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	175333	A. BUILDING _____ B. WING _____	03/07/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HICKORY POINTE CARE & REHAB CENTER	700 CHEROKEE PO BOX 307 OSKALOOSA, KS 66066

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The following citations represent the findings of a Health Resurvey and Complaint Investigation #KS00138623, KS00137956, KS00134836.	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, 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	F 578		

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

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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:
The facility identified a census of 38 residents. The sample included 31 residents, with 4 residents reviewed for advanced directive status (oral and written instructions about future medical care in the event the resident was unable to express his/her medical wishes). Based on record reviews, interviews, and observations the facility failed to clearly identify the expressed choices to initiate or withhold resuscitative measures (restoration to life or consciousness of one apparently dead, or whose respirations had ceased) for 3 (#3, #9, #23) of the 4 sampled residents.

Findings included:

- The Electronic Medical Record (EMR) for resident #3, listed diagnoses of diabetes mellitus (when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin), hypertension (elevated blood pressure), and depression (abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness and emptiness).

The admission Minimum Data Set (MDS) dated 11/11/18 documented a Brief Interview for Mental Status (BIMS) score of 8, which indicated a moderate cognitive impairment. The resident

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performed his/her Activities of Daily Living (ADLs) independently.

The quarterly MDS dated 2/8/19 documented a BIMS score of 8, which indicated a moderate cognitive impairment. The resident performed his/her Activities of Daily Living (ADLs) independently.

The ADL Care Area Assessment (CAA) dated 11/15/18 documented the resident performed his/her ADLs independently.

The revised Care Plan dated 3/5/19 lacked advanced directive documentation.

The Physician's Order Sheet (POS) dated 3/5/19 documented Do Not Resuscitate (DNR-an order to withhold resuscitative measures).

On 3/6/19 at 2:13 PM the resident's paper record lacked a DNR consent form signed by the resident and physician, a Transportable Physician Order for Patient Preferences form (TPOPP), a Physician Order for Life Sustaining Treatments form (POLST), or Physician Order for Scope of Treatment (POST) for (forms describing residents' wishes for health care in a medical emergency) under the advanced directive tab.

On 3/5/19 at 10:25 AM licensed staff H confirmed the resident's paper record lacked a DNR consent form.

On 3/7/19 at 3:05 PM licensed staff G stated he/she looked for a DNR consent form in the residents' paper chart.

On 3/7/19 at 4:00 PM administrative staff D

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stated a signed DNR consent form is placed under the advanced directive tab in the residents' paper chart and expected the directive to match the physician's order.

The facility's Advanced Directive Policy dated January 2018 documented the advanced directives, Cardiopulmonary Resuscitation (CPR-procedure to support and maintain breathing and circulation when a person's respirations and heart have stopped) wishes and the treatment wishes of the resident are documented to the facility staff via the comprehensive care plan, POS, and POLST, POST, and TPOPP forms.

The facility failed to clearly identify the expressed choices to initiate resuscitative measures for this resident.

- The Electronic Medical Record for resident #9 documented diagnoses of schizophrenia (psychotic disorder characterized by gross distortion of reality, disturbances, of language, communication, and fragmentation of thought), and depression (abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness, and emptiness).

The admission Minimum Data Set (MDS) dated 11/11/18 documented a Brief Interview for Mental Status (BIMS) score of 15, which indicated intact cognition. The resident required total facility staff assistance for his/her Activities of Daily Living (ADLs).

The quarterly MDS dated 3/5/19 documented a BIMS score of 13, which indicated intact cognition. The resident required total facility staff

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assistance for his/her ADLs.

The advanced directive (oral and written instructions about future medical care in the event the resident was unable to express his/her medical wishes) care plan dated 3/5/19 documented the resident wanted a Do Not Resuscitate (DNR-an order to withhold resuscitative measures) directive.

On 3/5/19 at 10:25 AM the resident's paper record lacked a DNR consent form signed by the resident and physician, a Transportable Physician Order for Patient Preferences form (TPOPP), a Physician Order for Life Sustaining Treatments form (POLST), or Physician Order for Scope of Treatment (POST) form (forms describing residents' wishes for health care in a medical emergency) under the advanced directive tab.

On 3/5/19 at 10:25 AM licensed staff H confirmed the resident's paper record lacked a DNR consent form.

On 3/7/19 at 3:05 PM licensed staff G stated he/she looked for a DNR consent form in the resident's paper chart.

On 3/7/19 at 4:00 PM administrative staff D stated the paper chart contained a signed DNR consent form under the advanced directive tab and expected the directive to match the physician's order.

The facility's Advanced Directive Policy dated January 2018 documented the advanced directives, Cardiopulmonary Resuscitation (CPR-procedure to support and maintain breathing and circulation when a person's

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respirations and heart have stopped) wishes and the treatment wishes of the resident are documented to the facility staff via the comprehensive care plan, POS, and POLST, POST, and TPOPP forms.

The facility failed to clearly identify the expressed choices to initiate resuscitative measures for this resident.

- The Electronic Medical Record (EMR) for resident #23 documented diagnoses of schizophrenia (psychotic disorder characterized by gross distortion of reality, disturbances, of language, communication, and fragmentation of thought), peripheral vascular disease (abnormal condition affecting the blood vessels), mild cognitive impairment, and delusional disorder (untrue persistent belief or perception held by a person although evidence shows it was untrue).

The significant change Minimum Data Set (MDS) dated 7/18/18 documented a Brief Interview for Mental Status (BIMS) score of 7, which indicated severe cognitive impairment. The resident required facility staff supervision to limited assistance with his/her Activities of Daily Living (ADLs).

The quarterly MDS dated 12/31/18 documented a BIMS score of 7, which indicated severe cognitive impairment. The resident required facility staff supervision to limited assistance with his/her ADLs.

The cognitive Care Area Assessment (CAA) dated 7/18/18 documented the resident had impaired daily decision- making ability and cognition.

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The revised Care Plan dated 3/5/19 lacked advanced directive (oral and written instructions about future medical care in the event the resident was unable to express his/her medical wishes) documentation.

The Physician's Order Sheet (POS) lacked Advanced Directive documentation.

The resident's paper record documented a Do Not Resuscitate (DNR-an order to withhold resuscitative measures) directive dated 3/9/16, signed by the resident's guardian, with no physician signature noted. The Transportable Physician Order for Patient Preferences form (TPOPP), signed by the guardian on 12/6/17 and the physician on 12/12/17, documented the resident wished cardiopulmonary resuscitation (CPR-emergency medical procedure for restoring normal heartbeat and breathing to victims of heart failure, drowning, etc.). The DNR document did not have a revocation signature.

On 3/6/19 at 11:04 AM administrative nursing staff D stated the two contradicting forms should not be in the paper record.

On 3/7/19 at 11:26 AM social services staff X stated the resident's guardians are not allowed to make advanced directive decisions for the residents.

The facility's Advanced Directive Policy dated January 2018 documented the advanced directives, CPR, and the treatment wishes of the resident are documented to the facility staff via the comprehensive care plan, POS, and TPOPP forms.

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F 578	Continued From page 7 The facility failed to clearly identify the expressed choices to initiate resuscitative measures for this resident.	F 578		
F 585 SS=F	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident. §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally	F 585		

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(meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system;
(ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations;
(iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated;
(iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law;
(v) Ensuring that all written grievance decisions include the date the grievance was received, a

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summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued;
(vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and
(vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision.
This REQUIREMENT is not met as evidenced by:
The facility identified a census of 38 residents. The sample included 31 residents. Based on observation, record review, and interview the facility failed maintain a grievance log and to ensure the right of the residents to file a grievance anonymously.

Findings included:

- Observations on 03/06/19 2:14 PM revealed surveyors were unable to locate a discrete location where grievances could be completed and turned in anonymously.

An interview on 03/06/19 at 3:00 PM with the resident council revealed the residents did not know how to obtain a grievance form without

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asking for one or how to formally file a grievance anonymously within the facility.

