2. The SSDD will review all residents, residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition, and residents review upon a significant change in status assessment a PASARR screen will be completed if needed. 4. The DON/Designee will do a quality monitor to assure a new PASARR is completed on residents that have had a new diagnosis of a mental disorder. A quality monitor will be done monthly for a total of one year to assure the correct screening process is being followed. Results of the monitoring will be reviewed at the Quality Assurance Meeting. 5.03/08/2019	

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F 644	Continued From page 4 during a hospital stay, which identified no major mental illnesses or mental disorders. The facility failed to complete an updated PASRR based on Resident #2's known diagnosis of psychosis and mood disorder. During an interview on the morning of 02/07/19, a supervisory nurse (#1) confirmed the facility had not completed an updated PASRR assessment for Resident #2 since 09/05/13.	F 644		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: THIS IS A REPEAT DEFICIENCY FROM THE SURVEY COMPLETED ON 01/31/18. Based on observation, policy review, review of manufacturer's guidelines, and staff interview, the facility failed to follow professional standards of practice when priming insulin pens for 2 of 3 observations (evening meal on 02/04/19 and 02/05/19) of insulin administration for Resident #18. Failure to remove the needle shield prior to priming an insulin pen may result in the resident receiving an inaccurate amount of insulin. Findings include: Review of the facility policy titled "Insulin Injections" occurred on 02/07/19. This undated policy stated, ". . . 6. If using an insulin pen . . .	F 658	1. The facility failed to follow professional standards of practice when priming insulin pens for 2 of 3 observations of insulin administration for Resident #18. On Resident #18 the facility will ensure staff to follow professional standards by correctly priming the insulin pen according to Manufactory guidelines. 2. All residents on insulin have the potential to be affected by these deficient practices. 3. All facility nursing staff will be in-serviced by DON/Designee on the proper priming of insulin products according the manufactory guidelines. 4. DON/Designee will do a quality monitor on nursing staff on proper use of insulin pens weekly x 4 weeks, than biweekly x	3/6/19

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F 658	Continued From page 5 Perform an air shot by turning the dial dosage to 2 units. While the needle is pointing up, tap the cartridge gently with your finger a few times to make any air bubbles collect at the top of the cartridge. Push the button and verify a drop of insulin appears at the tip. Verify the dose selector is at zero. Dial the number of units you need to inject. . . ." Review of manufacturer's guidelines for NovoLog insulin stated, ". . . Preparing your NovoLog FlexPen. Pull off the big outer needle cap. Before each injection small amounts of air may collect in the cartridge during normal use. To avoid injecting air and to ensure proper dosing: Turn the dose selector to select 2 units. Hold your NovoLog FlexPen with the needle pointing up. Tap the cartridge gently with your finger a few times to make any air bubbles collect at the top of the cartridge. Keep the needle pointing upwards, press the push-button all the way in. The dose selector returns to 0. A drop of insulin should appear at the needle tip. If not, change the needle and repeat the procedure no more than 6 times. . . ." Observation on 02/04/19 at 4:29 p.m. showed a licensed nurse (#5) primed Resident #18's NovoLog insulin FlexPen prior to administration. The nurse held the FlexPen upright, and without removing the cap over the needle, dialed 2 units, pressed the push-button, dialed another 2 units, pressed the push-button, and then dialed the dosage amount to administer. The nurse failed to remove the cap to visualize the insulin. Observation on 02/05/19 at 4:45 p.m. showed a licensed nurse (#6) primed Resident #18's	F 658	4, followed by monthly for a total of 1 year. The quality monitor will be initiated starting 03/04/19. Results of the monitoring will be reviewed at the Quality Assurance Meeting. 5. 03/06/19	

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F 658	Continued From page 6 NovoLog insulin FlexPen prior to administration. The nurse held the FlexPen upright, and without removing the cap over the needle, dialed 2 units, pressed the push-button, dialed another 2 units, pressed the push-button, and then dialed the dosage amount to administer. The nurse failed to remove the cap to visualize the insulin. During an interview on the morning of 02/07/19, a supervisory nurse (#1) confirmed staff should remove the cap over the needle to visualize the insulin when it is primed with the 2 units.	F 658		
F 689 SS=G	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 record review, review of facility policy, and staff interview, the facility failed to ensure each resident received adequate supervision and assistance devices for 1 of 1 sampled resident (Resident #2) who experienced a fall from a mechanical lift. Failure to follow the plan of care resulted in Resident #2 experiencing back pain secondary to a fall from a full body lift. Findings include: Review of the facility policy, "Lift Transfers" occurred on 02/07/19. This policy, dated	F 689	1. The facility failed to ensure each resident received adequate supervision and assistance devices for 1 of 1 sampled resident (resident #2) who experienced a fall from a mechanical lift. Failure to follow the plan of care resulted in Resident #2 experiencing back pain secondary to a fall from a full body lift. All nursing staff will be properly training on the proper use of a mechanical lift. A new policy has been implemented for hoyer lifts/stand up or Ez stand lifts. 2. All residents have the potential to be	3/6/19

