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	535040	A. BUILDING _____ B. WING _____	C 09/12/2019

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DOUGLAS CARE CENTER LLC	1108 BIRCH STREET DOUGLAS, WY 82633

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F 000	INITIAL COMMENTS A recertification survey was conducted by Healthcare Licensing and Surveys from 9/9/19 through 9/12/19. Also reviewed in the course of the survey were complaint intakes WY00002798, WY00002888, and WY00002930. The following common abbreviations are used throughout this document. ADLS: Activities of Daily Living ADON: Assistant Director of Nursing BIMS: Brief Interview for Mental Status CNA: Certified Nursing Assistant DON: Director of Nursing MDS: Minimum Data Set NHA: Nursing Home Administrator RN: Registered Nurse TNA: Temporary Nursing Assistant Less commonly used abbreviations will be annotated in each deficiency.	F 000		
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489,	F 578		10/27/19

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

Electronically Signed | 10/02/2019

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

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F 578	Continued From page 1 subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State Law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure the advanced directive was formulated and accurate for 1 of 24 residents reviewed (#21). The findings were: Review of the electronic medical record (EMR) showed resident #21 was listed as do not resuscitate (DNR). Further review of the medical record showed the resident's advance directive was signed and dated by the resident's	F 578	F578 Request/refuse/discontinue terminate; formulate advance directive The facility will ensure the advance directive is formulated and accurate for all residents. A) Resident #21 will have the advance directive that resident #21 of wishes with correct PCP signed orders. B) All residents will have the advance directive of their wishes followed and signed orders by he/she PCP this audit	

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F 578	Continued From page 2 representative on 3/31/16 and indicated "Yes, please Administer Cardiopulmonary resuscitation [CPR]." The following concerns were identified: a. Interview with the NHA on 9/11/19 at 9:19 AM revealed the admission orders the facility received from the resident's physician on 7/30/19 showed the CPR status of the resident was "No CPR" which had prompted the change of the resident's status in the EMR. b. Review of the 7/30/19 physician's admission orders showed the CPR status was marked as "No CPR" and the resident's representative was aware. Further review of the admission orders showed the "Advance directives issued?" and "Copy attached?" questions were left blank. c. Interview with the NHA on 9/12/19 at 9:49 AM confirmed the facility had the most current advance directive. In addition the resident's representative had been contacted and had stated there had been no change in the advance directive and the resident was to have CPR administered in the event of a medical emergency.	F 578	will be done now. C) Medical records and all IDT staff will be educated that advance directive orders match signed directives by resident and or representative. D) An audit will be done by medical records will be done now and then on going monthly on all current residents to ensure that all residents have POLST in place and signed by PCP and that they match any other advance directives done in the past. The audit will be brought to QAPI for three months or until resolved.	
F 582 SS=B	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those	F 582		10/27/19

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F 582	Continued From page 3	F 582		

services; and
(ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section.

§483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate.
(i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible.
(ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change.
(iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements.
(iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility.
(v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of

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F 582	Continued From page 4 these regulations. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure the appropriate Notice of Medicare Provider Non-Coverage (NOMNC) and Skilled Nursing Facility (SNF) Advance Beneficiary Notice of Non-coverage (ABN) were issued correctly for 3 of 3 sample residents (#1, #42, #154). The findings were: 1. The NOMNC/ABN for resident #1 indicated the last covered day for Medicare Part A services was 6/20/19; however the notices were not signed by the resident's representative until 7/24/19. 2. The NOMNC/ABN for resident #42 indicated the last covered day for Medicare Part A services was 7/12/19; however the notices were not signed by the resident's representative until 7/26/19. 3. Review of the SNF Beneficiary Protection Notification Review for Resident #154 showed the facility did not provide a NOMNC due to the resident initiating the discharge on 8/7/19. a. Review of a physician's order dated 8/6/19 showed the resident was to be discharged with medications. b. Review of a nurse progress note on 8/5/19 showed the resident was "excited to be discharged to home soon." 4. Interview with the business office manager on 9/11/19 at 5:20 PM revealed the NOMNC was not provided to resident #154. She confirmed it was a planned discharge, and that a NOMNC form should have been issued. In addition, she	F 582	F582 Medicaid/Medicare coverage/liability notice The facility will ensure the appropriate Notice of Medicare Provider Non-Coverage and Skilled Nursing Facility Advance Beneficiary Notice of Non-coverage are issued. A) Residents #1, #42 and #154 will have appropriate Notice of Medicare Provider Non-Coverage and Skilled Nursing Facility Advance Beneficiary Notice of Non-Coverage issued. This is unable to be corrected. B) All residents will have the appropriate Notice of Medicare Provider Non-Coverage and Skilled Nursing Facility Advance Beneficiary Notice of Non-Coverage is issued as soon as it is reasonable possible. C) The business office manager (BOM) will be educated that all residents will have the appropriate Notice of Medicare Provider Non-Coverage and Skilled Nursing Facility Advance Beneficiary Notice of Non-Coverage is issued as soon as it is reasonable possible. D) The BOM will do a monthly audit of all discharged residents to ensure that the appropriate Notice of Medicare Provider Non-Coverage and Skilled Nursing Facility Advance Beneficiary Notice of Non-Coverage have been issued. The audit will be brought to QAPI for three months and or until resolved.	