An interview on 03/07/19 at 2:47 PM with activities staff Z revealed residents could "go to any department head to file a grievance" and that "most complaints are handled with no paper trail." Activities staff Z reported that grievances were directed to and/or turned into the social worker. Activities staff A stated that he/she did have grievance forms but did not realize activities had grievance forms until the survey was in process. Activities staff A reported that most complaints or concerns were handled through Quality Assurance Performance Improvement (QAPI) and that resolutions to those concerns or complaints were not documented, leaving little to no paper trail for grievances.

An interview on 03/06/19 at 3:26 PM with social services staff X revealed staff completed the grievance forms and turned them into the appropriate department; during business hours the forms were turned into the administrator, director of nursing (DON), or the social worker. Grievance forms were kept in the nurse's office in a file cabinet and must be requested from staff and could be slid under the door of the administrator or social worker. Social services staff X stated that residents could verbally complain and that after three times of repeated complaints, the complaint became a grievance. Complaints were monitored through resident council and grievances were monitored through care plans. Some complaints would be in the form of nursing notes or social worker's notes and were put on a 24-hour sheet for review and were monitored through QAPI. Social service staff X confirmed that there was no grievance log.

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An interview on 03/07/19 at 4:24 PM with administrative nursing staff D revealed that grievance forms were kept in a file located in a desk drawer at the nurse's station, the social worker's office, or in the administrator's office. Residents could request a grievance form from any of those staff members. Administrative nursing staff D reported that residents completed the form independently, staff assisted resident's in completing the grievance, or residents were directed to the social worker for complaints/grievances. After completion, grievance forms were turned over to the administrator or to the social worker. When asked if there was a discrete location where residents could file a grievance, administrative nursing staff D reported that the grievance forms could be filed anonymously if the staff member placed the form inside the administrator or social worker's mail box located in the copy room. Administrative nursing staff D also stated the grievance forms could be placed under the door of the administrator or social worker and that family could mail a form if they wanted it to be anonymous. When asked for a grievance log, administrative nursing staff D reported that the social worker would have those logs and that he/she was unaware of any grievance logs.

The facility's grievance/complaint report form (undated) stated that grievances/complaints could be filed with the administrator without fear of threat or reprisal of any form, and instructed to complete, date, sign, and submit the form to the social services department. The form read that the filer would be provided with an oral and written report of the facility's findings within ten (10) working days of the date of the report. The

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facility's grievance/complaint form lacked instruction on how to file a grievance anonymously

The facility's admission packet (undated) requested that residents share concerns with appropriate staff, such as the Charge Nurse, Social Service Director, Department Manager, Administrator, or the Director of Nursing. The admission packet informed residents that if voiced concerns were not addressed, residents could then file a written grievance and administration would respond to concerns with results of follow up related to the issues. The information in the facility's admission packet lacked documentation and instruction regarding the residents right to file a grievance anonymously.

The facility's grievance/complaint policy dated 9/96 requested residents and their representatives to follow the procedures outlined in the policy when filing a grievance or complaint. The policy instructed to obtain a grievance form from the nurse's station, answer all questions accurately, sign and date the form, then give the form to the administrator or to the social services department. The policy instructed that if administrative staff were unavailable, the form could be turned into the charge nurse or slid under the door of the appropriate staff member. The policy designated the social services department for handling/investigating complaints/grievances, and that the filer would be informed of the results of the investigation within five (5) working days. Should there be a disagreement regarding the results of the investigation, a meeting could be scheduled with the administrator or the complaint/grievance

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F 585	Continued From page 13 could be filed "with any of the agencies listed on the resident's bulletin board." The policy read, "It is the policy of this facility to assist you in filing a grievance or complaint." The policy lacked documentation and instruction regarding the residents right to file a grievance anonymously. The facility failed to maintain a grievance log and to ensure the right of the residents to file a grievance anonymously.	F 585		
F 623 SS=D	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when-	F 623		

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(A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section;
(B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;
(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;
(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or
(E) A resident has not resided in the facility for 30 days.

§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:
(i) The reason for transfer or discharge;
(ii) The effective date of transfer or discharge;
(iii) The location to which the resident is transferred or discharged;
(iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;
(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;
(vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part

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F 623	Continued From page 15 C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: The facility identified a census of 38 residents. The sample included 31 residents. Based on observations, interviews, and record reviews the facility failed to provide written notification to the office of the state Long-Term Care Ombudsman for 2 (#26 and #41) of 2 residents sampled for hospitalization. Findings included:	F 623		

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- The Electronic Medical Record (EMR) for resident #26 documented diagnoses of Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure), skin cancer, hypertension (elevated blood pressure), anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), and depression (abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness, emptiness, and hopelessness).

The admission Minimum Data Set dated 10/19/18 documented the resident had severe cognitive impairment. The resident required extensive to total staff assistance with his/her Activities of Daily Living (ADLs.). The resident did not have any falls during the look back period.

The quarterly MDS dated 1/24/19 documented the resident had severe cognitive impairment. The resident required limited to extensive facility staff assistance for his/her ADLs. The resident had 2 or more non-injury falls during the look back period.

The ADL Care Area Assessment (CAA) dated 10/19/18 documented the resident had a decline in his/her ADL capabilities.

The Fall Care Plan dated 11/28/18 documented the facility staff encouraged the resident to ask for assistance with cares and instructed him/her on the proper use of adaptive equipment.

The nursing progress note dated 10/8/18 documented the resident transferred to the

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hospital for surgical correction of a broken right hip.

The EMR lacked documentation of the notification, for the resident's discharge to the hospital, to the state Long-Term Care Ombudsman.

On 3/5/19 at 4:23 PM the resident ambulated down a hallway, using a 4 wheeled walker.

On 3/7/19 at 11:26 AM social services staff X stated the facility failed to notify the ombudsman of the resident's discharged to the hospital.

The facility's Transfer and Discharge Policy dated October 2017 documented before the facility transferred or discharged a resident, social services, notified a representative of the Office of the State Long-Term Care Ombudsman.

The facility failed to notify the Ombudsman of the transfer for this resident who required hospitalization.

- The Electronic Medical Record for resident #41 documented diagnoses of schizophrenia (psychotic disorder characterized by gross distortion of reality, disturbances of language and communication and fragmentation of thought), arthritis (inflammation of a joint characterized by pain, swelling, heat, redness, and limitation of movement), and anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear).

The annual Minimum Data Set (MDS) dated 9/28/18 documented a Brief Interview for Mental Status (BIMS) score of 3, which indicated severe

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F 623	Continued From page 18 cognitive impairment. The resident required extensive to total staff assistance for his/her Activities of Daily Living (ADLs). The quarterly MDS dated 12/21/18 documented a BIMS score of 3, which indicated severe cognitive impairment. The resident requires extensive to total staff assistance for his/her Activities of Daily Living (ADLs). The cognition Care Area Assessment dated 9/28/18 lacked documentation. The nursing progress note dated 1/31/19 at 12:43 AM documented the resident transferred to the hospital for an elevated pulse and temperature. On 3/7/19 at 11:26 AM social services staff X stated the facility failed to notify the ombudsman of the resident's discharged to the hospital. The facility's Transfer and Discharge Policy dated October 2017 documented before the facility transferred or discharged a resident, social services, notified a representative of the Office of the State Long-Term Care Ombudsman. The facility failed to notify the Ombudsman of the transfer for this resident who required hospitalization.	F 623		
F 636 SS=D	Comprehensive Assessments & Timing CFR(s): 483.20(b)(1)(2)(i)(iii) §483.20 Resident Assessment The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.	F 636		

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§483.20(b) Comprehensive Assessments
§483.20(b)(1) Resident Assessment Instrument.
A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following:
(i) Identification and demographic information
(ii) Customary routine.
(iii) Cognitive patterns.
(iv) Communication.
(v) Vision.
(vi) Mood and behavior patterns.
(vii) Psychological well-being.
(viii) Physical functioning and structural problems.
(ix) Continence.
(x) Disease diagnosis and health conditions.
(xi) Dental and nutritional status.
(xii) Skin Conditions.
(xiii) Activity pursuit.
(xiv) Medications.
(xv) Special treatments and procedures.
(xvi) Discharge planning.
(xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS).
(xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts.

