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F 000	INITIAL COMMENTS The following citations represent the findings of a Health Resurvey and Complaint investigation #108540 and #108749.	F 000		
F 314 SS=D	483.25(b)(1) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES (b) Skin Integrity - (1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: The facility had a census of 92 residents. The sample included 15 residents. Based on observation, record review, and interview the facility failed to provide care and services to prevent the development and/or worsening of pressure ulcers for 1 of 1 sampled resident reviewed for pressure ulcers. (#5) Findings included: - Resident #5's quarterly (MDS) Minimum Data Set assessment, dated 7/21/16, indicated the	F 314		

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

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resident had a (BIMS) Brief Interview for Mental Status score of 8, which indicated the resident had moderately impaired cognition. The MDS indicated the resident required extensive assistance of 1 staff with bed mobility, transfers, dressing, toilet use, and totally dependent on 1 staff assistance with locomotion on and off unit, and bathing. The MDS indicated the resident was at risk for developing pressure ulcers, had no pressure ulcers, had 1 venous and arterial ulcer, and open lesions other than ulcers, rashes, cuts, or skin tears. The MDS indicated the resident had a pressure reducing device in his/her bed and chair, and received applications of ointments/medications other than to his/her feet.

The significant change MDS, dated 8/24/16, indicated the resident had short and long term memory problems, and modified independence for daily decision making. The MDS indicted the resident required the same assistance with (ADLs) Activities of Daily Living as the 7/21/16 MDS. The MDS indicated the resident at risk for developing pressure ulcers, and had 1 Stage 3 pressure ulcer, which measured 2.0 (cm) centimeters long by 0.5 cm wide by 0.2 cm deep with slough (dead tissue, usually cream or yellow in color). The MDS indicated the resident had a pressure reducing device for his/her bed and chair, and received pressure ulcer care. The MDS indicated the pressure ulcer was present on prior assessment.

The 8/24/16 (CAA) Care Area Assessment indicated the resident had a Stage 3 pressure ulcer on his/her right heel that began as a vasculitis lesion (lesion resulting from the leakage of blood into the skin through inflamed, damaged blood vessels). The assessment stated the

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physician had injected the pressure ulcer site periodically, and the resident's right heel worsened when the resident was previously in the hospital. The assessment instructed staff to apply a heel cup cushion to the resident's right heel when he/she was in bed and to use pillows to support the resident's heel. The assessment indicated the resident had previously attended the wound clinic for treatment to the wound on his/her heel, but recently stopped, due to the resident electing hospice services. The assessment indicated the resident had potential for additional skin issues due to his/her diagnoses of incontinence, decreased mobility, impaired skin integrity, hospice election, use of steroids (drugs used to relieve swelling and inflammation), and Diabetes Mellitus (when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin).

The 7/29/16 care plan indicated the resident was a high risk for developing skin integrity issues. The care plan instructed staff to elevate the resident's legs on several pillows when in bed, avoid pressure to the resident's right heel, provide weekly skin assessment, monitor areas to bilateral lower legs, and provide treatment as physician ordered.

The 8/28/2016 updated care plan indicated the resident had a history of heel and leg ulcers, and perform skin and wound treatments as ordered.

The updated 11/09/2016 updated care plan directed the staff not to leave the resident in his/her room unattended, and he/she was a high risk for falls and high risk for skin integrity issues with the foot pedals in place. The foot pedals are to have sheep skin on them for protection due to

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bruising in the lower shin area.

The 4/27/2016 Dietary Assessment indicated the resident weighed 126 #, and lacked documentation of any skin issues or interventions.

The 5/24/2016 physician's order directed the nurse to cleanse the right lower leg with normal saline, apply Xeroform gauze (a non adherent, fine mesh gauze dressing coated with petrolatum), then cover with stretch gauze until healed, twice daily.

The 7/20/16 Dietary Assessment indicated the residents weighed 131 #, and lacked documentation of any skin issues or interventions.

The Skin breakdown assessment, for predicting pressure ulcers, revealed the following:
2/1/16, 3/23, 4/22, and 7/10/16- score of 21 not at risk.
7/29/16 - score of 20, not at risk
11/09/16 and 11/10/16 - score of 18, mild risk

The 6/09/2016 at AM 11:40 AM, nurse's notes indicated (a late entry) that the resident's general skin condition for the resident right heel had a scabbed area with a reddened area surrounding the scab 3.0 cm x 2.0 cm. The notes stated staff provided skin treatment per physicians order, and would continue to observe.