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F 582	Continued From page 5 revealed the NOMNC/ABN forms for resident #42 had not been provided within the required time frame. She believed she may have mailed the notices to resident #1's representative within the required time frame, however was unable to provide documentation to confirm that information.	F 582		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure assessments were accurate for 2 of 20 sample residents (#15, #47). The findings were: 1. Review of the 4/4/19 significant change MDS assessment and the 7/5/19 quarterly MDS assessment for resident #15 showed the resident was coded as having received hospice services. The following concerns were identified: a. Review of the resident's care plan showed no indication hospice services were provided for the resident. Review of the entire medical record showed, with the exception of the 4/4/19 and 7/5/19 MDS assessments, no indication of hospice services. b. Interview with the ADON on 9/10/19 at 5:35 PM confirmed the resident had never been placed on hospice services. She confirmed the MDS assessments were not accurate. 2. Review of the 8/28/19 quarterly MDS assessment showed resident #47 was admitted	F 641	F641 Accuracy of Assessments The facility will ensure that resident assessments are accurate. A) Residents #15 and #47 will have accurate assessments done. The assessments were modified and corrected. B) All residents will ensure that accurate assessments are done. C) The MDS nurse will be educated the importance of accurate assessments. D) The MDS nurse will review assessments for accuracy monthly for three months and bring to QAPI for three months and or until resolved.	10/27/19

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F 641	Continued From page 6 to the facility on 7/30/12 with diagnoses which included dementia, diabetes, and neurogenic bladder which required an indwelling catheter. Further review showed the resident was coded as having a urinary tract infection (UTI) in the last 30 days. Review of the physician's orders showed an antibiotic was prescribed on 5/3/19 and again on 6/20/19 for a diagnosis of skin rash. Interview on 9/11/19 at 3:41 PM with the MDS coordinator revealed the resident did not have a UTI and confirmed the MDS assessment was not accurate.	F 641		
F 645 SS=D	PASARR Screening for MD & ID CFR(s): 483.20(k)(1)-(3) §483.20(k) Preadmission Screening for individuals with a mental disorder and individuals with intellectual disability. §483.20(k)(1) A nursing facility must not admit, on or after January 1, 1989, any new residents with: (i) Mental disorder as defined in paragraph (k)(3)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission, (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services; or (ii) Intellectual disability, as defined in paragraph (k)(3)(ii) of this section, unless the State intellectual disability or developmental disability authority has determined prior to admission-	F 645		10/27/19

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F 645	Continued From page 7	F 645		

(A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and
(B) If the individual requires such level of services, whether the individual requires specialized services for intellectual disability.

§483.20(k)(2) Exceptions. For purposes of this section-
(i)The preadmission screening program under paragraph(k)(1) of this section need not provide for determinations in the case of the readmission to a nursing facility of an individual who, after being admitted to the nursing facility, was transferred for care in a hospital.
(ii) The State may choose not to apply the preadmission screening program under paragraph (k)(1) of this section to the admission to a nursing facility of an individual-
(A) Who is admitted to the facility directly from a hospital after receiving acute inpatient care at the hospital,
(B) Who requires nursing facility services for the condition for which the individual received care in the hospital, and
(C) Whose attending physician has certified, before admission to the facility that the individual is likely to require less than 30 days of nursing facility services.

§483.20(k)(3) Definition. For purposes of this section-
(i) An individual is considered to have a mental disorder if the individual has a serious mental disorder defined in 483.102(b)(1).
(ii) An individual is considered to have an intellectual disability if the individual has an

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F 645	Continued From page 8 intellectual disability as defined in §483.102(b)(3) or is a person with a related condition as described in 435.1010 of this chapter. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure a pre-admission screening and resident review (PASARR) was completed timely for 2 of 2 sample residents (#6, #41) reviewed for PASARR screening. The findings were: 1. Review of the admission MDS assessment dated 12/19/18 showed resident #6 was admitted to the facility on 12/6/18 and was not currently considered by the State Level II PASARR process to have a serious mental illness and/or intellectual disability or related condition. Further review showed the resident had diagnoses which included psychotic disorder, anxiety disorder, and depression. The following concerns were identified: a. Review of the medical record showed a PASARR Level I was completed on the day of admission and a PASARR Level II was to be completed based on the presence of a psychiatric diagnosis. b. Review of the PASARR Level II showed it was completed after admission on 1/2/19; however the facility placement was determined to be appropriate with no specialized services recommended. c. Interview with the business office manager on 9/12/19 at 10:22 AM confirmed the PASARR Level II was completed after the admission date. 2. Medical record review showed resident #41 was admitted to the facility on 2/14/19 with diagnoses which included cerebral vascular	F 645	F645 PASARR Screening The facility will ensure a preadmission screening and resident review will be completed timely. A) Residents #6 and 41 will have PASAAR preadmission screening done. This deficiency cannot be corrected. B) All new admission residents will have a PASAAR done prior to admission as well as the PASAAR II will be completed prior to admission as well. C) The BOM, Social Service, Medical Records will be educated on PASAAR preadmission being done prior to admission. D) The Social Service Director will audit monthly all new admissions to ensure that PASAAR's done prior to admission and bring to QAPI for three months or until resolved.	