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F 689	Continued From page 7 01/18/14, stated, ". . . Transport Slings: 1. Two assist with all lifting and transferring procedures. . . ." Review of the "Hoyer Lift Instruction Sheet" occurred on 02/07/19. This instruction sheet, dated April 2001, stated "Always have 2 people to assist. Never leave resident unattended. . . ." - Review of Resident #2's medical record occurred on all days of survey. Resident #2's current care plan identified the following: ". . . Hoyer lift with sling with all transfers with assist x [times] 2. . . . I have . . . Left sided paralysis unable to ambulate. Assistance required with transfers, poor sitting balance . . . Potential for falls and injuries, history of seizure activity . . . I have a history of falls and am at risk for injury related to falls. . . ." The Certified Nurse Aide (CNA) Care Card for Resident #2 identified, ". . . Transfers: A 2 [assist of 2] Hoyer lift . . ." Review of Nurses Notes identified the following: *01/30/19 at 6:00 p.m. "CNA notified charge nurse that resident had slipped out of lift during transfer and landed on floor. Nurse observed resident laying on back on floor with lift machine above resident. CNA stated that lift strap became undone causing resident to fall out. Charge nurse performed ROM [range of motion] finding normal results. Full body assessment completed with no visual injuries. . . . Resident c/o [complained of] back pain . . . Tylenol 500 mg [milligrams] PRN [as needed] given for back pain." 01/30/19 at 8:00 p.m. ". . . c/o back pain. . . . " 01/31/19 11 p.m. - 7:00 a.m ". . . Tylenol ES	F 689	affected by these deficient practices. 3. All facility nursing staff will be in-serviced by DON/Designee on the proper use of a hoyer lift/stand up lift or Ez stand and the new facility policy. 4. DON/Designee will do a quality monitor nursing staff on proper use hoyer lift/stand up or Ez stand lift. All monitoring will be done weekly x 4 weeks, than bi weekly x 4, followed by monthly for a total of 1 year. Monitoring will be initiated starting 03/04/19. Results of the monitoring will be reviewed at the Quality Assurance Meeting. 5. 03/06/19	

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F 689	Continued From page 8 [extra strength] 500 mg [milligrams] given @ [at] 3 a.m. for c/o back pain. [No] visible injuries noted. Staff placed warm blankets under client to help relieve pain. . . ." 01/31/19 at 9:00 a.m. "Resident continues to c/o back pain. But unable to specify pain level. . . . given PRN pain medications with no relief. He has been agitated, complaining of pain during movement. . . ." 01/31/19 at 9:15 a.m. "[Physician] notified of residents complaints. [Physician] in agreement to send resident to ER [emergency room]." 01/31/19 at 12:17 p.m. "Nurse . . . from ER called facility regarding resident. She stated that resident will be discharged . . the X-ray results came back negative. . . ." 01/31/19 at 12:50 p.m. "Resident returned . . . New orders were sent back to give Ibuprofen, Baclofen [a muscle relaxant], [and] Lidocaine [pain medication] Patch. . . . Ibuprofen to start 12 hrs [hours] after injection of Toradal [pain medication] he received. . . . " 02/01/19 at 6:00 a.m. ". . . Client c/o back pain. Ibuprofen 800 mg given for back pain . . ." 02/01/19 at 6:00 p.m. "Resident was having pain before supper. Staff attempted to get resident out of bed and it was observed that he was in extreme pain as he was stiffening up his body and yelling at staff, 'stop it, that hurts. You are killing me.' . . . Nurse gave PRN Ibuprofen 800 mg at 4:25 p.m. By 5:45 p.m., there was no relief observed. Nurse was able to contact physician and he gave new orders for pain relief. . . ." 02/02/19 at 8:00 a.m. "TO [telephone order] from [physician] to increase oxycodone to 5 mg due to increased pain. . . . Resident complains of pain to back. He is unable to specify location but will holler out 'My back hurts.'	F 689		