The 6/30/2016 at 8:47 PM, nurse's notes indicated a skin treatment was completed but lacked documentation where.

The 7/02/2016 at 11:42 PM, nurse's notes

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documented the resident in his/her recliner had edema (swelling caused by excess fluid trapped in the body) to both lower legs, and the nurse removed the elastic wraps.

The 7/06/2016 at 10:36 PM, nurse's notes documented the resident's right heel scabbed over, measuring 3.0 x 2.6 cm, and staff provided skin treatment per physician's order, and would continue to observe.

The 7/13/2016 at 10:28 PM, nurse's notes documented the resident's right heel had a black/purple discoloration, 4.0 cm x 3.5 cm, and staff continue to observe.

The 7/22/2016 at 10:10 PM, nurse's notes documented staff applied polysporin (antibiotic ointment) and a telfa pad every day to the resident's right heel, and would continue to observe.

The 7/27/2016 wound care consultation from the hospital documented a Stage 3 right heel wound 3.5 cm length x 3.0 cm width x 0.3 cm depth. The wound appearance was yellow/brown slough, black eschar (a piece of dead tissue that is cast off the wound/skin), pink epithelium (tissue composer of one or more layers of cells forming the outer layer of the skin), and boggy (tissue that is painful, firm, mushy, warmer or cooler to the touch than the surrounding tissue).

The weekly skin integrity review sheets documented the following for the resident's right heel:

6/09/16 - scabbed area with reddened area surrounding the scab 3.0 cm x 2.0 cm.

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6/29/16 - 2.4 cm x 3.0 cm
7/13/16 - black/purple discoloration 4.0 cm x 3.5 cm.
7/20/16 - refuses to have right heel wound measured. States " it would hurt too bad".
The resident was hospitalized from 7/23/2016 until 7/29/2016.
8/03/16 - open wound 3.5 cm x 3.2 cm x 0.2 cm.
8/10/16 - 2.0 cm x 0.5 cm x 0.2 cm.
8/17/16 - 2.0 cm x 0.5 x 0.2 cm
8/24/16 - 2.0 cm 0.5 cm x 0.2 cm.
8/31/16 - ulcer 0.6 cm x 0.5 cm x 0.2 cm.
9/07/16 - ulcer 1.0 cm x 0.5 cm x 0.2 cm
9/14/16 - ulcer 1.5 cm x 0.5 cm x 0.1 cm.
9/21/16 - ulcer 1.0 cm x 0.4 cm x 1.0 cm with light amount of drainage
9/28/16 - ulcer scabbed over, 1.0 cm x 0.4 cm, no depth and no drainage.
10/05/16 - ulcer scabbed over, 1.0 cm x 0.4 cm, no depth and no drainage
10/12/16 - ulcer 1.1 cm x 0.6 cm, no depth and no drainage.
10/19/16 - wound 1.0 cm x 0.5 cm, no depth no drainage
11/02/16 - ulcer 1. cm x 0.5 cm with small amount of red drainage
11/16/16 - wound 2.5 cm x 1.0 cm with no depth or drainage
11/23/16 - open area measuring 1.0 cm x 0.5 cm x 0.2 cm with a small amount of red drainage.
11/30/2016 - 2.0 cm x 1.0 cm x 0.2 cm with a small amount of red drainage
12/07/2016 refused weekly skin assessment.

On 12/12/20016 at 4:00 PM, observation revealed the resident sitting in his/her recliner, Nurse J removed the gauze dressing from his/her right heel, and measured the area at 1.3 cm x 1.2 cm, with a scab over the area. Nurse J cleansed the

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heel wound with wound cleanser and temporarily covered the area with a foam dressing and gauze until Hospice delivers more Hydrogel (90% water in a gel base used to help regulate fluid exchange from the wound surface) that evening and staff will redress the wound with hydrogel and Allevyn heel.

On 12/12/2016 at 1:56 PM, Nurse G stated staff cleansed the resident's pressure ulcer on his/her heel with wound cleanser, skin prep around the wound, hydrogel to the wound bed, allyven heel cushion, and cover with Telfa and Kerlix, three times a week.

On 12/13/2016 at 5:05 PM, Administrative Nurse C stated the resident received injections in his/her heel before the ulcer developed. The resident had a pressure relieving mattress and cushion since admission.