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F 645	Continued From page 9 accident and anxiety. Review of the PASARR Level I showed the resident triggered a PASARR Level II evaluation. The following concerns were identified: a. The PASARR Level II evaluation was completed on 3/15/19; one month after the resident was admitted. b. Interview on 9/11/19 at 4:33 PM with the business office manager and the NHA revealed the assessment was started on 2/15/19, after the resident was admitted and confirmed it should have been completed prior to admission.	F 645		
F 656 SS=D	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	F 656		10/27/19

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F 656	Continued From page 10 recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on medical record review and resident and staff interview, the facility failed to develop a comprehensive person-centered care plan for 4 of 20 sample residents (#6, #8, #28, #34). The findings were: 1. Review of the 6/21/19 quarterly MDS assessment showed resident #6 was admitted to the facility on 12/6/18. Further review showed the resident had diagnoses which included non-Alzheimer's dementia, anxiety disorder, depression, and a psychotic disorder (other than schizophrenia). Review of the September 2019 medication administration record (MAR) showed the resident was prescribed Lexapro (antidepressant) 20 mg daily, with a start date of 12/6/18 for major depressive disorder; lorazepam (antianxiety) 0.5 mg 3 times daily, with a start date of 7/26/19 for anxiety disorder; and Zyprexa (antipsychotic) 2.5 mg 1.5 tablets daily and 2.5	F 656	F 656 Development/Implement Comprehensive Care Plan The facility will ensure to develop a comprehensive person-centered care plan. A) Resident #6 will have a comprehensive care plan showing target behavior for each psychoactive medication, in addition the care plan will address the resident’s behaviors and the potential side effects for each of the psychoactive medications administered. B) Resident #8 will have a care plan to address his/her aggressive toward other residents and staff, it will also address his/her sexually inappropriate behavior. Resident #8 will have a care plan to address possible side effects of the resident’s medications to include quetiapine and clonazepam.	

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F 656	Continued From page 11 mg at bedtime, with a start date of 5/28/19 for unspecified dementia with behavioral disturbance. Review of the August 2019 and September 2019 through 9/12/19 MARs showed the resident's behaviors were monitored 3 times daily. Behaviors documented included obsessive, anxious, restless, angry, guarded, stoic, withdrawn, compulsive, sleeping, anxiety, depressed, and short-tempered. The following concerns were identified: a. Review of the entire care plan showed target behaviors for each psychoactive medication were not identified. In addition, there was not an individual plan to address the resident's behaviors or the potential side effects for each of the psychoactive medications administered. b. During an interview with the NHA on 9/12/19 at 9:15 AM she acknowledged care plans should be individualized to meet the needs of each individual resident. 2. Review of the 12/11/18 admission MDS assessment showed resident #8 was admitted to the facility on 11/28/18 with diagnoses which included non-Alzheimer's dementia and depression. Review of the 5/19/19 "Pending Response to Pharmacy Recommendations" showed the resident's physician altered the diagnosis of non-Alzheimer's dementia to include behaviors. Review of the resident's care plan showed a 1/11/19 plan to address behavioral symptoms identified as follows: "I have been known to treat my [spouse] poorly. I do not understand [his/her] condition and I sometimes will kick, poke, or pinch [him/her] trying to get [him/her] to do something." The approach was as follows: "Staff will monitor me and my behaviors when my [spouse] is visiting me." Other care	F 656	C) Resident #28 will have a care plan addressing interventions for pain management. D) Resident #34 will have a care plan addressing target behaviors for each psychoactive medication and the potential side effects for each of the psychoactive medications administered. E) An audit of all residents will be done to ensure they all have individualized care plans to meet the needs of each individual resident specifically pain and behavior monitoring for psychoactive. F) The IDT care plan team will be educated that all residents will have individualized care plans to meet the needs of all of our residents. G) An audit will be done weekly at each care plan meeting that each resident who are scheduled for a care plan have individualized care plans complete. The audit will be brought to QAPI for three months or until resolved.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535040	A. BUILDING _____ B. WING _____	C 09/12/2019

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F 656	Continued From page 12	F 656		

planned behavior symptoms included the resident placing food in his/her pockets, and wandering. Review of physician orders showed an 11/28/18 order for quetiapine (antipsychotic) 25 mg oral at bedtime. In addition, the review showed a 7/9/19 order for clonazepam (antiseizure) 0.5 mg by mouth twice a day PRN (as needed). The following concerns were identified:

a. Review of "Resident Progress Notes" showed the following: A note dated 2/23/19 and timed [7:10 PM] revealed, "It was reported that this PT (patient) was seen kicking another PT. When asked about this incident this resident states [s/he] didn't kick anyone. [ADON] notified and police were notified..." A note dated 6/11/19 at 12:54 PM revealed, "Resident is having sexual behaviors towards staff and a resident. Example, spanking staff members on the bottom and asking staff members if [s/he] can play with them."

b. Review of the entire care plan showed no individual plan to address the resident's aggressive behavior toward other residents and staff, and the plan failed to address sexually inappropriate behavior. Review of a 5/31/19 plan regarding resident rights revealed there was a plan to address a relationship between the resident and another resident. However, the plan did not address aggression or sexually inappropriate behaviors. Further review showed the plan failed to address possible side effects of the resident's medications to include quetiapine and clonazepam.

c. Interview with the ADON on 9/11/19 at 4:52 PM confirmed the resident's care plan failed to address aggressive behaviors toward residents and sexually inappropriate behaviors toward staff and other residents.