§483.20(b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this

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chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs.
(i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or therapeutic leave.)
(iii)Not less than once every 12 months.
This REQUIREMENT is not met as evidenced by:
The facility identified a census of 38 residents. The sample included 31 residents. Based on record review, observations and interview, the facility failed to complete the Care Area Assessment (CAA) 14 days after transmission of the MDS for 2 residents (#14 and #26).

Findings Included:

- Resident #14 January 2019 physician order sheet documented diagnoses that included: hypothyroidism (condition characterized by decreased activity of the thyroid gland), bipolar disorder (major mental illness that caused people to have episodes of severe high and low moods), depression (Abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness and emptiness), and hypertension (elevated blood pressure).

The Significant change MDS assessment, dated 11/20/18, documented a BIMS score of 12 which indicated intact cognition.

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The Cognitive Loss care area assessment (CAA), dated 11/20/18 triggered, but was not care planned.

Review of the resident's MDS assessment reference date (ARD) revealed that the Significant change MDS with the ARD date of 11/20/18 was completed and transmitted timely, but the CAA was not completed until 12/18/18.

On 3/4/19 at 3:30 PM, administrative nursing staff D confirmed the MDS was late being completed and transmitted.

The facility's policy "Resident Assessment Instrument and Person-Centered Care Plan", dated 3/18 documented that the MDS was to be completed by the Interdisciplinary Team (IDT) per Resident Assessment Instrument (RAI) guidelines. CMS's RAI instructed staff that the MDS must be submitted within 14 days after the MDS completion date and that the CAA should be completed 14 days after the transmission date of the MDS.

The facility failed to ensure completion of the CAAs within 14 days after the ARD for resident #14.

- Resident #26 January 2019 physician order sheet documented diagnoses that included: Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure), depression (abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness, emptiness and hopelessness), and hypertension (elevated blood pressure).

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F 636	Continued From page 22 The Admission MDS assessment, dated 10/19/18, documented staff interview that indicated short and long-term memory problems. The care area assessment (CAA), dated 11/15/18, for activities of daily living documented the resident had trouble finding words. Review of the resident's MDS ARD revealed that the Admission MDS with the ARD date of 10/19/18 was completed and transmitted timely, but the CAA was not completed until 11/15/18. On 3/4/19 at 3:30 PM, administrative nursing staff D confirmed the MDS was late being completed and transmitted. The facility's policy "Resident Assessment Instrument and Person-Centered Care Plan", dated 3/18 documented that the MDS was to be completed by the Interdisciplinary Team (IDT) per Resident Assessment Instrument (RAI) guidelines. CMS's RAI instructed staff that the MDS must be submitted within 14 days after the MDS completion date and that the CAA should be completed 14 days after the transmission date of the MDS. The facility failed to complete CAA data within 14 days after completion of the MDS assessment for resident #26.	F 636		
F 640 SS=E	Encoding/Transmitting Resident Assessments CFR(s): 483.20(f)(1)-(4) §483.20(f) Automated data processing requirement- §483.20(f)(1) Encoding data. Within 7 days after	F 640		

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a facility completes a resident's assessment, a facility must encode the following information for each resident in the facility:
(i) Admission assessment.
(ii) Annual assessment updates.
(iii) Significant change in status assessments.
(iv) Quarterly review assessments.
(v) A subset of items upon a resident's transfer, reentry, discharge, and death.
(vi) Background (face-sheet) information, if there is no admission assessment.

§483.20(f)(2) Transmitting data. Within 7 days after a facility completes a resident's assessment, a facility must be capable of transmitting to the CMS System information for each resident contained in the MDS in a format that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by CMS and the State.

§483.20(f)(3) Transmittal requirements. Within 14 days after a facility completes a resident's assessment, a facility must electronically transmit encoded, accurate, and complete MDS data to the CMS System, including the following:
(i)Admission assessment.
(ii) Annual assessment.
(iii) Significant change in status assessment.
(iv) Significant correction of prior full assessment.
(v) Significant correction of prior quarterly assessment.
(vi) Quarterly review.
(vii) A subset of items upon a resident's transfer, reentry, discharge, and death.
(viii) Background (face-sheet) information, for an initial transmission of MDS data on resident that does not have an admission assessment.

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§483.20(f)(4) Data format. The facility must transmit data in the format specified by CMS or, for a State which has an alternate RAI approved by CMS, in the format specified by the State and approved by CMS.
This REQUIREMENT is not met as evidenced by:
The facility identified a census of 38 residents. The sample included 31 residents. Based on record review, observations and interview, the facility failed to electronically transmit encoded, accurate, and complete Minimum Data Set (MDS) data within 14 days after completion of 3 resident assessments (#29, #9, #14).

Findings Included:

- Resident #29's January 2019 Physician Order Sheet (POS) documented diagnoses that included: hypertension (elevated blood pressure), Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure), anxiety (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear), and depression (abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness, emptiness and hopelessness).

The Annual MDS assessment dated 10/23/18, documented a Brief Interview for Mental Status (BIMS) score of 11 which indicated moderately impaired cognition.

The Cognitive Loss Care Area Assessment (CAA), dated 11/28/18 indicated that resident #29 had memory loss, disorientation, and forgetfulness.

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Review of residents MDS assessment reference date (ARD) revealed that the Annual MDS with the ARD date of 10/23/18 was not completed and transmitted until 12/3/18.

On 3/4/19 at 3:30 PM, administrative nursing staff D confirmed the MDS was late being completed and transmitted.

The facility's policy "Resident Assessment Instrument and Person-Centered Care Plan", dated 3/18 documented that the MDS was to be completed by the Interdisciplinary Team (IDT) per Resident Assessment Instrument (RAI) guidelines. CMS's RAI instructed staff that the MDS must be submitted within 14 days after the MDS completion date.

The facility failed to electronically transmit MDS data within 14 days after completion for resident #29.

- Resident #9's January 2019 physician order sheet documented diagnoses that included: neurogenic bladder (dysfunction of the urinary bladder caused by a lesion of the nervous system), schizophrenia (psychotic disorder characterized by gross distortion of reality, disturbances of language and communication and fragmentation of thought), and depression (abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness, emptiness and hopelessness).

The Quarterly MDS assessment, dated 2/15/19, documented a BIMS score of 13 which indicated intact cognition.

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The CAA, dated 11/19/18, for urinary incontinence documented that an indwelling catheter was in place.

Review of residents MDS assessment reference date (ARD) revealed that the Quarterly MDS with the ARD date of 2/15/19 was not completed and transmitted until 3/5/19.

On 3/4/19 at 3:30 PM, administrative nursing staff D confirmed the MDS was late being completed and transmitted.

The facility's policy "Resident Assessment Instrument and Person-Centered Care Plan", dated 3/18 documented that the MDS was to be completed by the Interdisciplinary Team (IDT) per Resident Assessment Instrument (RAI) guidelines. CMS's RAI instructed staff to that MDS must be submitted within 14 days after the MDS completion date.

The facility failed to electronically transmit MDS data within 14 days after completion for resident #9.

- Resident #14's January 2019 physician order sheet documented diagnoses that included: hypothyroidism (condition characterized by decreased activity of the thyroid gland), bipolar disorder (major mental illness that caused people to have episodes of severe high and low moods), depression (Abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness and emptiness), and hypertension (elevated blood pressure).

The Quarterly MDS assessment, dated 2/18/19, documented a BIMS score of 12 which indicated

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 640	Continued From page 27 intact cognition. The Cognitive Loss CAA, dated 11/20/18 triggered, but was not care planned. Review of the resident's MDS assessment reference date (ARD) revealed that the Quarterly MDS with the ARD date of 2/18/19 was not completed and transmitted until 3/5/19. On 3/4/19 at 3:30 PM, administrative nursing staff D confirmed the MDS was late being completed and transmitted. The facility's policy "Resident Assessment Instrument and Person-Centered Care Plan", dated 3/18 documented that the MDS was to be completed by the Interdisciplinary Team (IDT) per Resident Assessment Instrument (RAI) guidelines. CMS's RAI instructed staff that the MDS must be submitted within 14 days after the MDS completion date. The facility failed to electronically transmit MDS data within 14 days after completion for resident #14.	F 640		
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: The facility identified a census of 38 residents. The sample included 31 residents. Based on observation, interview and record review, the facility failed to complete as accurate Minimum	F 641		

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Data Set (MDS) assessment for one resident sampled for unnecessary medication (#18).

