STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355041	A. BUILDING _____ B. WING _____	03/01/2018

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LUTHERAN HOME OF THE GOOD SHEPHERD	1226 1ST AVE N NEW ROCKFORD, ND 58356

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F 000	INITIAL COMMENTS The standard Medicare/Medicaid recertification started on 02/26/18 and concluded on 03/01/18.	F 000		
F 600 SS=G	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, facility staff failed to follow the plan of care for 1 of 1 discharged resident (Resident #10) who experienced a fall with major injury. Failure to follow a resident's plan of care may be neglect if staff do not follow identified care interventions and result in compromising the residents quality of life. Findings include: Review of the closed medical record for Resident #10 occurred on February 28, - March 1, 2018. Resident #10's diagnoses included left side hemiparesis secondary to a stroke and history of	F 600	Past noncompliance: no plan of correction required.	3/15/18

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

Electronically Signed | 03/21/2018

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right hip replacement. A "Transfer Assessment," dated 04/19/17, and the care plan stated, "Transfer with Hoyer lift 2 assist."

Nursing progress notes identified the following:
* 10/20/17 at 10:16 p.m., "[6:40 p.m.] Called to [Resident #10's] room. Upon entering room, observed resident lying on her back on the floor besides her bed. Her head was at the foot of the bed. CNA [certified nurse aide] stated that she had been transferring resident to bed and [the resident] slid out of the lift sheet. CNA had tried to catch resident and had ahold of [resident's] butt but she con't [continued] to fall. CNA stated that resident did not hit her head, and that she had landed on her left shoulder. CNA also stated that she heard a crack when resident landed. . . . assessed resident. . . . Is alert and responding to yes or no questions appropriately. ROM [range of motion] to LEs [lower extremities] within normal limits and denied pain. ROM to right arm within normal limits. Left arm is almost flaccid. Shoulder feels displaced. . . . Attempted slight vertical ROM with almost instantaneous 'Ow' from resident and grimace. Also heard grinding noise. . . . no further ROM attempted. . . . no other injuries observed at this time. [vital signs taken] . . . Daughter . . . notified of fall and impending transfer to [hospital] . . . agreeable to transfer. [7:00 p.m.] . . . DON, notified of fall. [7:05 p.m.] . . . Administrator, notified of fall. 911 called. [Hospital] called and informed of impending arrival of resident and updated on her condition. . . . [ambulance] here . . . left arm secured to body to prevent further movement. Scoop used to lift to cot with 4 assist. [7:23 p.m.] Left per [ambulance] . . . [8:55 p.m.] Received call from [Hospital]. Informed that resident did have fx [fracture] of left

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F 600	Continued From page 2	F 600		

shoulder and probably will be coming back to facility tonight. [9:00 p.m.] Daughter, [name], called facility to let us know what [Hospital] said and to let us know resident coming back tonight. . . ."

* 10/20/17 11:09 p.m., "Resident returned from [Hospital] [at] 10:55 [p.m.] Fracture to L [left] proximal humerus [sic]. Immobilizer in place to L shoulder. Orders received for tramadol 50 mg [milligrams] po [by mouth] q [every] 4-6 hrs. [four to six hours] PRN [as needed]. . . ."

* 10/21/17 Addendum 2:02 p.m., ". . . CNA was educated at the time of fall about proper placement of lift sheet, going over care guides, and requesting assistance when needed."

* 10/21/17 10:15 p.m., "Alert. . . . [Resident #10] is in pain when we turned her to changed [sic] the product. PRN Tramadol given. . . . Immobilizer on at all times."

* 10/22/17 5:47 p.m., ". . . Minimal discomfort observed to left shoulder. . . . assessed right leg again . . . no change from this morning. . . . [5:15 p.m.] PRN Tramadol given."

* 10/23/17 10:02 a.m., "Residents O2 [oxygen] sat [saturation] 85% was started on oxygen [at] 2 L [liters] per nasal canal. Daughter . . . called and informed of oxygen use. Will continue to monitor. Sat up to 93% after 15 minutes."