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F 656	Continued From page 13	F 656		

3. Review of the admission MDS assessment dated 8/8/19 showed resident #28 was admitted to the facility with diagnoses which included heart failure, diabetes mellitus and cervical stenosis. Further review showed the resident was coded as receiving an opioid (pain medication) regularly. The following concerns were identified:

a. Interview with the resident on 9/9/19 at 2:47 PM revealed s/he had pain in his/her shoulder and neck and received an injection to help with pain management.

b. Review of the medication administration record showed the resident received gabapentin 100 mg every night (for pain) and MS Contin 15 mg twice a daily (opioid) for pain.

c. Review of the care plan failed to show interventions for pain management.

d. Interview with the ADON on 9/11/19 at 5:15 PM revealed pain triggered in the care area and there should have been a care plan with interventions to treat and manage pain, however it was missed.

4. Review of the 8/15/19 significant change MDS assessment showed resident #34 was admitted to the facility on 10/30/18. Further review showed the resident had diagnoses which included Alzheimer's disease, non-Alzheimer's dementia, and depression. Review of the most current physician orders showed the resident was prescribed citalopram (antidepressant) 20 mg daily with a start date of 2/12/19; lorazepam (anti-anxiety) 0.5 mg 3 times daily with a start date of 5/7/19; and quetiapine (anti-psychotic) 25 mg daily, and 50 mg daily at bedtime with a start date of 11/14/18. Further review showed an order for behavior monitoring twice daily. Review of the August 2019 and September through 9/12/19 MARs showed the resident had documented

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 656	Continued From page 14 behaviors of agitated, tearful, refusing medications, calm, anxious, withdrawn, stoic, refused food, lethargic, uncooperative, and sleeping. a. Review of the entire care plan showed target behaviors for each psychoactive medication were not identified. In addition, there was not an individual plan to address the resident's behaviors or the potential side effects for each of the psychoactive medications administered. b. During an interview with the NHA on 9/12/19 at 9:15 AM she acknowledged care plans should be individualized to meet the needs of each individual resident.	F 656		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (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 657		10/27/19

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F 657	Continued From page 15 (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 medical record review, and staff interview, the facility failed to ensure the comprehensive care plan was revised as needed to reflect the resident's current needs for 1 of 20 sample residents (#34). The findings were: 1. Review of the medical record showed resident #34 had a significant change MDS assessment with an assessment reference date of 8/15/19. The following concerns were identified: a. Review of a progress note dated 8/20/19 showed the resident was refusing meals and had not been as social as normal. b. Review of a progress note dated 8/31/19 showed the resident had refused multiple meals during the week and had also refused "Ensure/Boost" (a nutritional supplement). c. Interview with the NHA on 9/11/19 at 5:07 PM revealed a significant change assessment had been completed for the resident related to his/her change in appetite and refusing medications. d. Review of the nutritional care plan with an approach start date of 11/30/18 showed "I have Kennedy cups and scoop plate for meals." An additional approach dated 5/20/19 showed the resident had a mechanical soft diet. Further review showed no evidence of changes or revisions since the significant change assessment was completed.	F 657	F657 Care Plan Timing and Revision The facility will ensure the compressive care plan will be revised as need to reflect the resident's current needs. A) Resident #34 will have his/her care updated to include interventions such as assisting he/she at meals and crushing her/his meds. B) An audit of all residents with a significant change will be done to ensure all residents will have their care plans updated to include interventions when a change of condition is done. C) The IDT care plan team will be educated that all interventions are care planned at the change in resident. D) The IDT care plan team will be responsible for auditing monthly when a change of condition happens all interventions are care planned. The audit will be taken to QAPI for three months or until resolved.	

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F 657	Continued From page 16 e. Interview on 9/12/19 at 9:15 AM with the NHA revealed interventions which included assisting the resident at meals, crushing his/her medications, and monitoring for a urinary tract infection were implemented. The NHA confirmed the care plan had not been revised.	F 657		
F 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and staff interview, the facility failed to ensure interventions to prevent weight loss were implemented for 1 of 4 sample residents (#12) reviewed for nutrition. The findings were:	F 692	F692 Nutrition/Hydration Status Maintenance The facility will ensure interventions to prevent weight loss are implemented. A) Resident #12 has been seen by OT/SLP and has seen the dentist.	10/27/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 692	Continued From page 17 1. Review of the 6/26/19 quarterly MDS assessment showed resident #12 was admitted to the facility on 3/16/18 with diagnoses which included traumatic brain injury, anoxic brain damage, adult failure to thrive, dysphagia following other cerebrovascular disease, and gastroparesis. Further review showed the resident required the extensive assistance of one staff member for eating; had a swallowing disorder of loss of liquids/solids from mouth; and was prescribed a mechanically-altered diet. The following concerns were identified: a. Review of the medical record showed the resident weighed 105.5 pounds on 3/14/19 and 94.4 pounds on 9/4/19, a weight loss of 10.52% in 6 months. b. Observation on 9/9/19 at 5:30 PM showed TNA #1 was assisting the resident in the dining room. The meal was provided by the dietary staff in separate mugs. The TNA poured the entire content of the mug into a nosey cup; stood over the resident and held the nosey cup to the resident's mouth for him/her to drink. The resident coughed and regurgitated the food and soiled the clothing protector. The TNA changed the clothing protector and continued with the same feeding technique having to change the clothing protector several times. c. Observation on 9/11/19 at 9:16 AM showed CNA #1 was assisting the resident in the dining room. The meal was again provided by the dietary staff in separate mugs. The CNA poured a small portion from the mug into the nosey cup and held the cup for the resident to drink. The resident did not cough or regurgitate any of the food. The CNA continued at a slow pace and allowed the resident plenty of time to swallow the food before offering the cup again. d. Interview with the Alzheimer's unit	F 692	B) An audit will be done to ensure that all residents who need assistants with feeding will be done to ensure that the proper technique is done. All residents will have their nutrition/hydration status maintained. C) OT and PT will be notified immediate that there is an order for them. Review them the following day after written. C) An education was done for all employees to ensure they are providing dignity to our residents while assisting them with eating. E) An education will be done for ADON/DON/MDS that orders from PT/OT are done immediately and given to OT/PT. D) The IDT for weight and skin will be educated on nutrition/hydration status maintenance. E) Residents weight will be reviewed weekly by the IDT weight and skin and any issues that arise out of that meeting will be brought to QAPI for three months or until resolved.	