Findings included:

- Resident # 18's January Physician Order Sheet documented diagnoses which included: diabetes type 2 (when the body cannot use glucose, not enough insulin made, or the body cannot respond to the insulin), depressive disorder (abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness, emptiness, and hopelessness) and hypertension (elevated blood pressure).

The Admission MDS assessment dated 12/19/18 documented a Brief Interview for Mental Status Score (BIMS) score of 14 which indicated intact cognition. It indicated that 5 injections were received during the look back period, but no insulin was administered.

The CAA for psychotropic medications dated 12/19/18 indicated the use of psychotropic (class of medications that affect a person's mental state), antidepressant (class of medications used to treat mood disorders and relieve symptoms of depression) and anxiolytic (medication used to reduce anxiety) medications.

The Physician order dated 12/7/18 noted Lantus 35 units to be given daily for diabetes type 2.

Review of the medication administration review noted that the resident received insulin injections 6 out of the 7 days during the look back period.

On 3/7/19 at 5:30 PM, administrative nursing staff D acknowledged that the insulin injections were

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F 641	Continued From page 29 missed. The facility's policy "Resident Assessment Instrument and Person-Centered Care Plan", dated 3/18 documented that the MDS was to be completed by the Interdisciplinary Team (IDT) per Resident Assessment Instrument (RAI) guidelines. The facility failed to develop an accurate MDS assessment which indicated injections received during the look back period for resident #18.	F 641		
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		

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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:
The facility identified a census of 38 residents. The sample included 31 residents. Based on observations, record reviews and interviews, the facility failed to develop a person-centered care plan for resident #14's dental and fall needs and to address resident #29's mental health care needs.

Findings included:

- The Electronic Medical Record (EMR) for resident #14 listed diagnoses of morbid obesity (a person who is over 100 pounds greater then his/her ideal body weight), depression (abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness and emptiness), bipolar disorder (major mental illness that caused people to have episodes of severe high and low moods), neuropathy (a disease or dysfunction of one or more peripheral nerves,

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typically causing numbness or weakness), traumatic brain injury (a nondegenerative , noncongenitally insult to the brain from an external mechanical force), and diabetes mellitus (when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin).

The significant change Minimum Data Set (MDS) dated 11/21/18 documented a Brief Interview for Mental Status (BIMS) score of 12, which indicated moderate cognitive impairment. The resident required extensive assistance of two persons for bed mobility, total assistance of two person for transfers, dressing, bathing, supervisor with set up assistance for eating, total assistance of one person for locomotion on and off the unit, activity of personal hygiene only occurred one to two times and the activity of ambulation and toilet use did not occur during the look back period.

The quarterly MDS dated 3/5/19 documented a BIMS score of 10, which indicated moderate cognitive impairment. The resident required total assistance of two persons for transfer, locomotion on and off unit, dressing, personal hygiene, bathing, extensive assistance of two persons for bed mobility. Ambulation and toilet use did not occur during the look back period.

The Care Area Assessment (CAA) dated 12/18/18 for dental care documented he/she had a broken partial, needed assistance with activities of daily living (ADLs), was very slow with eating, had behaviors and refused care.

The care plan lacked any documentation of dental issues.

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On 3/4/19 at 3:39 P.M. resident #14 reported he/she had concerns related to his/her missing teeth and broken partials.

On 3/5/19 at 4:34 P.M. sat in a wheelchair in the main dining room eating supper without any difficulty.

On 3/7/19 at 2:32 P.M. interview with social service staff X stated resident #14 admitted to the facility with broken partial and missing teeth, he/she saw a dental hygienist. The dental group was checking to see if the partial can be repaired.

On 3/7/19 at 4:00 P.M. interview with licensed administrative staff member D stated that baseline care plan was completed by social services but now it is completed by MDS coordinator, revision should be completed as necessary and quarterly.

The facility policy titled Resident Assessment Instrumental Person-Centered Care Planning dated 3/7/19 documented the comprehensive care plan will be developed to ensure the resident received the desired care and services to attain or maintain their highest practicable physical, mental and psychosocial well-being.

The facility failed to develop and implement a comprehensive person-centered care plan for resident #14 addressing the resident's dental issues.

-The Electronic Medical Record (EMR) for resident #29 listed diagnoses of hallucinations (sensing things while awake that appear to be real, but the mind created), schizoaffective disorder (psychotic disorder characterized by

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gross distortion of reality, disturbances of language and communication and fragment of thought), insomnia (inability to sleep), depression (abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness and emptiness), and anxiety (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear).,

The admission Minimum Data Set (MDS) dated 10/9/18 documented a Brief Interview for Mental Status (BIMS) score of 11, which indicated moderate cognitive impairment. The resident required facility staff supervision for his/her Activities of Daily Living (ADLs). The resident received an anxiolytic (medications used to treat anxiety) and an antidepressant (medications used to treat depression) 7 of 7 days in the look back period.

The quarterly MDS dated 1/18/19 documented a BIMS score of 11, which indicated moderate cognitive impairment. The resident required supervision to limited facility staff assistance for his/her ADLs. The resident received an anxiolytic and an antidepressant 7 of the 7 days in the look back period.

The cognitive Care Area Assessment (CAA) dated 11/28/18 documented the resident had memory loss, confusion, disorientation, and forgetfulness.

The care plan dated 11/28/18 lacked documentation for the resident's diagnoses of schizoaffective disorder, depression, or anxiety.

The Physician's Order Sheet (POS) documented orders for Citalopram (medication to treat

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depression) 30 milligrams (mgs.) orally daily on 10/9/18 and Wellbutrin (medication to treat depression) 150mgs. orally daily dated 1/2/19.

On 3/6/19 at 10:30 AM the resident sat upright in his/her bed displaying no outward signs of depression, anxiety, or hallucinations.

On 3/7/19 at 3:05 PM licensed staff G stated care plans are developed by the nurses, director of nursing, or the MDS coordinator.

On 3/7/19 at 4:00 PM administrative staff D stated the social services designee had previously initiated the baseline care plans and they are currently done by the MDS coordinator He/she would expect a care plan for depression, anxiety, schizophrenia, and/or behavioral issues.

The Resident Assessment Instrument and Person-Centered Care Planning policy dated March 2018 documented a comprehensive care plan is developed to ensure the resident receives the desired care and services to attain or maintain their highest practicable physical, mental, and psychosocial well- being.

The facility failed to develop a comprehensive care plan with interventions to address the resident's mental health care needs.

- Resident #14's January 2019 physician order sheet documented diagnoses which included: morbid obesity (a person who is over 100 pounds greater than his/her ideal body weight), depression (abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness and emptiness), bipolar disorder (major mental illness that caused people

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to have episodes of severe high and low moods), neuropathy (a disease or dysfunction of one or more peripheral nerves, typically causing numbness or weakness), traumatic brain injury (a nondegenerative, noncongenitally insult to the brain from an external mechanical force), and diabetes mellitus (when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin).

The significant change Minimum Data Set (MDS) dated 11/21/18 for resident #14 documented a Brief Interview for Mental Status (BIMS) score of 12, which indicated moderate cognitive impairment. The resident required extensive assistance of two person for bed mobility, total assistance of two persons for transfer, dressing, bathing, total assistance of one person for locomotion on and off the unit. Resident #14 did not ambulate during the look back period. The resident had a fall prior to admission and no falls since admission.

The quarterly MDS dated 3/5/19 for resident #14 documented a BIMS score of 10, which indicated moderate cognitive impairment. The resident required total assistance of two persons for transfers, locomotion on and off unit, dressing, personal hygiene, bathing, extensive assistance of two person for bed mobility. Ambulation and toilet use did not occur during the look back period. The resident had 2 or more falls without major injury since prior assessment

The Care Area Assessment (CAA) for falls, dated 11/21/18, triggered but lacked analysis of findings.

The CAA for Activities of Daily Living, dated

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11/21/18, noted a decline in behavior and to continue care plan.