* 10/24/17 2:28 p.m., "Res. [Resident] c/o [complains of] left sided rib pain and right sided hip pain. No outward rotation of hip noted. Also sats drop to low 80's without oxygen. Sats up to 93% with O2 on [at] 3l/nc [three liters per nasal cannula]. . . . MD [medical doctor] notified and did say only left shoulder x-rays were completed. . . . Orders received for x-rays hips and chest x-ray."

Radiology reports of the 10/24/17 hip and chest

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F 600	Continued From page 3 x-rays showed: * Hip: ". . . No evidence of fracture or loosening. . . ." * Chest: ". . . There is a fracture of the left 4th rib poterolaterally [sic]. No additional rib fracture is apparent . . . ." Review of the facility fall investigation, dated 10/20/17 at 8:30 p.m., showed: * The CNA was on orientation at the time of Resident #10's fall. The fall occurred "due to the hoyer sling not being positioned properly. . . . Resident did slide out of the sling because lift sheet was not crossed at the legs." The CNA did admit to not being familiar with the mechanical lift and reported she had not used a lift sling that crossed between the resident's legs before. * Interviews with two CNAs who assisted with the involved CNA's orientation identified she had not worked with this specific lift prior to the fall. * At the time of the fall, the nurse on duty, educated the CNA on the importance of reading the resident's care guides and understanding how to use a Hoyer lift. The nurse then removed the CNA from working without her orientating CNA. * On the night of the fall the DON educated the CNA demonstrating on the specific lift used including appropriate placement of the sheet to prevent sliding and signs the resident may be shifting in the sling. The DON also educated the CNA on the importance of reading care guides for directions on each resident's method of transfer and directed her to ask for assistance if she has not worked with a piece of equipment before. During interviews on 03/01/18 at 8:23 a.m. and	F 600		

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F 600	Continued From page 4 1:10 p.m., an administrative nurse (#1) identified and documented the steps the facility took to prevent another resident from falling from a sling/transfer sheet: * The DON observed the involved CNA as she completed a transfer competency evaluation on 10/20/17. * Nursing staff observed facility CNAs complete transfer competency evaluations beginning 10/21/17, as the staff were on duty, completing most evaluations by 10/31/17. As part time or travel staff worked since the fall nursing staff observed as they completed transfer competency evaluations. * The facility provided education on 11/28/17 and 11/29/17 for all nurses and CNAs on the use of mechanical lifts. * Staff changed care plans for all residents using a Hoyer lift to two person assist. Prior to the fall, if care planned, one person could use the portable Hoyer lift for a transfer. * The facility programed the CNA kiosks, on 10/21/17, to show a resident's mode of transfer upon opening the resident's task page. CNAs no longer need to go to the nurse's station to obtain this information. * The nurse (#1) stated the facility monitors the continued implementation of competency evaluations as part of the facility's quality improvement plan. The survey team determined a deficient practice existed on 10/20/17. The facility implemented corrective action on 10/20/17 and completed facility wide nursing staff education on 11/29/17. At the time of the survey, the facility maintained an ongoing education program and quality assurance plan to prevent reoccurrence of a	F 600		

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F 600	Continued From page 5 similar fall.	F 600		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on record review, review of facility policy, and staff interview, the facility failed to ensure staff reviewed and revised the comprehensive care plan to reflect the resident's current status for 1 of 18 sampled residents (Resident #32).	F 657	1. Immediate corrective action was taken for resident #32 on 2/28/18. The MDS Coordinator reviewed and updated the care plan for resident #32 to include a care plan relating to the resident receiving	3/27/18