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F 692	Continued From page 18 coordinator on 9/11/19 at 9:21 AM revealed it was common for the resident to "spit out" the food as s/he would drink too fast. e. Review of the dietitian's progress note dated 8/30/19 showed the resident was reviewed during an IDT meeting due to a weight change. Further "Risk continues overall with fluctuating intake and hx of wt loss. We have been following [the resident's] eating and preferences and [s/he] may do better with a straw as this assists [his/her] intake and ability if tolerated. We will refer to OT/SLP for review to see if straws are a safe option at this time." f. Review of the medical record showed no evidence OT/SLP had evaluated the resident. g. Interview with the NHA on 9/11/19 at 9:52 AM revealed information about a successful technique to feed the resident should have been shared with the other staff members. An additional interview on 9/12/19 at 9:10 AM revealed the OT/SLP had not received the recommendation from the dietitian for the safety evaluation.	F 692		
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.	F 756		10/27/19

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F 756	Continued From page 19 (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. §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 medical record review, staff interview, and antibiotic stewardship policy review, the facility failed to ensure medication irregularities were identified and reported to the physician for 3 of 8 sample residents (#8, #31, #38) reviewed for unnecessary medications. The findings were: 1. Review of the 12/11/18 admission MDS assessment showed resident #8 was admitted to the facility on 11/28/18 with diagnoses which included non-Alzheimer's dementia and depression. Review of the 5/19/19 "Pending	F 756	F756 Drug Regimen Review, Report Irregular, Act On The facility will ensure medication irregularities are identified and reported to the physician. A) Resident #8 will have his/her PCP document a risk benefit explanation concerning the Clonazepam. Will have a stop date and a rational of continued use of the psychoactive. B) Resident #8 will have a monthly pharmacy medication regimen review	

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F 756	Continued From page 20 Response to Pharmacy Recommendations" showed the resident's physician altered the diagnosis of non-Alzheimer's dementia to include behaviors. The following concerns were identified: a. Review of the 7/9/19 "Request For Psychopharmacological Medication Change" revealed a new order for "Clonazepam (anti-seizure) 0.5 mg (milligrams) PO (by mouth) BID (twice a day) to PRN (as needed) for agitation. The order failed to have a stop date. b. Review of the August and September 2019 MARs (medication administration records) showed the 7/9/19 clonazepam was still ordered, and was administered 24 times in August and 8 times in September. c. Review of the 2019 monthly pharmacy medication regimen reviews for July and August showed the reviews failed to identify the 7/9/19 PRN order for clonazepam as an irregularity and to report the irregularity to the physician. d. Interview with the ADON on 9/11/19 at 4:52 PM confirmed the resident had a 7/9/19 PRN order for clonazepam that was current and had no end date. She further confirmed the facility failed to identify the irregularity and report it to the physician, and the physician had not documented a risk benefit explanation. 2. Review of the 5/13/19 admission MDS assessment showed resident #31 was admitted to the facility on 5/8/19 with diagnoses which included urinary tract infection. The following concerns were identified: a. Review of physician orders revealed a 5/8/19 order for Macrobid (antibiotic) 100 mg PO at bedtime for a diagnosis of urinary tract infection. The order failed to have a stop date and showed the order was open-ended.	F 756	done to identify the Clonazepam as an irregularity and reported to the residents PCP. C) Resident #31 will have a monthly pharmacy medication regimen review done to identify the Macrobid as an irregularity and reported to the residents PCP. A risk benefit statement will be done to justify its continued use. D) Resident #31 will have his/her PCP document a risk benefit explanation concerning the Macrobid. E) Resident #38 will have a monthly pharmacy medication regimen review done to identify the Trimethoprim as an irregularity and reported to the residents PCP. A risk benefit statement will be done to justify its continued use. F) Resident #38 will have his/her PCP document a risk benefit explanation concerning the Trimethoprim. G) An audit of all residents on psychoactive or on prophylactic antibiotics will be done to ensure there is a risk benefit statement done to justify continued use. And that there is a stop date and rational for the use of a psychoactive. H) The contracted pharmacy will be educated on the importance of monthly pharmacy medication regimen review and identifying medications as an irregularity and reported to the PCP. I) The PCP will be educated on documenting a risk benefit explanation for certain medications like PRN's and antibiotics. J) The ADON/DON will be educated on both monthly pharmacy medication regimen review and risk benefit	

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	535040	A. BUILDING _____ B. WING _____	C 09/12/2019