The facility 7/2000 Pressure ulcer policy indicated the facility would identify residents at risk for development of pressure ulcers and attempt to avoid development of pressure ulcers. The policy indicated the facility would monitor and provide appropriate treatment and services to the residents who develop a pressure ulcer. The facility would assess for actual or potential pressure ulcer on admission, every 90 days with the MDS assessment and a visual inspection of the resident's skin and document the findings. The facility would monitor the resident's skin with dressing, bathing, toileting and with personal cares, and evaluate nutrition, hydration, continence and mobility status. The facility would utilize preventative nursing techniques per nursing assessment for turning/repositioning program, encourage the residents who are able

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F 323 SS=D	483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES (d) Accidents. The facility must ensure that - (1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements.	F 323		

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(1) Assess the resident for risk of entrapment from bed rails prior to installation.

(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation.

(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight.
This REQUIREMENT is not met as evidenced by:
The facility had a census of 92 residents. The sample included 15 residents of which 4 were reviewed for accidents. Based on observation, record review, and interview the facility failed to ensure the environment remained free from accident hazards and to provide supervision, as care planned. Staff failed to remain in Resident #5's room during toileting when he/she obtained a skin tear, which required 16 sutures. Staff continued to have Resident #92's electric recliner plugged in, with the feet elevated, after it was determined to unplug it, causing multiple falls.

Findings included:

- Resident #5's quarterly (MDS) Minimum Data Set assessment, dated 11/16/16, recorded the resident had a (BIMS) Brief Interview for Mental Status score of 7, indicating severe cognitive impairment. The MDS documented the resident had disorganized thinking behaviors, delusions (thinking and emotions that indicate that the person experiencing them has lost contact with reality), verbal behavior symptoms directed toward others, and rejection of care behaviors. The MDS revealed the resident required

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extensive assistance of 1 staff for bed mobility, transfers, walking in room, locomotion on and off unit, dressing, toilet use, and personal hygiene. The MDS recorded the resident's balance unsteady, only able to stabilize with staff assistance, had no functional limitation in upper and lower extremities, used a walker and wheelchair for mobility, and was occasionally incontinent of bladder. The MDS further revealed the resident had a history of falls, had 2 non injury falls, and 2 falls with injury since prior assessment. The MDS revealed the resident had open lesions other than ulcers, rashes, cuts, skin tears, and used a pressure reducing device for chair and bed.

The 8/24/16 Falls (CAA) Care Area Assessment revealed the resident continued to experience general weakness, usually called for assistance to the bathroom, but was observed toileting himself/herself and had a room at the front of the hall where he/she could be observed more readily. The CAA directed staff to reinforce the need for assistance to avoid falls, indicated that the resident's bones were thin and porous (having minute spaces or holes through which liquid and air can pass) due to long term steroid use, used a wheeled walker equipped with oxygen for use to the bathroom, and used a wheelchair with oxygen outside of his/her room.

The 12/10/16 care plan revealed the resident had a history of falls, poor judgement skills, and directed staff to consider behavioral safety risk factors when caring for the resident. The care plan directed staff to ensure the resident's door remained open at all times, including mealtimes,

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make frequent visual checks, and not to leave the resident alone in the wheelchair in his/her room. The care plan instructed staff to assist the resident with pulling up his/her pants after toileting, use a 4 wheeled walker, transfer with assistance, ensure adequate pain management, and implement a floor mat in front of the bed for safety. The care plan instructed staff to educate the resident on basic home safety precautions, how to prevent injury, requesting assistance to ambulate, use of the night light, safe footwear, and instruct the resident regarding potential effect of medications on his/her risk of falling. The care plan instructed staff to wake the resident up and toilet him/her each round at night, encourage the resident to use the call light for assistance at night, perform frequent visual checks during the night, and assist the resident with managing his/her oxygen tubing, since it was a tripping hazard. The care plan instructed staff on 8/9/16 to not leave the resident unattended in the bathroom, and instruction reinforced on 11/28/16, which included direction to staff to wait outside the bathroom door and ask the resident when he/she finished, to assist with peri care.