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F 657	Continued From page 6 Failure to revise the care plan to reflect Resident #32's current status limited the staff's ability to communicate needs and ensure continuity of care for residents. Findings include: Review of the facility's policy titled "Care Plans" occurred on 02/28/18. This policy, revised October 2017, stated, ". . . Care plans are revised as changes in the resident's condition dictates. . . ." Review of Resident #32's medical record occurred on all days of survey. Diagnoses included adult failure to thrive, dementia, gout, osteoarthritis, pain, hypertension, constipation, and major depressive disorder. A physician's order, dated 02/14/18, stated, "d/c [discontinue] all oral meds [medications]. . . ." Those medications included Allopurinol 100 milligrams (mg) twice daily for gout, Tylenol Extra Strength 1000 mg three times daily for pain, and Celexa 10 mg for depression. A physician's note, dated 02/21/18, stated, ". . . [Resident] is basically now on palliative care and comfort measures. . . ." The current care plan failed to identify the changes made on 02/14/18 to discontinue all oral medications or current care needs since 02/21/18 for palliative care and comfort measures. The care plan failed to discontinue the intervention for medications per physician and include new monitoring or interventions for the medication changes, palliative care, and comfort measures. During an interview on 02/28/18 at 9:45 a.m., a nursing staff member (#6) agreed staff had not	F 657	comfort cares. 2. The facility has determined that all residents electing to have comfort/palliative care have the potential to be affected. 3. The facility will provide education to Licensed Nursing staff on 3/27/18 regarding the new policies titled Care Plan Revisions Upon Status Change Policy, Providing End of Life Care, and the checklist used to audit documentation related to end of life. A fixed care plan has been developed and will be reviewed at the nurses meeting on 3/27/18. This care plan will be implemented and individualized for those residents electing to receive palliative or comfort cares. 4. The Director of Nursing or Designee will complete an audit on those residents electing to receive palliative or comfort cares weekly X 4, quarterly X 3 and monthly X 3 to ensure new or modified interventions have been addressed and documented regarding the resident□s care. 5. Corrective action completion date will be on 3/27/18.	

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F 657	Continued From page 7 updated the care plan to reflect the resident's current status.	F 657		
F 658 SS=E	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: Based on observation, record review, review of facility policy, staff interview, and review of manufacturer's reference, the facility failed to ensure staff followed standards of practice for 5 of 18 sampled residents (Residents #12, #20, #32, #171 and #271), during medication administration. Failure to administer medications as ordered (Resident #12, #20, and #32), administer eye drops appropriately (Resident #271) and ensure the resident (Resident #171) consumed all of her medications may result in a medication error, eye infections, and/or affect the efficacy of the medications. Findings include: Review of the facility policy titled "Administration of Medications" occurred on 03/01/18. This policy, dated March 2016, stated, ". . . 2. Medications must be administered in accordance with the written orders of the attending physician. . . . 6. . . . Nurse must observe resident taking in medication unless resident is SAMA [self administration medication assessment]. . . ." - Observation on 02/26/18 at 11:13 a.m. showed	F 658	1. Corrective action for those found to be affected included placing a reminder on resident #217□s Restasis eye drops to indicate that eye drops are to be discarded after single use. Resident # 171 has now had a SAMA assessment completed and has been determined to be safe to self- administer medication. No corrective action for resident□s # 12, 20, and 32 as physician order is no longer active and this is a past event. 2. All resident□s receiving single-use eye drops have the potential to be affected. All residents not assessed to be SAMA appropriate have the potential to be affected. All residents with new or changed physician orders have the potential to be affected. 3. Nursing staff will be educated on 3/27/18 on single-use medication. They will also be reeducated on the SAMA policy. The SAMA policy has been updated to include that residents will not have medications left with them until the SAMA assessment is completed. They will be educated on the new policy titled	3/27/18