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F 756	Continued From page 21 b. Review of the 2019 MARs for May, June, July, August, and September showed the resident received Macrobid 100 mg by mouth daily. c. Review of the monthly pharmacy medication regimen reviews from May 2019 through August 2019 showed the reviews failed to identify the 5/8/19 Macrobid order as an irregularity and to report the irregularity to the physician. d. Interview with the ADON on 9/12/19 at 11:20 AM confirmed the resident had a 5/8/19 order for Macrobid that was current and had no end date. She further confirmed the facility failed to identify the irregularity and report it to the physician, and the physician had not documented a risk benefit explanation. 3. Review of the 8/21/19 quarterly MDS assessment showed resident #38 was admitted to the facility on 11/6/17 with diagnoses which included urinary tract infection. The following concerns were identified: a. Review of physician orders revealed an 8/13/19 order for trimethoprim (sulfa antibiotic) 50 mg oral at bedtime. The order failed to have a stop date and showed the order was open-ended. b. Review of the August and September 2019 MARs showed the resident received trimethoprim at bedtime daily. c. Review of the monthly pharmacy medication regimen review for August 2019 showed the review failed to identify the 8/13/19 trimethoprim order as an irregularity and to report the irregularity to the physician. d. Interview with the ADON on 9/12/19 at 11:20 AM confirmed the resident had an 8/13/19 trimethoprim order that was current and had no end date. She further confirmed the facility failed to identify the irregularity and report it to the	F 756	explanation. K) An audit of PRN psychotropic and antibiotics will be done monthly and brought to QAPI for three months or until resolved. The audit will be done by the ADON/DON/MDS.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 756	Continued From page 22 physician, and the physician had not documented a risk benefit explanation. 4. Review of the 10/5/19 antibiotic stewardship policy revealed the following, "...4. The program includes antibiotic use protocols and a system to monitor antibiotic use. A. Antibiotic use protocols: v. All prescriptions for antibiotics shall specify the dose, duration, and indication for use. vi. Reassessment of empiric antibiotics is conducted after 2-3 days for appropriateness and necessity, factoring in results of diagnostic tests, laboratory reports, and/or changes in the clinical status of the patient. vii. Whenever possible, narrow-spectrum antibiotics that are appropriate for the condition being treated shall be utilized..."	F 756		
F 757 SS=D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or	F 757		10/27/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535040	A. BUILDING _____ B. WING _____	C 09/12/2019

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F 757	Continued From page 23 §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on medical record review, staff interview, and antibiotic stewardship policy review, the facility failed to ensure resident drug regimens were free from unnecessary drugs for 2 of 8 sample residents (#31, #38) reviewed for unnecessary drugs. The findings were: 1. Review of the 5/13/19 admission MDS assessment showed resident #31 was admitted to the facility on 5/8/19 with diagnoses which included urinary tract infection. The following concerns were identified: a. Review of physician orders revealed a 5/8/19 order for Macrobid (antibiotic) 100mg PO at bedtime for a diagnosis of urinary tract infection. The order failed to have a stop date and showed the order was open-ended. b. Review of the 2019 MARs for May, June, July, August, and September showed the resident received Macrobid 100mg by mouth daily. c. Review of the entire medical record showed no physician documentation of a risk benefit statement for the use of Macrobid without a stop date. d. Interview with the ADON on 9/12/19 at 11:20 AM confirmed the resident had a 5/8/19 order for Macrobid that was current and had no end date. She further confirmed the facility failed to ensure the physician documented a risk benefit explanation. 2. Review of the 8/21/19 quarterly MDS assessment showed resident #38 was admitted to the facility on 11/6/17 with diagnoses which	F 757	F757 Drug Regimen is Free from Unnecessary Drugs The facility will ensure resident's drug regiments are free from unnecessary drugs. A) Resident #31 will have his/her PCP document a risk benefit statement for the use of his/her Macrobid without a stop date. B) Resident #38 will have his/her PCP document a risk benefit statement for the use of his/her Trimethoprim without a stop date. C) An audit of all residents on psychoactive or on prophylactic antibiotics will be done to ensure there is a risk benefit statement done to justify continued use. And that there is a stop date and rational for the use of a psychoactive. C) The ADON/MDS/MDS/PCP will be educated that there needs to be documentation of a risk benefit statement for the use of antibiotics with no stop date. D) An audit will be done be the ADON/DON/MDS monthly on all antibiotics to ensure that 1. There are stop dates 2. If there is no stop date the PCP does documentation of a risk benefit statement for the use of the antibiotic. The audit will be brought to QAPI for three months or until resolved.	

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	535040	A. BUILDING _____ B. WING _____	C 09/12/2019

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F 757	Continued From page 24 included urinary tract infection. The following concerns were identified: a. Review of physician orders revealed an 8/13/19 order for trimethoprim (sulfa antibiotic) 50mg oral at bedtime. The order failed to have a stop date and showed the order was open-ended. b. Review of the August and September 2019 MARs showed the resident received trimethoprim at bedtime daily. c. Review of the entire medical record showed no physician documentation of a risk benefit statement for the use of trimethoprim without a stop date. d. Interview with the ADON on 9/12/19 at 11:20 AM confirmed the resident had an 8/13/19 trimethoprim order that was current and had no end date. She further confirmed the facility failed to ensure the physician documented a risk benefit explanation. 3. Review of the 10/5/19 antibiotic stewardship policy revealed the following, "...4. The program includes antibiotic use protocols and a system to monitor antibiotic use. A. Antibiotic use protocols: v. All prescriptions for antibiotics shall specify the dose, duration, and indication for use. vi. Reassessment of empiric antibiotics is conducted after 2-3 days for appropriateness and necessity, factoring in results of diagnostic tests, laboratory reports, and/or changes in the clinical status of the patient. vii. Whenever possible, narrow-spectrum antibiotics that are appropriate for the condition being treated shall be utilized..."	F 757		
F 758 SS=E	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	F 758		10/27/19

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	535040	A. BUILDING _____ B. WING _____	C 09/12/2019

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F 758	Continued From page 25	F 758		

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 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.