The care plan dated 12/18/18 lacked any fall prevention strategies.

The fall investigation dated 12/25/18 revealed the resident was found on the floor in his/her room. The resident reported he/she was going to walk. The fall investigation documented that staff would reorient the resident to the call light system and to contact staff prior to transferring at all times due to use of Hoyer lift.

The fall investigation dated 1/25/19 revealed the resident was found sitting on the floor in his/her room. The fall investigation documented an intervention to reorient to call light system, education on risks of transferring his/her self without staff.

The fall investigation dated 2/11/19 revealed the resident transferred self out of bed. The fall investigation documented an intervention of physical and occupational therapy screen.

The fall investigation dated 2/20/19 revealed the resident reached for water on bedside table, fell and obtained an abrasion on right knee. The fall investigation documented staff educated the resident on call light use, and the need to wait for staff assistance prior to all transfers. The direct care staff was educated to maintain bed in lowest position.
On 3/5/19 at 4:34 PM the resident sat in his/her wheelchair with foot pedals at the dining room table.

On 3/6/19 at 8:05 AM the resident was lying on

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F 656	Continued From page 37 his/her right side in bed with quarter rails up and the call light in reach. On 3/7/19 at 11:30 AM, direct care staff O reported that the resident wanted to stay in bed due to the resident being tired. On 3/7/19 at 1:30 PM administrative nursing staff D stated that the falls have been reviewed and an initial intervention is added to the Certified Nurses Aids care sheets every day that we have an Interdisciplinary Team meeting (IDT). The facility's policy "Resident Assessment Instrument and Person-Centered Care Planning" dated 3/18 directed staff that the care plan will be developed to ensure the resident receives the desired care and services to attain or maintain their highest practicable physical, mental and psychosocial well-being. It further directed staff to revise the care plan as often as necessary to ensure that it provides and accurate depiction of care for the resident. The facility failed to develop a comprehensive person-centered care plan for falls to prevent further falls from happening for resident #14.	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.	F 657		

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(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:
The facility identified a census of 38 residents. The sample included 31 residents. Based on observations, interviews, and record review the facility failed to identify and implement interventions through the comprehensive care plan to address resident (#6's) mental health needs.

-The Electronic Medical Record (EMR) for resident #6 listed diagnoses of schizoaffective disorder (psychotic disorder characterized by gross distortion of reality, disturbances of language and communication and fragment of thought), anxiety (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear), unspecified psychosis (any major mental disorder characterized by a gross impairment in reality testing), post- traumatic

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stress disorder ((PTSD-psychiatric disorder characterized by an acute emotional response to a traumatic event or situation involving severe environmental stress, such as natural disaster, military combat, serious automobile accident, airplane crash or physical torture), and borderline personality disorder (disorder characterized by disturbed and unstable interpersonal relationships and self-image along with impulsive, reckless, and often self-destructive behavior).

The admission Minimum Data Set (MDS) dated 5/6/18 documented the resident had a Brief Interview for Mental Status (BIMS) score of 15, which indicated intact cognition. The resident did not display behavioral disturbances. The resident performed his/her Activities of Daily Living (ADLs) independently with some facility staff supervision. The resident received an antipsychotic (medications used to treat psychosis), an anxiolytic (medications used to treat anxiety) and an antidepressant (medications used to treat depression) 7 of 7 days in the look back period.

The quarterly MDS dated 10/30/18 documented the resident had a BIMS score of 15, which indicated intact cognition. The resident did not display behavioral disturbances. The resident required facility staff supervision to limited assistance with his/her ADLs. The resident received antipsychotic, anxiolytic, and antidepressant medications 7 of 7 days in the look back period.

The psychotropic drug use Care Area Assessment dated 5/7/18 documented the resident had received psychoactive medications (medications to treat psychosis, depression, and anxiety) for many years. The resident's condition

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F 657	Continued From page 40 was currently stable. The behavioral care plan dated 5/8/18 documented the resident had anxiety and depression. The facility staff offered reassurance and encouragement to the resident when he/she displayed verbal outbursts. The nursing progress note dated 1/28/19 at 7:27 PM documented the resident felt suicidal and facility staff obtained an order to send him/her to the hospital for evaluation. On 3/7/19 at 4:00 PM administrative staff D stated the residents' care plans were revised quarterly and as necessary when new concerns arise. The Resident Assessment Instrument and Person-Centered Care Planning policy dated March 2018 documented the care plans are revised as often as necessary to ensure that is provides an accurate depiction of the care of the resident. The care plan is an evolving document that is updated continuously as care needs change. The facility failed to develop a comprehensive care plan with interventions to address the resident's (#6) mental health needs.	F 657		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such	F 695		

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care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart.
This REQUIREMENT is not met as evidenced by:
The facility identified a census of 38 residents. The sample included 31 residents. Based on observation, record review, and interview the facility failed to provide necessary respiratory care and services for 1 resident reviewed for respiratory care. Resident #31 required continuous positive airway pressure (CPAP).

Findings included:

- The electronic medical record (EMR) for resident #31 documented diagnoses of shortness of breath, anemia (a condition in which there are not enough healthy red blood cells to carry adequate oxygen to the body's tissues), chronic obstructive pulmonary disease (COPD, a progressive lung disease), and obstructive sleep apnea (a condition in which breathing stops involuntarily for brief periods of time during sleep).

The Admission Minimum Data Set (MDS) dated 01/29/19 documented a Brief Interview for Mental Status (BIMS) score of 12 which indicated intact cognition. Resident #31's functional status required set up help for eating and limited to extensive assistance of 1-2 staff members for activities of daily living (ADL's). Resident #31 had a range of motion impairment of both arms and legs and required the use of oxygen and a non-invasive mechanical ventilator or continuous positive airway pressure (CPAP) therapy.

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The Care Area Assessment (CAA) for ADL function dated 02/12/19 that lacked further details and information.

The Care Plan dated 02/05/19 documented resident #31 required prompting and the encouragement of staff to wear the CPAP at night.

Review of the 'order summary report' for active orders as of 01/14/19 lacked acknowledgment by nursing staff of the physician's order for resident #31 to use CPAP at night per home settings. There were check marks on the order summary report that showed nursing staff checked the physician orders; however, the order for the CPAP was left blank without a checkmark to indicate that
nursing staff checked the order.

Review of resident #31's admission inventory list revealed the resident had a CPAP machine with a case.

Review of the nursing admission worksheet/checklist for resident #31 dated 01/16/19 was incomplete and lacked documentation that nursing staff completed the section for 'missing physician orders' and the nursing admission worksheet, showing they did not complete the admission checklist to ensure all orders were correct and in place.

Record review revealed a physician's order dated 01/16/19 for CPAP at night using resident's home settings.

Record review revealed a physician order (signed by physician) in the chart on 01/16/19 to clean the

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resident's CPAP machine and mask once weekly on Friday nights starting on 01/16/19.

Record review documented a physician's order on 02/12/19 to increase Resident #31's supplemental oxygen from 2 liters to 3 liters per nasal cannula due to oxygen saturation of 89-92% on 2 liters of oxygen.

Record review documented a physician's order on 02/19/19 to increase Lasix (a medication that pulls excess fluid from the body) from 20mg to 40mg daily for increased edema (fluid) in both legs and increased shortness of breath.

A physician's order on 02/18/19 directed staff to titrate oxygen to 4 liters per nasal cannula to keep oxygen saturation levels above 90%.

Record review of resident #31's oxygen saturation levels varied throughout all shifts between 02/18/19 through 03/07/19 between 90-97% on 3-4 liters of oxygen per nasal cannula.

Record review of the medication and treatment administration record did not reflect the physician's order for resident #31 to wear a CPAP at night and lacked documentation of the resident's use of the CPAP between the date of admission 01/16/19 and 03/07/19.

A nurse's note on 02/22/19 at 01:17 AM documented the resident was sleeping with the mask on.

A nurse's note on 02/24/19 at 09:59 AM documented that resident's oxygen saturation was 97% on 3 liters of oxygen per nasal cannula.

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An observation on 03/06/19 at 11:56 AM revealed a CPAP machine and mask set up on the night stand next to resident #31's bed.