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F 658	Continued From page 8 a medication cup on Resident #171's bedside table contained one unidentifiable medication. During an interview on 02/26/18 at 3:10 p.m., Resident #171 stated, "the nurse left the pill in here this morning and told me to take it when I got back from my appointment." During an interview on 02/28/18 at 4:40 p.m., an administrative nurse (#1) stated Resident #171 is not a SAMA and staff should not leave medication at her bedside. - Observation of medication pass on 02/28/18 at 10:38 a.m. showed a certified medication aide (CMA) (#4) obtain an opened, dated, Restasis single-use vial from Resident #271's box of Restasis. The CMA administered one drop of Restasis to each of Resident #271's eyes. The manufacturer's website "Restasis" home page link "FAQS" (frequently asked questions), dated 2018, stated, "Restasis (R) is packaged in single-use vials because it does not contain preservatives, use 1 vial each time, and immediately discard after use." During an interview on 02/28/18 at 10:10 a.m., a staff nurse (#5) identified staff should not have used the opened Restasis single-use vial. During an interview on 02/28/18 at 2:55 p.m., an administrative nurse (#1) confirmed staff should not have used the opened Restasis single-use vial. - Review of Resident #12's medical record occurred on all days of survey. Review of the	F 658	Medication Orders, which provides instructions on entering physician orders. And finally, education will be provided on 3/27/18 on entering physician orders correctly. Staff responsible for entering orders, which includes nursing staff and ward clerks, will now be required to view the EMAR/ETAR following every change or new physician order. This process will assure that the new or changed order will fire correctly on the EMAR/ETAR. 4. The Director of Nursing or Designee will complete a QA on medication administration that includes administration of eye drops on 4 residents weekly X 4, quarterly X 3, monthly X 3, and reevaluate for further monitoring or interventions. The Director of Nursing or Designee will also conduct an audit on new physician orders or changes in physician orders to assure that they are properly entered into the EMAR. This will be completed on 4 residents weekly X 4, monthly X 3, and quarterly X 3, and reevaluated for further monitoring or interventions.	

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resident's January 2018 electronic medication administration record (eMAR) identified Tamiflu 75 milligrams (mg) capsule 1 tablet by mouth times 10 days for influenza prophylaxis. The eMAR showed staff administered Tamiflu on 01/04/18 at 6:00 p.m. and again at 7:00 p.m. and then administered daily for the following eight days. The facility failed to follow physician orders.

Review of the facility's policy titled "Physician Orders" occurred on 03/01/18. This undated policy stated, ". . . Make sure the start date and order date are ok. Press SAVE when complete. . . ."

- Review of Resident #20's medical record occurred on all days of survey. Review of the resident's January 2018 eMAR identified Tamiflu 75 mg capsule 1 tablet by mouth times 10 days for influenza prophylaxis. The eMAR showed staff administered Tamiflu on 01/04/18 at 6:00 p.m. and again at 7:00 p.m. and daily for the following eight days. The facility failed to follow physician orders.

- Review of Resident #32's medical record occurred on all days of survey. Review of the resident's January 2018 eMAR identified Tamiflu 75 mg capsule 1 tablet by mouth times 10 days for influenza prophylaxis. The eMAR showed staff administered Tamiflu on 01/04/18 at 12:00 p.m. and daily for the following eight days for a total of nine days. The facility failed to ensure physician orders were followed.

During an interview on the morning of 03/01/18, a nurse manager (#1) stated nursing staff had entered the physician's order incorrectly onto the