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F 689	Continued From page 9 02/02/19 at 1:00 p.m.". . . during transfer, resident continued to c/o pain to his back. . . ." 02/03/19 7:00 a.m. - 3:00 p.m. "Resident continues to c/o pain to back during transfers [and] turning. PRN's given for pain." Review of Resident #2's Medication Administration Record (MAR) identified the resident received the following PRN pain medications for back pain following his fall: Ibuprofen 400 mg: 2/02/19, 2/03/19 (twice), 2/04/19, 2/05/19, 2/06/19 (twice), and 2/07/19. Ibuprofen 800 mg: 2/01/19 (twice). Oxycodone 2.5 mg: 2/01/19 and 2/02/19. Oxycodone 5 mg: 2/02/19 (twice), 2/03/19 (twice), 2/04/19 (twice), 2/05/19 (twice), 2/06/19 (twice), and 2/07/19 (twice). Baclofen 10 mg: 2/02/19, 2/03/19, 2/06/19 (twice). In addition, the physician ordered a Lidocaine (pain medication) 5% (percent) patch for low back pain daily for 30 days. Review of the facility's investigation of the fall, dated 01/31/19, stated, "Staff member [#7] used a hoyer lift with the assist x 1, resulting in . . . a fall on 01/30/19 at 6pm. . . . did not follow care plan, which states all transfers per hoyer lift x 2 assist. . . . [Staff member #7] . . . . states . . . did not know that staff needed 2 assist with all hoyer lifts. . . .did not intentionally try to hurt [resident]. The sling was not properly positioned right and sling came undone from the hoyer lift. . . . [staff member] was educated on facility policy, care plan, care card, and all hoyer and stand lift proper procedures for usage on 01/31/19. All nursing staff will be educated on the proper use of hoyer lifts and stand up lifts per owners	F 689		

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F 689	Continued From page 10 manual and facility policy." Observation on 02/05/19 at 9:18 a.m. showed two certified nurse assistants (CNAs) (#8 and #9) utilized a hoyer lift to transfer Resident #2 from the bed to the wheelchair. Resident #2 identified back pain during the transfer. Review of the staff member's (#7) personnel file identified the staff member completed inservice education on lifting, transfers and positioning on 10/02/18. Review of the nursing in-service records, dated February 1 and 2, 2019 identified six CNAs and four nurses viewed the video and read the facility policy and manufacturer's instructions on lift transfers. Review of the list of current employees identified 14 CNA's and seven nurses have not yet viewed the video and read the policy regarding lift transfers. During an interview on the morning of 02/07/19, a supervisory nurse (#1) confirmed staff should follow the care plan/care card when transferring residents. This staff member (#1) also confirmed there are nursing and CNA staff who have not completed the in-service training and stated the facility has not monitored staff during resident transfers to ensure they are following the care plan/care card. Failure to provide the necessary assistance when transferring Resident #2 as directed on the plan of care resulted in the resident experiencing pain secondary to a fall from the mechanical lift and requiring PRN pain medications three or more times a day since the fall.	F 689		

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F 698 SS=D	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive 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, record review, review of professional reference, and staff interview, the facility failed to ensure residents received the care and services consistent with professional standards of practice for 2 of 2 sampled residents (Resident #9 and #19) receiving hemodialysis outside the facility. Failure to assess/monitor hemodialysis vascular access sites (arterial-venous fistulas) on a regular basis can result in complications with access function and possible loss of the access site. Findings include: - Review of Resident #9's medical record occurred on all days of survey. Diagnoses included end stage renal disease. The quarterly Minimum Data Set (MDS), dated 12/25/18, identified the resident cognitively intact. Resident #9's current care plan stated, "I have kidney dialysis 3 x [times] weekly . . . r/t [related to] end stage renal failure. . . . nursing staff to monitor my AV [arterial-venous] shunt for signs of infection and report to provider as needed. Nursing staff to monitor my site for signs of leaking or clotting (dark/separated blood within shunt, site cool to touch, absence of bruit/thrill) . . . Nursing staff will assess left arm for	F 698	1. The facility failed to ensure residents received the care and services consistent with professional standards of practice for 2 of 2 sampled residents (Resident #9 and #19) receiving hemodialysis outside the facility. Failure to assess/monitor hemodialysis vascular access sites (arterial-venous fistuals) on a regular basis can result in complications with access function and possible loss of the access site. Resident #9 and #19 site will be assess daily and after each dialysis appointment. A new form has been implemented to assure residents #9 and #19 are being assessed after each dialysis appointment. 2.All residents on hemodialysis have the potential to be affected by these deficient practices. 3.All professional staff will be in-serviced on proper assessment skills to assess a hemodialysis vascular access site. All professional staff will be in-serviced on the new form implemented for resident who are receiving dialysis. 4. DON/Designee will do a quality monitor to assure nursing staff are using the form correctly after each dialysis appointment	3/6/19