An interview on 03/04/19 at 02:51 PM with resident #31 revealed that the resident was on continuous supplemental oxygen. Resident #31 reported that he/she used a CPAP at home, but did not use the CPAP at night while staying in the facility.

An interview on 03/06/19 at 05:32 PM with direct care staff O revealed that he/she was unaware that resident #31 had anything other than supplemental oxygen per nasal cannula to help with breathing at night while asleep.

An interview on 03/06/19 at 05:56 PM with direct care staff M and N revealed they prepared resident #31 for bed at night by making sure the resident had supplemental oxygen at night and reported resident #31 did not use the CPAP and revealed they did not know what the machine was for, stating they thought it might be a "machine used for breathing treatments or something."

An interview on 03/07/19 at 08:36 AM with nursing staff I revealed resident #31 was on continuous supplemental oxygen and was unable to confirm any other information without reviewing resident's chart.

An interview on 03/07/19 at 08:38 AM with administrative nursing staff D stated that resident #31 has short term memory problems that vary and worsened with the severe anemia, but the resident was able to put the CPAP on independently. Administrative nursing staff D confirmed the physician's order on 01/16/19 did

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F 695	Continued From page 45 not get transcribed when the resident admitted to the facility. Administrative nursing staff D confirmed that two nurses check new medication orders against the medication administration record only and the director of nursing reviewed the admission checklist that the nurses sign to ensure completion of the admission process. On 03/07/19 at 09:12 AM the facility was unable to provide the ordered settings for resident #31's CPAP. On 03/07/19 at 12:38 PM administrative nursing staff D confirmed the facility did not have a copy of resident #31's CPAP settings and confirmed the facility did not know what the CPAP should have been. The facility's oxygen policy last revised on 09/16 lacked information regarding the use of CPAP therapy. The facility failed to provide necessary respiratory care and services for resident #31 who required CPAP for sleep apnea.	F 695		
F 732 SS=E	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and	F 732		

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unlicensed nursing staff directly responsible for resident care per shift:
(A) Registered nurses.
(B) Licensed practical nurses or licensed vocational nurses (as defined under State law).
(C) Certified nurse aides.
(iv) Resident census.

§483.35(g)(2) Posting requirements.
(i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift.
(ii) Data must be posted as follows:
(A) Clear and readable format.
(B) In a prominent place readily accessible to residents and visitors.

§483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard.

§483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.
This REQUIREMENT is not met as evidenced by:
The facility identified a census of 38 residents. The sample included 31 residents. Based on record review, observation and interview the facility failed to post and retain the Full Time Equivalent (FTE) total number of hours worked for June 6, 2018 through November 30, 2018, 176 days and include the facility census.

Findings included:

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F 732	Continued From page 47 - On 3/5/19 at 2:15 PM, unable to locate posted nursing hours during facility tour. Review of the nursing schedule form 6/7/18 to 3/5/19 revealed 7 months that lacked any documentation with correct posted hours worked in the facility or the number of residents being cared for. On 3/7/19 at 3:22 PM, administrative nursing staff D acknowledged that there were no posted nursing hours prior to be requested and that he/she was aware the posted hours were to be kept on file. The facility's protocol "Nurse Staff Posting Protocol", dated 9/11 documented that the form is to be posted 24 hours a day, 7 days a week and directed staff to retain this daily posted form for a minimum of 18 months from the date posted. The facility failed to post the FTE hours worked by licensed and unlicensed nursing staff directly responsible for resident care per shift and indicate the number of residents in the facility.	F 732		
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	F 756		

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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.

§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:
The facility identified a census of 38 residents. The sample included 31 residents, 5 residents were reviewed for unnecessary medication. Based on record review, observation and interview, the facility failed to ensure that the pharmacist noted the missed documentation for pain monitoring and behavior monitoring for 2 residents (#24 and #23).

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Findings Included:

-Resident #24's January physician order sheet documented diagnoses that included: dysphasia (swallowing difficulty), anxiety (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear), major depression disorder (major mood disorder), and impulse disorder (lack of self-control).

The Annual Minimum Data Set (MDS) assessment, dated 4/25/18, documented a Brief Interview for Mental Status (BIMS) score of 99 which indicated severely impaired cognition. Resident received antidepressants (class of medications used to treat mood disorders and relieve symptoms of [depression- abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness and emptiness]) 7 out of 7 days during the look back period, he/she was not having pain and did not receive scheduled pain medication but did receive pain medicine as ordered. There were no behaviors noted.

The Quarterly MDS assessment dated 1/11/19 documented the same information for BIMS and antidepressant medication. The pain interview was done, the resident was noted to have pain but rarely and the resident had scheduled pain medication. The resident was noted to have behaviors towards others 1 to 3 days during the look back period and behaviors of acting out 4 to 6 days during the look back period.

The Care Area Assessment (CAA), dated 4/25/18, for cognition documented that the resident had wandering behaviors and impaired cognitive decision-making ability that required

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staff to cue and supervise for all cares.

The CAA for behaviors, dated 4/25/18, documented the resident had a history of impulsive disorder and would sit for a few minutes and then get up and wander.

The care plan dated 4/25/18 directed staff to redirect and reduce stress and to provide small daily decisions. It also directed staff to administer medications as ordered and observe for side effects and effectiveness.
The care plan dated 1/28/19 directed staff to note character of pain.

The nurses order dated 12/6/17 antidepressant (class of medications used to treat mood disorders and relieve symptoms of [depression-abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness and emptiness]) targeted behavior for Lexapro on every shift.

The nurses order dated 5/11/17 to record pain level on every shift.

Review of the treatment administration record from July 1, 2018 to March 4, 2019 noted missed opportunities of documented pain assessment for 35 times.

Review of the treatment administration record from July 1,2018 to March 4, 2019 noted missed opportunities of documented antidepressant behavior monitor 34 times.

On 3/6/19 at 8:10 AM, resident noted to ambulate into the T.V. room and sit down on the couch.

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On 3/7/19 at 2:44 PM, resident was noted to come out of his/her room to get a snack off the snack tray.

On 3/7/19 at 3:05 PM, licensed nursing staff G stated the computer will give a report on the missed items on the medication administration review and treatment administration review. He/she further revealed that administration did an audit and talked to the nursing staff about the missed documentation.

On 3/7/19 at 4:30 PM, administrative staff A stated that he/she was not aware of missed documentation, and it had not been talked about in quality assurance/performance improvement (QAPI).

Unable to obtain pharmacist consultant interview due to unavailability.

The facility policy "Pain Recognition and Management Protocol" dated 9/17 directed staff to chart the resident's daily pain level in the electronic computer system.

The facility policy "Timeliness of Medication Regimen Review" dated 5/18 lacked direction for pain monitoring, antidepressant side effect or antidepressant behaviors.

The facility's policy "Psychoactive Medication Protocol" dated 9/17 directed staff to enter the appropriate target behaviors in the appropriate electronic computer system treatment administration review folder and begin documenting every shift.

The facility failed to ensure that the pharmacist

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acknowledged missed documentation for pain monitoring, antidepressant side effect monitoring, and antidepressant behavioral monitoring for resident #24.

- Resident #23's January 2019 physician order set document diagnoses of schizophrenia (psychotic disorder characterized by gross distortion of reality, disturbances, of language, communication, and fragmentation of thought), peripheral vascular disease (abnormal condition affecting the blood vessels), mild cognitive impairment, and delusional disorder (untrue persistent belief or perception held by a person although evidence shows it was untrue).

The significant change Minimum Data Set (MDS) dated 7/18/18 documented a Brief Interview for Mental Status (BIMS) score of 7, which indicated severe cognitive impairment. The resident required facility staff supervision to limited assistance with his/her Activities of Daily Living (ADLs). Resident was noted to receive antipsychotic (class of medications used to treat psychosis, any major mental disorder characterized by a gross impairment in reality testing, and other mental emotional conditions), antianxiety (class of medications that calm and relax people with excessive anxiety, mental or emotional reaction characterized by apprehension, uncertainty and irrational fear, nervousness, or tension), antidepressant (class of medications used to treat mood disorders and relieve symptoms of depression- abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness and emptiness) and anticoagulant (blood thinner) medication 7 out of 7 days during the look back period. The resident interview stated no pain

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without scheduled or as needed pain medication.