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F 658	Continued From page 10 eMAR, and the facility had no process to ensure licensed nurses and/or ward clerks had correctly entered physician orders onto the eMAR.	F 658		
F 697 SS=D	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, record review, staff interview, and resident interview, the facility failed to provide care and services in a manner to maintain the highest practicable physical well-being for 1 of 1 sampled resident (Resident #32) observed experiencing pain during a mechanical lift transfer. Failure of staff to report, document, and act on Resident #32's pain placed residents at risk for continued pain and worsening health conditions. Findings include: Review of Resident #32's medical record occurred on all days of survey. Diagnoses included adult failure to thrive, dementia, gout, osteoarthritis, pain, and major depressive disorder. A physician's order, dated 02/14/18, stated, "d/c [discontinue] all oral meds [medications]. . . ." Those medications included Allopurinol 100 milligrams (mg) twice daily for gout, Tylenol Extra Strength 1000 mg three times daily for pain, and Celexa 10 mg for depression.	F 697	1. Corrective action was taken immediately for resident #32. On 2/28/17 a duragesic patch was started along with liquid tylenol to be used as needed. She was also started on biofreeze to be applied topically three times a day prior to cares. 2. All residents have the potential to be affected. 3. The Interdisciplinary team will continue to meet on a weekly basis to review pain with each resident. Pain assessments continue to be scheduled one month prior to resident□s scheduled MDS assessment and again completed during their scheduled/unscheduled MDS assessment period. CNAs screen for pain daily with cares. Nurses were assigned to complete a Health Care Academy course titled Advanced Pain Management in Long Term Care and CNAs were assigned to complete a Health Care Academy titled Pain Screening for	3/28/18

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F 697	Continued From page 11 A physician's note, dated 02/21/18, stated, ". . . [Resident] is basically now on palliative care and comfort measures. . . ." Random observations during all days of survey showed Resident #32 either in her wheelchair or sitting/resting quietly in her recliner chair. Observation on 02/28/18 at 12:05 p.m. showed a certified nursing assistant (CNA) (#7) transfer Resident #32 from her wheelchair into the bathroom and into her recliner utilizing a mechanical sit-to-stand lift. During the placement of the lift sling the resident moaned, complained of pain and asked, "Why am I so stiff?" The resident continued to moan in pain when reaching for the handle of the lift, completion of the sling placement, and when raised from the wheelchair by the lift. The resident continued to moan and complain of pain in her arm and all over her body until placed in the recliner. The CNA (#7) stated the resident has had some pain during transfers, morning personal cares, and dressing. During an interview, after the above transfer, Resident #32 stated, "Pain all over," and agreed she needed something for pain from the nurse to be more comfortable. During an interview on 02/28/18 at 12:45 p.m. and on 03/01/18 at 11:30 a.m., a staff nurse (#8) stated since the physician had discontinued all of Resident #32's oral medications on 02/14/18, the facility had not implemented any interventions for pain. The nurse indicated the resident had not often complained of pain but in the last two weeks has had some pain during personal cares	F 697	Certified Nursing Assistants. Scheduled nursing staff will be expected to complete courses by 4/5/18. Casual Nursing staff will be expected to complete prior to working their next scheduled shift. A Pain Management Policy,to provide guidance to assure residents approaching end of life, receive needed care and services that are individualized and resident-centered and a Providing End of Life Care Policy have been developed, along with a checklist for end of life care. Education will be provided on 3/27/18 to Licensed Nurses and 3/28/18 to CNAs on regulations for F697 and the new policies. 4. The Director of Nursing or Designee will complete a QA on all residents who elect comfort/palliative cares to assure pain is being assessed and managed. This will be completed weekly X 4, monthly X 3, and quarterly X 3, then reevaluate for further monitoring and interventions. 5. Date of completion is 3/28/18.	

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F 697	Continued From page 12 and transfers. Review of the progress notes from 02/14/18 through 02/27/18 showed no documentation of the resident's pain or pain interventions.	F 697		
F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record.	F 756		3/27/18