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F 758	Continued From page 26 §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 medical record review and staff interview, the facility failed to ensure residents were free from unnecessary medications for 5 of 8 residents (#6, #8, #21,#28, #34) reviewed for unnecessary medications. The findings were: 1. Review of the 6/21/19 quarterly MDS assessment showed resident #6 was admitted to the facility on 12/6/18. Further review showed the resident had diagnoses which included non-Alzheimer's dementia, anxiety disorder, depression, and a psychotic disorder (other than schizophrenia). Review of the September 2019 medication administration record (MAR) showed the resident was prescribed Lexapro (antidepressant) 20 mg daily, with a start date of 12/6/18 for major depressive disorder; lorazepam (antianxiety) 0.5 mg 3 times daily, with a start date of 7/26/19 for anxiety disorder; and Zyprexia (antipsychotic) 2.5 mg 1.5 tablets daily and 2.5 mg at bedtime, with a start date of 5/28/19 for unspecified dementia with behavioral disturbance. The following concerns were identified: a. Review of the August 2019 and 9/1/19 through 9/12/19 MARs showed the resident's behaviors were monitored 3 times daily. Behaviors documented included obsessive, anxious, restless, angry, guarded, stoic, withdrawn, compulsive, sleeping, anxiety, depressed, and short-tempered. There was no	F 758	F758 Free from Unnecessary Psychotropic Meds/PRN Use The facility will ensure residents are free from unnecessary medications. 1 A) Resident #6 will have his/her behaviors monitored for each medication based the dx for that medication. 1B) Resident #6 will have side effects of each medication prescribed, identified and monitored. 2A) Resident #8 PRN order for Clonzepam .5mg will have a stop date and if resident #8 PCP, a rational of continued use of the psychoactive medication will be done. 2B) Resident #8 will have his/her PCP identify which medication he/she is choosing not to attempt to taper dose at this time. 3A) Resident #21 will have his/her behavior monitored for each medication based on the dx for that medication. 3B) Resident #21 will have his/her medications identified, what side effects are for those medications and will be monitored. 4A) Resident # 28 will have a stop date for his/her Lorzepam, if the residents PCP rational of continued use of the psychoactive medication will be done. 5A) Resident #34 will have his/her	

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F 758	Continued From page 27 method to determine which behaviors were being monitored for each medication. b. Review of the medical record showed no evidence the side effects of each medication prescribed had been identified and were being monitored. 2. Review of the 12/11/18 admission MDS assessment showed resident #8 was admitted to the facility on 11/28/18 with diagnoses which included non-Alzheimer's dementia and depression. Review of the 5/19/19 "Pending Response to Pharmacy Recommendations" showed the resident's physician altered the diagnosis of non-Alzheimer's dementia to include behaviors. The following concerns were identified: a. Review of physician orders showed an 11/28/18 order for quetiapine (antipsychotic) 25 mg orally at bedtime. In addition, the review showed a 7/9/19 order for clonazepam 0.5 mg by mouth twice a day PRN (as needed). b. Review of the 7/8/19 "Request For Psychopharmacological Medication Change" revealed a new order for, "Clonazepam (anti-seizure) 0.5 mg (milligrams) PO (by mouth) BID (twice a day) to PRN for agitation. The order failed to have a stop date. The area at the top of the form for medications also listed quetiapine 25 mg qday (daily) and mirtazapine (antidepressant)15 mg. Under "Response from medical provider" the physician chose the 'do not attempt to taper the dose of this drug' risk benefit statement. However, three medications were listed at the top of the form and the statement failed to identify which medication was being referred to. c. Review of the August and September 2019 MARs (medication administration records)	F 758	behaviors monitored for each medication based on on the dx for that medication. 5B) Resident #34 will have his/her medications identified, what the side effects are for those medications and the side effects will be monitored. A) All residents will be free of unnecessary psychotropic meds/PRN Use. An audit of all PRN medications will be done on all residents have stop dates. B) ADON/DON/MDS nurses will be educated on the importance of residents having stop dates on PRN medications, identifying which medication the PCP is choosing to DC or not to change, that residents have to have behaviors targeted for each medication, what the side effects of those medications are and the resident will be monitored for. C) The ADON/DON/MDS nurse will be responsible for auditing the above on a monthly basis and will bring to QAPI three months or until resolved.	

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F 758	Continued From page 28	F 758		

showed the 7/9/19 clonazepam was still ordered, and was administered 24 times in August and 8 times in September.

d. Interview with the ADON on 9/11/19 at 4:52 PM confirmed the resident had a 7/9/19 PRN order for clonazepam that was current and had no end date. She further confirmed the physician had not documented a risk benefit explanation for clonazepam or quetiapine, and the area chosen by the physician for the risk benefit statement on the 7/8/19 "Request For Psychopharmacological Medication Change" had three medications listed at the top of the form. The chosen risk benefit statement by the physician failed to identify which of the 3 medications the risk benefit statement was for.