The 11/18/16 at 5:30 PM, incident note revealed the resident had a skin tear to his/her left shin. Upon assessment, staff noted a sharp edge on the side of his/her walker, indicating a possible cause of injury, as resident may have bumped the area on that side of the walker. The note revealed staff observed moderate amount of red drainage, unable to obtain measurement of the skin tear due to resident being transferred to (ER) Emergency Room for evaluation. The note revealed staff notified the physician, family, and (DON) Director of Nursing, and updated the care

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plan with the new intervention to apply sheepskin to the walker adjustments on the side of the walker until therapy can evaluate for new walker.

The 11/18/16 at 9:41 PM, nurse's note revealed the resident had a tear/cut to left shin in a V shape measuring 8.0 (cm) centimeters x 4.0 cm, with 16 sutures to the area and 5 steri-strips covering sutures and directed staff to continue to observe.

On 12/12/2016 at 1:03 PM observation revealed the resident in his/her room, seated in his/her recliner eating lunch, resident attempted to stand up unattended, with only socks on his/her feet. Continued observation revealed Medication Aide F assisted the resident, asking him/her to sit back down. Observation revealed the resident stated he/she needed to go to the bathroom. Medication Aide F directed the resident to sit down and placed slippers on the resident's feet. Medication Aide F placed a gait belt on the resident, and ambulated to the restroom, using the 4 wheeled walker. After toileting, observation revealed the resident ambulated to his/her recliner, using gait belt and walker, and as the resident approached his/her recliner, he/she decided to walk rather than sit down, so he/she walked out the door with staff assistance. Observation revealed the resident refused to stop walking to change oxygen tubing from the compressor to the tank on the wheelchair, forcing staff to remove the oxygen tubing. Observation revealed the resident was followed by the hospice aide who was propelling the resident's wheelchair, attempting to put the oxygen from the wheelchair on the resident, but the resident refused to stop walking. Observation

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revealed the resident ambulated approximately 20 feet without his/her oxygen before sitting down, and staff applied oxygen from the wheelchair. Observation revealed the resident stood back up and ambulated to the main entrance using his/her walker followed by the hospice aide and Medication Aide F. When the resident arrived at the main entrance, he/she began bumping his/her walker against the exit door, trying to leave. Medication Aide F, Nurse G, and the hospice aide attempt to redirect the resident without success. Observation revealed at 1:25 PM, the resident sat down in his/her wheelchair but refused to let go of the walker. At 1:30 PM, the resident let go of the walker and agreed to go back to his/her room, foot pedals applied to wheelchair and staff pushed the resident back to his/her room in his/her wheelchair.

On 12/13/2016 at 9:13 AM, observation revealed the resident standing outside his/her room in front of his/her wheelchair, hanging on to the arms of the wheelchair and 2 staff attempted to assist the resident to sit down in the wheelchair. Observation revealed the resident leaning forward hanging on to the arms of the wheelchair, using only the chair to hold him/her up, and staff by the resident. Observation revealed after a few minutes, the resident sat back down in his/her wheelchair, and staff assisted him/her back to the room.

On 12/16/16 at 2:08 PM, Nurse Aide L stated when he/she walked into the resident's room, Medication Aide K was in the bathroom, and the resident was on the toilet. Nurse Aide L stated

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he/she pulled the resident's walker from beside the resident, to in front of the sink, so the resident could wash his/her hands. The resident and Nurse Aide L then walked over to the resident's bed. Nurse Aide L stated he/she then assisted the resident to sit on his/her bed, Nurse Aide L then moved the resident's walker so he/she could lift the resident's legs into the bed. When Nurse Aide L placed the resident's legs in the bed, the resident grabbed his/her left leg, so Nurse Aide L pulled up the resident's pant leg and and noticed a long scrape on the resident's outer left leg with a hole and a skin tear at the bottom. Nurse Aide L stated that he/she took the resident's sock off, the blood was starting to clot, like it had been there for awhile. Nurse Aide L stated he/she wrapped a towel around the resident's leg until the nurse came to the resident's room. Nurse Aide K stated there was a skin tear, shaped like a V, with a 1/4 inch round area in the middle, the scratch was probably about 2-3 inches in length.