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F 756	Continued From page 13 §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on record review, review of facility policy, and staff interview, the consulting pharmacist failed to identify and report drug regimen irregularities regarding gradual dose reductions (GDRs) to the attending physician, the medical director, and the director of nursing for 3 of 3 supplemental residents (Resident #38, #46, and #54) selected for unnecessary medication review. Failure to suggest GDRs may result in the residents receiving unnecessary medications and experiencing adverse consequences related to the medications. Findings include: Review of the facility policy 'Medication Regimen Review" occurred on 03/01/18. The policy, dated 11/22/16, stated, ". . . The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and the reports must be acted upon. . . . Based on a comprehensive assessment of a resident the facility will ensure: . . . Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. . . ."	F 756	F756 Pharmacy Services 1. The facility reviewed resident # 38, 46, and 54□s physician orders for anti-anxiety medication use and determined that a gradual dose reduction was needed. A dose reduction is being attempted on resident #38 as of 2/28/18, #46 as of 3/21/18 and #54 as of 3/5/18. 2. The facility has determined that all residents receiving a psychotropic medication have the potential to be effected. 3. The Pharmacy Consultant was reeducated on 2/28/18 on regulations on the requirements of gradual dose reductions for antipsychotic medications. The Pharmacy Consultant will continue to do monthly pharmacy review. All residents receiving an antianxiety medication will have been reviewed as of 3/21/18. The physician is in the process of reviewing all residents receiving antidepressants for medication adjustments and changes will be made based on physician recommendations. Nursing staff RNs and LPNs will be educated by the Director of Nursing on 3/27/18 on requirements of compliance	

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F 756	Continued From page 14 - Review of Resident #38's record occurred on all days of survey and identified diagnoses including anxiety disorder and depression. A quarterly Minimum Data Set, dated 02/07/18, identified the resident received an antianxiety and an opioid [for pain] on all seven days of the assessment period. Resident #38's record identified physician's orders, dated 05/09/17, for Percocet (opioid pain reliever) 5-325 milligrams (mg) one every evening and Ativan (antianxiety) 0.5 mg twice a day. The Monthly Pharmacy Review sheet identified the pharmacist reviewed Resident #38's medication regimen monthly since her admission on 05/09/17, but failed to recommend dose reductions until 02/17/18 when he/she recommended a reduction for the resident's Percocet. The record lacked evidence the pharmacist recommended a dose reduction for the Ativan. During an interview on 02/28/18 at 12:08 p.m., an administrative nurse (#1) confirmed the facility had not attempted dose reductions for Resident #38's Ativan and Percocet until 02/17/18. - Review of Resident #54's record occurred on 03/01/18 and identified diagnoses including anxiety disorder, Alzheimer's disease, and dementia. A quarterly MDS, dated 12/25/17, identified the resident received an antianxiety medication four of seven days of the assessment period and a quarterly MDS, dated 09/25/17, identified Resident #54 received an antianxiety medication all seven days of the assessment period. Resident #54's physician's orders identified an order, dated 08/17/16, for	F 756	for F tag 756. A spreadsheet has been developed for antipsychotics, anti-anxiety meds, anti-depressant, and hypnotic medications to include the resident receiving the psychotropic medication, the medication and dose prescribed, and the date the medication was started. The spreadsheet automatically figures out the date that the 1st, 2nd and annual dose reductions are required. The Pharmacy Consultant will be responsible for requesting dose reductions for all those on a psychotropic medications. Resident Care Coordinators will update spreadsheet as reductions are attempted and also make recommendations according to the dose reduction schedule. 4. The Director of Nursing or Designee will QA 10 residents receiving psychotropic medications weekly X 4 weeks, monthly X 3, and quarterly X 3 to assure that residents receiving these medications have dose reductions as scheduled or proper documentation is available as to why the gradual dose reduction was contraindicated, then reevaluate for further monitoring and interventions. 5. Date of correction will be on 3/27/2018.	