3. Review of the most current physician orders showed resident #21 was prescribed citalopram (antidepressant) 20 mg daily for paranoid schizophrenia with a start date of 7/30/19, and quetiapine (antipsychotic) 75 mg twice a day for paranoid schizophrenia with a start date of 8/27/19. Further review showed the resident was to be monitored every shift for signs of depression and side effects of psychoactive medication use. In addition the facility was to document the amount of time the resident required 1:1 with staff due to behaviors. The following concerns were identified:

a. Review of the August 2019 and September through 9/12/19 MARs showed documented behaviors of agitated, yelling, short tempered, anxious, confrontational, pacing, restless, obsessive, sleeping, and isolated in room. There was no method to determine which behaviors were being monitored for each medication.

b. Review of the medical record showed no evidence the side effects of each medication

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 758	Continued From page 29	F 758		

prescribed had been identified and were being monitored.

4. Review of the admission MDS assessment dated 8/8/19 showed resident #28 was admitted with diagnoses which included heart failure, diabetes mellitus, and dementia. Review of the physician orders dated 8/22/19 showed an order for lorazepam 1 mg four times a day as needed (antianxiety). The following concerns were identified:

a. Review of the medication administration record showed the lorazepam did not have a stop date.

b. Interview on 9/11/19 at 6:11 PM with the ADON revealed there should have been an order to either continue or stop the medication, and it was missed.

5. Review of the 8/15/19 significant change assessment showed resident #34 was admitted to the facility on 10/30/18. Further review showed the resident had diagnoses which included Alzheimer's disease, non-Alzheimer's dementia, and depression. The following concerns were identified:

a. Review of the most current physician orders showed the resident was prescribed citalopram (antidepressant) 20 mg daily with a start date of 2/12/19; lorazepam (anti-anxiety) 0.5 mg 3 times daily with a start date of 5/7/19; and quetiapine (anti-psychotic) 25 mg daily, and 50 mg daily at bedtime with a start date of 11/14/18. Further review showed an order for behavior monitoring twice daily.

b. Review of the August 2019 and 9/1/19 through 9/12/19 MARs showed the resident exhibited behaviors of agitated, tearful, refusing medications, calm, anxious, withdrawn, stoic,

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F 758	Continued From page 30 refused food, lethargic, uncooperative, and sleeping. There was no method to determine which behaviors were being monitored for each medication. c. Review of the medical record showed no evidence the side effects of each medication prescribed had been identified and were being monitored. 6. Interview with the ADON on 9/12/19 at 8:43 AM revealed the facility did not identify target behaviors or side effects in relation to specific medications and the effectiveness of the medication could not be determined.	F 758		
F 791 SS=D	Routine/Emergency Dental Srvcs in NFs CFR(s): 483.55(b)(1)-(5) §483.55 Dental Services The facility must assist residents in obtaining routine and 24-hour emergency dental care. §483.55(b) Nursing Facilities. The facility- §483.55(b)(1) Must provide or obtain from an outside resource, in accordance with §483.70(g) of this part, the following dental services to meet the needs of each resident: (i) Routine dental services (to the extent covered under the State plan); and (ii) Emergency dental services; §483.55(b)(2) Must, if necessary or if requested, assist the resident- (i) In making appointments; and (ii) By arranging for transportation to and from the dental services locations;	F 791		10/27/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 791	Continued From page 31 §483.55(b)(3) Must promptly, within 3 days, refer residents with lost or damaged dentures for dental services. If a referral does not occur within 3 days, the facility must provide documentation of what they did to ensure the resident could still eat and drink adequately while awaiting dental services and the extenuating circumstances that led to the delay; §483.55(b)(4) Must have a policy identifying those circumstances when the loss or damage of dentures is the facility's responsibility and may not charge a resident for the loss or damage of dentures determined in accordance with facility policy to be the facility's responsibility; and §483.55(b)(5) Must assist residents who are eligible and wish to participate to apply for reimbursement of dental services as an incurred medical expense under the State plan. This REQUIREMENT is not met as evidenced by: Based on medical record review, and staff and family interview, the facility failed to ensure dental services were provided for 1 of 1 sample resident (#12) reviewed for dental service needs. The findings were: 1. Review of the 6/26/19 quarterly MDS assessment showed resident #12 was admitted to the facility on 3/16/18 with diagnoses which included traumatic brain injury, anoxic brain damage, adult failure to thrive, dysphagia following other cerebrovascular disease, and gastroparesis. The resident had a BIMS score of 99 and was then determined by staff to be severely impaired for cognitive skills for daily decision making. Further review showed the resident required the extensive assistance of one	F 791	F791 Routine/Emergency Dental Services in Nursing Facilities. The facility will ensure dental services are provided for residents. A) Resident #12 was seen by a dentist. B) All residents dental needs will be met 1) Routing dental service to the extent covered under the State plan 2) emergency dental services 3) making appointments 4) by arranging for transportation to and from dental services locations. C) The IDT will be educated on the above. D) An audit of residents who need to be seen or requested to be seen will be done and then continued weekly weight and	

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	535040	A. BUILDING _____ B. WING _____	C 09/12/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 791	Continued From page 32 staff member for all ADLs except bathing which required the total assistance of 2 staff members. The following concerns were identified: a. Interview with the resident's representative on 9/10/19 at 8:44 AM revealed she was concerned about a visible build-up of plaque on the resident's teeth and to her knowledge the resident had not seen a dentist since s/he was admitted to the facility. b. Review of the entire medical record showed no evidence dental care had been provided to the resident by a dentist. c. Interview with the NHA on 9/11/19 at 5:08 PM revealed not every resident saw a dentist routinely. During an additional interview with the NHA on 9/12/19 at 9:10 AM she confirmed the resident had not seen a dentist since admission.	F 791	skin meetings and brought to QAPI for three months or until resolved.	