On 12/6/16 at 3:42 PM, Medication Aide K stated on 11/18/16 he/she administered medication to the resident after supper, the resident wanted to go to the bathroom, and complained of pain. Medication Aide K further stated that he/she pulled the resident's pants down, assisted the resident to sit on the toilet, and left the resident unassisted, to tell the nurse the resident needed pain medication. Medication Aide K stated that when he/she came back to the resident's bathroom, the resident was trying to get up off the toilet unassisted, so Medication Aide K assisted the resident to sit back down. Medication Aide K stated that he/she called for help to transfer the resident, when the resident stood up off from the toilet, Nurse Aide L came into the resident's room

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to assist in transferring the resident back to his/her bed. Medication Aide K stated that when the resident made it back to his/her bed, Medication Aide K was starting to leave the resident's room when Nurse Aide L noticed a discolored area on the resident's pant leg, pulled up the resident's pant leg and noticed the scratch to his/her left shin. Medication Aide K stated that it was in the resident's care plan not to leave him/her alone in the bathroom, but Medication Aide K stated that he/she wasn't aware of this until after the incident happened.

On 12/13/16 at 4:21 PM, Nurse I stated the amount of assistance the resident needs can vary from day to day, he/she is a 1 person assist, but lately has been needing 2 person assist due to being more tired and sleepy. Nurse I stated staff have tried several interventions to prevent the resident from falling, including putting up signs to remind the resident to use his/her call light, Gel sleeves to protect him/her when he/she does fall, frequent observation, and a lot of anticipation. Nurse I stated that he/she felt like the interventions weren't really working, with the resident's cognition, there probably wasn't an intervention to keep the resident from getting up all the time.

On 12/13/16 at 5:05 PM, Administrative Nurse C stated that educating the resident on how to use the call light is not an appropriate intervention anymore, it was when his/her BIMS was higher, but not now.

The facility's 7/10/14 Abuse, Neglect, Exploitation Policy stated the management of resident

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behavior will take place with treatment as prescribed by the resident's physician and the resident's care plan.

The facility failed to ensure the environment remained as free from accident hazards as possible, for Resident #5 who sustained a skin tear, requiring 16 sutures, from his/her walker.

- Resident #92's 12/07/2016 progress notes revealed a diagnosis of dementia (a chronic or persistent disorder of the mental process caused by brain disease or injury and marked by memory disorders, personality changes, and impaired reasoning).

The annual (MDS) Minimum Data Set assessment, dated 11/01/2016, indicated the resident had a (BIMS) Brief Interview for Mental Status score of 3, which indicated the resident had severely impaired cognitive skills, and was totally dependent on staff for all transfers and wheelchair mobility.

The 11/03/2016 (CAAs) Care Area Assessment for Falls/Accidents indicated the resident was totally dependent on staff for all mobility, transfers and used a sit to stand lift (an electric lift designed to assist staff to raise a weight bearing resident from a seated to a standing position) for transfers.

The 10/26/2016 care plan directed staff to perform frequent visual checks on the resident, ensure the call light was within reach, and ensure the residents wearing non-skid socks. The

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updated 10/27/2016 care plan directed the staff to unplug the electric recliner and have the resident's feet down when he/she was in the electric recliner.

The 10/26/2016 Fall risk assessment revealed a score of 13 which indicated the resident was a high risk for falls.

The 10/27/2016 Electric recliner Assessment revealed the resident was unable to operate the electric recliner, and his/her recliner was is to be unplugged and his/her feet are to remain down when he/she was in the recliner.

The 10/27/2016 at 5:20 AM, nurse's notes revealed the resident was sitting on his/her left hip on the floor, leaning on his/her left arm and hand. The note revealed the foot rest on the recliner was in the up position.

The 11/09/2016 at 5:45 PM, nurse's notes revealed the resident was sitting on the floor on his/her bottom, with legs straight out in front of him/her. The notes revealed the foot rest on the recliner was in the up position and the recliner leaning against the wall.

On 12/06/2016 at 1:25 PM, observation revealed the resident, sitting in the brown electric recliner in his/her room, with the foot rest elevated. The hand control was draped over the left armrest towards the back of the chair, easily accessible, and the surveyor verifiedthe chair was plugged into an electric outlet.