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F 756	Continued From page 15 Clonazepam (antianxiety) 1 mg twice a day for anxiety. The "Monthly Pharmacy Review" form identified the pharmacist reviewed Resident #54's medication monthly from 07/30/17 through 01/30/18, but failed to recommend a dose reduction for the Clonazepam. During an interview on the afternoon of 02/28/18, an administrative nurse (#1) identified the facility could not provide documentation showing medication reviews completed by the pharmacist prior to 07/31/17. The nurse (#1) stated Resident #54 has received the same dose of Clonazepam for the past 18 months. - Review of Resident #46's medical record occurred on 03/01/18. Diagnoses included anxiety disorder and depression. A quarterly MDS, dated 01/09/18, identified Resident #46 received an antianxiety medication on all seven days of the assessment period. Review of Resident #46's physician's orders identified and order, dated 04/26/16, for Clonazepam 1 mg twice daily for anxiety. The Monthly Pharmacy Review sheet identified the pharmacist reviewed Resident #46's medication regimen each month since January 2016, but failed to recommend a dose reduction for the Clonazepam. During an interview on 02/28/18 at 2:20 p.m., an administrative nurse (#1) confirmed the facility had not attempted a dose reduction for Resident #46's Clonazepam.	F 756		
F 812	Food Procurement,Store/Prepare/Serve-Sanitary	F 812		4/5/18

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F 812 SS=E	Continued From page 16 CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, review of facility policy/procedure, facility cleaning schedules, and staff interview, the facility failed to store, prepare, and serve food under sanitary conditions in 2 of 5 food preparation areas (Main Kitchen and Faith Kitchenette). Failure to ensure the cleanliness of food preparation and storage areas has the potential to result in foodborne illness to residents, staff, and visitors. Finding include: Review of the facility policy, "Cleaning freezer every Sunday in each Kitchenette" occurred on	F 812	1. The dietary staff members were educated by the Dietary Manager and Consulting Dietician in a meeting on 3/20/18 for proper cleaning, storage, preparation and distribution in accordance with professional standards for food safety. All identified cleaning to screens, stove, seals on freezer, deep fryer, cart and hood were completed. Repairs to the seal of the freezer, shelf liner on cupboard and deep fryer cart was painted and top was laminate. Facility ordered a new counter top to replace the butcher block top with the unsealed wood.	

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F 812	Continued From page 17 03/01/18. This policy, dated 10/02/14, stated, "Purpose: To ensure all freezers are clean and food is properly rotated. . . . Procedure: 1. Dietary staff assigned to specific kitchenette is responsible for his/her own freezer each Sunday afternoon. . . . 4. Wipe rubber door seal. . . ." Review of kitchen cleaning schedules, on 03/01/18, identified, "Daily Cleaning . . . Clean ovens below stove after each shift." Review of the "Maintenance Assist Cleaning Schedule 2017" occurred on 03/01/18. This schedule stated, "quarterly or as needed, hood vent cleaning Main Kitchen" and identified the kitchen hood cleaned on "7/2017." The main dietary tour occurred on 03/01/18 at 9:05 a.m. with an administrative dietary staff member (#2). Observations showed the following: * Wood topped cupboard with cut marks, black stains, and unsealed wood. * Dirt/grease build up on the stove hood and fire suppression system for the stove. * Grill side of the stove with dried food debris and grease on the side of the stove. Staff explained, when used, the deep fryer is placed beside stove. * Rust on/in cupboard under juice machine. * Wooden cart used for the deep fryer coated in grease with unsealed edges, leaving an uncleanable surface. * Entire surface of the deep fryer coated in grease. * The screen on the interior side of the window, across from the stove, contains a thick layer of debris.	F 812	2. The facility has determined that all residents who consume food by mouth have the potential to be affected. 3. A monthly cleaning checklist was developed to monitor that cleaning tasks are completed and signed off. All dietary staff have been educated on the facilitie□s Cleaning schedule and cleaning policy to prevent food borne illness by the Dietary Manager and designee. 4. Facility developed a QA checklist to monitor each unit and main kitchen for daily cleaning assignments and monthly cleaning schedule. The Dietary Manager (DM) or designee will complete random observations on all kichenettes and main kitchen for compliance of dietary staff cleaning weekly X 4, monthly X 2 and quarterly X 3 to ensure staff are performing cleaning in accordance with facility policy. Monitoring will begin on 3/26/18. 5. Dietary Deficient practices involving cleaning were completed on 3/15/18. The new counter top was ordered and will be installed by 4/5/18.	