The quarterly MDS dated 12/31/18 documented a BIMS score of 7, which indicated severe cognitive impairment. The resident required facility staff supervision to limited assistance with his/her ADLs. Resident received antianxiety, antidepressant and anticoagulant medication 7 out of 7 days during the look back period. The resident interview stated no pain without scheduled or as needed pain medication.
The cognitive Care Area Assessment (CAA) dated 7/18/18 documented the resident had impaired daily decision- making ability and cognition.

The Care Plan dated 4/23/18 directed staff to monitor for side effects, assess physical symptoms, medication effectiveness and medication side effects and to notify medical director if pain was not controlled.

The nurses order dated 7/23/17 directed staff to monitor antidepressant targeted behavior for Lexapro on every shift.

The nurses order dated 7/23/17 to record pain level on every shift.

The nurses order dated 7/23/17 antipsychotic targeted behavior for Depakote on every shift.

The nurses order dated 7/23/17 antianxiety targeted behavior for Buspar on every shift.

The nurses order dated 4/19/18 antidepressant targeted behavior for Remeron on every shift.

Review of the treatment administration record

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from July 1, 2018 to March 4, 2019 noted missed opportunities of documented pain assessment for 38 times.

Review of the treatment administration record from July 1,2018 to March 4, 2019 noted missed opportunities of documented behavior monitoring for Depakote 39 times.

Review of the treatment administration record from July 1,2018 to March 4, 2019 noted missed opportunities of documented behavior monitoring for Lexapro 39 times.

Review of the treatment administration record from July 1,2018 to March 4, 2019 noted missed opportunities of documented behavior monitoring for Remeron and Buspar 39 times.

Review of the treatment administration record from July 1,2018 to March 4, 2019 noted missed opportunities of documented behavior monitoring for Remeron 39 times.

Review of the medication reconciliation review for November 2018 to February 2019 lacked identification of missed documentation for pain and behavior monitoring.

On 3/6/19 at 10:20 AM resident #23 was noted to be playing cards in the dining room.

On 3/7/19 at 2:43 PM resident #23 was noted to be seated in the living room watching T.V.

On 3/7/19 at 3:05 PM, licensed nursing staff G stated the computer gave a report on the missed items on the medication administration review and treatment administration review. He/she

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F 756	Continued From page 55 further revealed that administration did an audit and talked to the nursing staff about the missed documentation. On 3/7/19 at 4:30 PM, administrative staff A stated that he/she was not aware of missed documentation, and it had not been talked about in quality assurance/performance improvement (QAPI). Unable to obtain pharmacist consultant interview due to unavailability. The facility policy "Pain Recognition and Management Protocol" dated 9/17 directed staff to chart the resident's daily pain level in the electronic computer system. The facility policy "Timeliness of Medication Regimen Review" dated 5/18 lacked direction for pain monitoring, antidepressant side effect or antidepressant behaviors. The facility's policy "Psychoactive Medication Protocol" dated 9/17 directed staff to enter the appropriate target behaviors in the appropriate electronic computer system treatment administration review folder and begin documenting every shift. The facility failed to ensure that the consultant pharmacist identified missed documentation for pain monitoring, antidepressant side effect monitoring, and antidepressant behavioral monitoring for resident #23.	F 756		
F 757 SS=D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6)	F 757		

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F 757	Continued From page 56 §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 §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: The facility identified a census of 38 residents. The sample included 31 residents, 5 residents were reviewed for unnecessary medication. Based on record review, observation and interview, the facility failed to review and address the missed documentation for pain monitoring, antidepressant side effect monitoring, and antidepressant behavioral monitoring for 2 residents (#24 and #23). Findings Included: -Resident #24's January physician order sheet documented diagnoses that included: dysphasia (swallowing difficulty), anxiety (mental or	F 757		

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emotional reaction characterized by apprehension, uncertainty and irrational fear), major depression disorder (major mood disorder), and impulse disorder (lack of self-control).

The Annual Minimum Data Set (MDS) assessment, dated 4/25/18, documented a Brief Interview for Mental Status (BIMS) was done by staff interview which noted impaired short and long-term memory problems. Resident received antidepressants (class of medications used to treat mood disorders and relieve symptoms of [depression- abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness and emptiness) 7 out of 7 days during the look back period, he/she was not having pain and did not receive scheduled pain medication as needed but did receive pain medicine as ordered. There were no behaviors noted.

The Quarterly MDS assessment dated 1/11/19 documented the same information for BIMS and antidepressant medication. The pain interview was done, the resident had rare pain and received scheduled pain medication. The resident had behaviors towards others 1 to 3 days during the look back period and behaviors noted of yelling or swinging at objects 4 to 6 days during the look back period.

The Care Area Assessment (CAA), dated 4/25/18, for cognition documented that the resident had wandering behaviors and impaired cognitive decision-making ability that required staff to cue and supervise for all cares.

The CAA for behaviors, dated 4/25/18, documented the resident had a history of

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impulsive disorder and would sit for a few minutes and then get up and wander.

The care plan dated 4/25/18 directed staff to redirect and reduce stress and to provide small daily decisions. It also directed staff to administer medications as ordered and observe for side effects and effectiveness.
The care plan dated 1/28/19 directed staff to note character of pain.

The nurses order dated 12/6/17 antidepressant (class of medications used to treat mood disorders and relieve symptoms of [depression-abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness and emptiness]) targeted behavior for Lexapro on every shift.

The nurses order dated 5/11/17 to record pain level on every shift.

Review of the treatment administration record from July 1, 2018 to March 4, 2019 noted missed opportunities of documented pain assessment for 35 times.

Review of the treatment administration record from July 1,2018 to March 4, 2019 noted missed opportunities of documented antidepressant behavior monitor 34 times.

On 3/6/19 at 8:10 AM, resident ambulated into the television room and sat on the couch.

On 3/7/19 at 2:44 PM, resident came out of his/her room to get a snack off the snack tray.

On 3/7/19 at 3:05 PM, licensed nursing staff G

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stated the computer gave a report on the missed items on the medication administration review and treatment administration review. He/she further revealed that administration did an audit and talked to the nursing staff about the missed documentation.

On 3/7/19 at 4:30 PM, administrative staff A stated that he/she was not aware of missed documentation, and it had not been talked about in quality assurance/performance improvement (QAPI).

The facility policy "Pain Recognition and Management Protocol" dated 9/17 directed staff to chart the resident's daily pain level in the electronic computer system.

The facility policy "Timeliness of Medication Regimen Review" dated 5/18 lacked direction for pain monitoring, antidepressant side effect or antidepressant behaviors.

The facility's policy "Psychoactive Medication Protocol" dated 9/17 directed staff to enter the appropriate target behaviors in the appropriate electronic computer system treatment administration review folder and begin documenting every shift.

The facility failed to adequately review and address the missed documentation for pain monitoring, antidepressant side effect monitoring, and antidepressant behavioral monitoring for resident #24.

- Resident #23's January 2019 physician order set document diagnoses of schizophrenia (psychotic disorder characterized by gross

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distortion of reality, disturbances, of language, communication, and fragmentation of thought), peripheral vascular disease (abnormal condition affecting the blood vessels), mild cognitive impairment, and delusional disorder (untrue persistent belief or perception held by a person although evidence shows it was untrue).

The significant change Minimum Data Set (MDS) dated 7/18/18 documented a Brief Interview for Mental Status (BIMS) score of 7, which indicated severe cognitive impairment. The resident required facility staff supervision to limited assistance with his/her Activities of Daily Living (ADLs). Resident received antipsychotic (class of medications used to treat psychosis, any major mental disorder characterized by a gross impairment in reality testing, and other mental emotional conditions), antianxiety (class of medications that calm and relax people with excessive anxiety [mental or emotional reaction characterized by apprehension, uncertainty and irrational fear], nervousness, or tension), antidepressant (class of medications used to treat mood disorders and relieve symptoms of depression- abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness and emptiness) and anticoagulant (blood thinner) medication 7 out of 7 days during the look back period. The resident interview stated no pain with no scheduled or as needed pain medications.