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	355080	A. BUILDING _____ B. WING _____	02/07/2019

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F 698	Continued From page 12 abnormalities by listening for bruit with stethoscope and palpating for thrill if indicated. . . ." During an interview on 02/05/19 at 3:08 p.m., Resident #9 stated he just returned from the hospital because his "fistula clotted off." The resident stated he "had surgery to fix it, but had to get a catheter placed in his chest for dialysis." The resident stated the staff at the nursing home do not check his fistula or listen to it. Observation showed an AV fistula in Resident #9's left arm and a central venous catheter in his upper chest. The medical record lacked evidence facility staff monitored Resident #9's fistula site. - Review of Resident #19's medical record occurred on all days of survey. Diagnoses included end-stage renal disease. The resident's current care plan stated, ". . . I have kidney dialysis 3 x weekly . . . related to renal failure. I have AV fistula in my left arm . . . " Observation on 02/06/19 showed a fistula site to Resident #19's left arm. The resident identified he goes to dialysis on Monday, Wednesday, and Friday. The medical record lacked evidence the facility monitored Resident #19's fistula site. During an interview on 02/06/19 at 1:30 p.m., a nursing staff member (#3) stated an assessment of the fistula is documented in the Treatment Administration Record (TAR). This nurse reviewed the TAR and stated staff failed to document the assessment in the TAR.	F 698	and to assure all professional staff are assessing the hemodialysis vascular assess site on a daily basis. Quality Monitoring will be done weekly x 4 weeks, then bi weekly x 4, followed by monthly for a total of 1 year. Monitoring will initiated starting 03/04/19. Results of the monitoring will be reviewed at the Quality Assurance Meeting. 5. 03/06/19	

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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 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	F 758		3/6/19

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F 758	Continued From page 14 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 record review, review of facility policy, and staff interview, the facility failed to ensure orders for as needed (PRN) psychotropic drugs were limited to 14 days for 1 of 3 sampled residents (Resident #15) reviewed for psychotropic medications. Failure to ensure the physician renewed the PRN order after 14 days placed the resident at risk for receiving unnecessary medications and experiencing adverse consequences related to their use. Findings include: Review of the facility's policy titled "Use of Psychotropic Drugs" occurred on 02/07/19. This policy, revised November 2017, stated, ". . . PRN orders for psychotropic drugs are limited to 14 days, expect as provided 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 . . ." Review of Resident #15's medical record occurred on all days of survey and identified a	F 758	1.The facility failed to ensure orders for as needed (PRN) psychotropic drugs were limited to 14 days for 1 of 3 sampled residents (Resident #15) reviewed for psychotropic medications. Failure to ensure the physician renewed the PRN order after 14 days placed the resident at risk for receiving unnecessary medication and experiencing adverse consequences related to their use. Resident #15 order for Ativan 1mg q 8HRS AS NEEDED was updated and reviewed by the physician. A new procedure was implemented and posted at nurses station for all professional staff to follow when taking psychotropic drugs PRN orders to assure the professional nursing staff are following the facility policy. 2.All residents have the potential to be affected by these deficient practices. 3.All Professional nursing staff will be in-serviced on the new procedure when taking psychotropic drug PRN orders and the facility policy. 4.DON/Designee will do a quality monitor on all psychotropic drug PRN orders to	

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F 758	Continued From page 15 physician's order, dated 01/17/19, for Ativan (antianxiety) 1 milligram (mg) every 8 hours (hrs) PRN. Review of the February 2019 medication administration record (MAR) showed Resident #15 received PRN Ativan on the 3rd (3 days after the 14th day). Staff failed to discontinue the medication or obtain a new physician's evaluation and order for the PRN Ativan after 14 days. During an interview on the morning of 02/07/19, a supervisory nurse (#1) confirmed staff failed to obtain a new physician's order after 14 days for Resident #15's Ativan.	F 758	assure professional nursing staff are following facility psychotropic procedure and policy. Quality monitor will be done weekly x 4 weeks, than bi weekly x4, followed by monthly for a total of 1 year. Quality monitoring will be initiated starting 03/04/19 and results will be reviewed at the Quality Assurance Meeting. 5. 03/06/19	