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F 812	Continued From page 18 * Faith Kitchenette: Cracked rubber gasket at the top of the freezer door with black debris embedded in the gasket. During an interview during the dietary tour, the administrative dietary staff member (#2) identified maintenance cleans the stove hood, and staff need to clean and/or report needed repairs in other areas.	F 812		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident	F 842		3/27/18

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F 842	Continued From page 19	F 842		

representative where permitted by applicable law;
(ii) Required by Law;
(iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;
(iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.

§483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.

§483.70(i)(4) Medical records must be retained for-
(i) The period of time required by State law; or
(ii) Five years from the date of discharge when there is no requirement in State law; or
(iii) For a minor, 3 years after a resident reaches legal age under State law.

§483.70(i)(5) The medical record must contain-
(i) Sufficient information to identify the resident;
(ii) A record of the resident's assessments;
(iii) The comprehensive plan of care and services provided;
(iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State;
(v) Physician's, nurse's, and other licensed professional's progress notes; and
(vi) Laboratory, radiology and other diagnostic

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F 842	Continued From page 20 services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and resident and staff interview, the facility failed to ensure a complete and accurately documented medical record for 3 of 18 sampled residents (Resident #1, #171, and #32). Failure to have a complete and accurate medical record limited staff's access to the most recent medical information regarding the residents. Findings include: - During an interview on 02/26/18 at 3 p.m., Resident #171 stated she had been at an appointment that morning. Review of the medical record occurred on all days of survey. The record identified instructions for an EGD (esophagogastroduodenoscopy: a test to examine the esophagus, stomach and part of intestines) scheduled for 02/26/18 at 11:00 a.m. The instructions stated the following: * Day Before Surgery - eat a normal diet until supper, have clear liquid supper, drink only water after supper and nothing to eat or drink after midnight." The medical record lacked information regarding when the resident left and returned from the appointment and if staff ensured the resident followed the above instructions. - Observation on 02/26/18 at 4:42 p.m. showed a dressing on Resident #1's left ring finger. Review of the medical record occurred on all	F 842	1. Immediate corrective action was taken for resident #1 by updating progress notes to include information on what her finger looked like prior to the start of treatment. Resident #32□s progress notes were updated immediately to include notification of resident representative regarding changes on 2/28/18 of discontinuation of medication. No corrective action was completed for resident #171□s as resident□s appointment had already occurred and is a past event. 2. The facility has determined that all residents have the potential to be affected by this practice. 3. Licensed Nursing Staff will be inserviced on 3/27/18 regarding maintaining complete, accurate, and readily accessible documentation as well as the Basic Principles for Long-Term Care Documentation. They will also be educated on the updated policy on Administration of Medication and or Treatment. On 3/27/18, nursing staff will also be educated on the entering of physician orders to include instructions for procedures to assure instructions prior to those procedures are followed through and documented. A fixed treatment order was developed to include instructions to assure proper documentation is complete prior to a procedure such as an EGD. 4. The Director of Nursing or Designee will conduct a QA on all resident□s	

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F 842	Continued From page 21 days of survey. The treatment administration record identified an order dated 02/21/18 for Epsom salt soaks to the left ring finger twice a day for seven days. The medical record failed to identify information why the resident required a treatment to her left ring finger. During an interview on 03/01/18 at 10:10 a.m., an administrative nurse (#1) stated she would expect staff to document when a treatment is started. - Review of Resident #32's medical record occurred on all days of survey and showed a physician's order, dated 02/14/18, to discontinue all oral medications. The medical record showed no documentation the nurse had notified the family/resident representative of the change. During an interview on 02/28/18 at 12:30 p.m., a staff nurse (#8) agreed she had failed to document in the progress notes the notification of the resident's representative regarding changes on 02/28/18.	F 842	progress notes weekly X 4, monthly X 3, and quarterly X 3 to assure complete and accurate documentation is provided in the progress notes, and will reevaluate for further monitoring or interventions. 5. Date of correction will be 3/27/18.	