The quarterly MDS dated 12/31/18 documented a BIMS score of 7, which indicated severe cognitive impairment. The resident required facility staff supervision to limited assistance with his/her ADLs. Resident was noted to receive antianxiety, antidepressant and anticoagulant medication 7

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out of 7 days during the look back period. The resident interview stated no pain with no scheduled or as needed pain medications.

The cognitive Care Area Assessment (CAA) dated 7/18/18 documented the resident had impaired daily decision-making ability and cognition.

The Care Plan dated 4/23/18 directed staff to monitor for side effects, assess physical symptoms, medication effectiveness and medication side effects and to notify medical director if pain is not controlled.

The nurses order dated 7/23/17 directed staff to monitor antidepressant targeted behavior for Lexapro on every shift.

The nurses order dated 7/23/17 to record pain level on every shift.

The nurses order dated 7/23/17 antipsychotic targeted behavior for Depakote on every shift.

The nurses order dated 7/23/17 antianxiety targeted behavior for Buspar on every shift.

The nurses order dated 4/19/18 antidepressant targeted behavior for Remeron on every shift.

Review of the treatment administration record from July 1, 2018 to March 4, 2019 noted missed opportunities of documented pain assessment for 38 times.

Review of the treatment administration record from July 1,2018 to March 4, 2019 noted missed opportunities of documented behavior monitoring

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for Depakote 39 times.

Review of the treatment administration record from July 1,2018 to March 4, 2019 noted missed opportunities of documented behavior monitoring for Lexapro 39 times.

Review of the treatment administration record from July 1,2018 to March 4, 2019 noted missed opportunities of documented behavior monitoring for Remeron and Buspar 39 times.

Review of the treatment administration record from July 1,2018 to March 4, 2019 noted missed opportunities of documented behavior monitoring for Remeron 39 times.

On 3/6/19 at 10:20 AM resident #23 was noted to be playing cards in the dining room.

On 3/7/19 at 2:43 PM resident #23 was noted to be seated in the living room watching T.V.

On 3/7/19 at 3:05 PM, licensed nursing staff G stated the computer gave a report on the missed items on the medication administration review and treatment administration review. He/she further revealed that administration did an audit and talked to the nursing staff about the missed documentation.

On 3/7/19 at 4:30 PM, administrative staff A stated that he/she was not aware of missed documentation, and it had not been talked about in quality assurance/performance improvement (QAPI).

The facility policy "Pain Recognition and Management Protocol" dated 9/17 directed staff

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F 757	Continued From page 63 to chart the resident's daily pain level in the electronic computer system. The facility policy "Timeliness of Medication Regimen Review" dated 5/18 lacked direction for pain monitoring, antidepressant side effect or antidepressant behaviors. The facility's policy "Psychoactive Medication Protocol" dated 9/17 directed staff to enter the appropriate target behaviors in the appropriate electronic computer system treatment administration review folder and begin documenting every shift. The facility failed to adequately review and address the missed documentation for pain monitoring, antidepressant side effect monitoring, and antidepressant behavioral monitoring for resident #23.	F 757		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used	F 758		

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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.

§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:
The facility identified a census of 38 residents. The sample included 31 residents with 5 residents reviewed for unnecessary medications and psychotropic drug use. Based on observations, interviews, and record reviews, the facility failed to ensure 2 (#29 and #18) of 5

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residents did not receive unnecessary psychotropic medications and adequately monitor for behavioral disturbances.

Findings included:

- The Electronic Medical Record (EMR) for resident #29 listed diagnoses of hallucinations (sensing things while awake that appear to be real, but the mind created), schizoaffective disorder (psychotic disorder characterized by gross distortion of reality, disturbances of language and communication and fragment of thought), insomnia (inability to sleep), depression (abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness and emptiness), and anxiety (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear),

The admission Minimum Data Set (MDS) dated 10/9/18 documented a Brief Interview for Mental Status (BIMS) score of 11, which indicated moderate cognitive impairment. The resident required facility staff supervision for his/her Activities of Daily Living (ADLs). The resident received an anxiolytic (medications used to treat anxiety) and an antidepressant (medications used to treat depression) 7 of 7 days in the look back period.

The quarterly MDS dated 1/18/19 documented a BIMS score of 11, which indicated moderate cognitive impairment. The resident required supervision to limited facility staff assistance for his/her ADLs. The resident received an anxiolytic and an antidepressant 7 of the 7 days in the look back period.

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The cognitive Care Area Assessment (CAA) dated 11/28/18 documented the resident had memory loss, confusion, disorientation, and forgetfulness.

The care plan dated 11/28/18 lacked documentation for the resident's diagnoses of schizoaffective disorder, depression, or anxiety.

The Physician's Order Sheet (POS) documented orders for Citalopram (medication to treat depression) 30 milligrams (mgs.) orally daily on 10/9/18 and Wellbutrin (medication to treat depression) 150 mgs. orally daily dated 1/2/19.

Review of the behavior monitoring on the EMR from 10/15/18 through 3/6/19 revealed the targeted behaviors for the use of Citalopram lacked documentation for 9 of 14 evening shifts and 1 of 15 night shifts in October; 2 of 30 evening shifts and 4 of 20 night shifts in November; 4 of 31 evening shifts and 2 of 31 night shifts in December;1 of 31 night shifts in January and 1 of 28 night shifts and 1 of 28 evening shifts in February. The EMR lacked documentation on signs of depression, to monitor for, to warrant the continuing use of Wellbutrin.

On 3/6/19 at 10:30 AM the resident sat upright in his/her bed displaying no outward signs of depression, anxiety, or hallucinations.

On 3/7/19 at 3:45 PM the resident sat on the edge of his/her bed. He/she did not display behavioral disturbances.:

On 3/7/19 at 3:05 PM facility staff G stated the nursing staff monitor targeted behaviors for all psychotropic medications (medications used to

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F 758	Continued From page 67 treat depression, anxiety, and schizoaffective disorders). On 3/7/19 at 4:00 PM administrative staff D stated the nursing staff monitor behaviors for all psychotropic medications. The facility's Psychoactive Medication Protocol policy dated September 2017 documented the facility staff entered the appropriate target behaviors in the Treatment Administrative Record (TAR) and documented every shift. The facility failed to adequately monitor resident #29 for signs of depression while receiving antidepressant medications. - The Electronic Medical Record (EMR) for resident #18 revealed diagnoses of depression (abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness and emptiness) and anxiety (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear). The admission Minimum Data Set (MDS) dated 12/19/18 documented a Brief Interview for Mental Status (MDS) score of 14, which indicated intact cognition. The resident required limited to extensive staff assistance with his/her Activities of Daily Living (ADLs). The resident received an anxiolytic (medications used to treat anxiety) 2 0 7 days in the look back period and an antidepressant (medications used to treat depression) 5 of 7 days in the look back period. The psychotropic drug use Care Area Assessment dated 12/19/18 documented the resident required the use of anxiolytic and	F 758		

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antidepressant medications.

The medication care plan dated 12/13/18 documented the resident had a potential for adverse side effects from long term use of antidepressants and anxiolytics.

The Physician's Order Sheet (POS) documented orders for Trazodone 50 milligrams (mgs.) orally dated 12/7/18 and Citalopram 20 mgs. orally dated 12/8/18 (antidepressant medications).

The Treatment Administration Record (TAR) lacked documentation for the effectiveness of the antidepressants.

On 3/7/19 at 2:30 PM the resident sat in a wheelchair in his/her room looking through his/her personal items. The resident did not display any signs of depression.

On 3/7/19 at 3:05 PM facility staff G stated the nursing staff monitor targeted behaviors for all psychotropic medications (medications used to treat depression, anxiety, and schizoaffective disorders).

On 3/7/19 at 4:00 PM administrative staff D stated the nursing staff monitor behaviors for all psychotropic medications.

The facility's Psychoactive Medication Protocol policy dated September 2017 documented the facility staff entered the appropriate target behaviors in the Treatment Administrative Record (TAR) and documented every shift.

The facility failed to adequately monitor resident #18 for signs of depression while receiving

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F 758	Continued From page 69 antidepressant medications.	F 758		