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F 323	Continued From page 17 On 12/06/2016 at 3:40 PM, observation revealed the resident, in the electric recliner, in his/her room, with the foot rest elevated. The hand controller behind the chair, and the chair plugged in and operable. On 12/06/2016 at 3:00 PM, Administrative Staff C verified the resident had severely impaired cognition, he/she was assessed at a high fall risk and unable to safely operate the electric recliner chair safely. Administrative Staff C verified the recliner is to be unplugged and the resident's feet to remain down when he/she is in the recliner chair. The 3/04/2004 facility policy for falls indicated the facility would provide an environment that was free from fall hazards and provide adequate supervision and assistive devices to prevent accidents. The facility failed to provide supervision to prevent accidents for Resident #92, who fell, when getting out of his/her electric recliner. The facility failed to keep the electric recliner unplugged and the foot rest down after it was determine it was unsafe for the resident to have the recliner operable.	F 323		
F 329 SS=D	483.45(d) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS (d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used--	F 329		

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F 329	Continued From page 18 (1) In excessive dose (including duplicate drug therapy); or (2) For excessive duration; or (3) Without adequate monitoring; or (4) Without adequate indications for its use; or (5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or (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 had a census of 92 residents. The sample included 15 residents, of which 5 residents were reviewed for unnecessary medications. Based on observation, record review and interview, the facility failed to ensure 2 of the 5 sampled residents did not receive unnecessary medications. The facility failed to continue to follow up regarding a gradual dose reduction of the medication Seroquel (an antipsychotic) and Zoloft (an antidepressant) per pharmacist recommendations medications for Resident #85. The facility failed to evaluate the duplicate use of the same classification of medications for Resident #82. Findings included: - Resident #85's quarterly (MDS) Minimum Data Set assessment, dated 11/17/16, indicated the resident had a (BIMS) Brief interview for Mental Status score of 8 (moderate cognitive	F 329		

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impairment). The MDS also indicated the resident required supervision with transfers, walking, dressing, eating, toileting and personal hygiene. The MDS further indicated the resident received antidepressant and antipsychotic medications 7 days a week.

The 7/20/2016 (CAA) Care Area Assessment for psychotropic medications revealed the resident received antipsychotic and antidepressant medications for his/her decrease in cognition. The CAA indicated the resident had cognitive deficits, paranoia (a thought process believed to be influenced by anxiety or fear that other people think badly of them or mistrust), and was anxious at times.

The 11/16/2016 care plan directed staff to administer physician ordered Zoloft (antidepressant medication) and Seroquel (antipsychotic) medication to the resident and report adverse side effects to the physician. The care plan also directed the staff to report unusual behaviors and change in physical condition to the physician.

The 12/01/2016 physician's order sheet directed staff to administer physician ordered Zoloft, 100 (mg) milligrams, every evening, to the resident for anxiety, initiated on 11/11/2015, and Seroquel, 12.5 mg in the morning and 12.5 mg in the evening to the resident for depression, initiated on 2/08/2016.

The pharmacist communication to the physician indicated the following:
4/11/2016 - Seroquel 12.5 mg daily, requested a gradual dose reduction or reason to continue. The physician did not return the fax and

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Administrative Nurse D documented, " Physician refused to answer."

8/17/2016 - Seroquel 12.5 mg daily, request a gradual dose reduction or reason to continue. The physician did not return the fax and Administrative Nurse D documented, "physician refused to answer."

10/19/2016 - Zoloft, 100 mg daily, request a gradual dose reduction or reason to continue. The physician did not return the fax and Administrative Nurse D documented, "Physician refused to answer."

Review of the medical record revealed lack of documentation staff continued follow up after the physician failed to respond to the pharmacist's recommendations for a gradual dose reduction of Seroquel and Zoloft.

On 12/12/2016 at 8:30 AM, observation revealed Certified Medication Aide E administered medications to the resident.

On 12/12/2016 at 4:30 PM, Administrative Nurse D stated the physician had not addressed the consulting pharmacist recommendations for the gradual dose reduction and he/she had failed to return the fax sheet back to the facility for the past 8 months. Administrative Nurse D also stated he/she had called the physician's office numerous times and had not received an answer for the pharmacist recommendations. Administrative Nurse D verified he/she had not contacted the Medical Director regarding the lack of the physician addressing the consulting pharmacist recommendations.

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The facility's Psychotropic Medication Policy, dated 7/2000, directed nursing staff to administer the psychotropic medications at the lowest effective dose to control a resident's symptoms and to be evaluated periodically by a physician, psychiatrist, or a nurse clinician.

The facility's undated consultant pharmacist policy indicated the pharmacist would be aware of all the federal and state drug laws, rules and regulations and provide the facility with current information pertaining to drug services. The pharmacist would make every effort to assure the maximum level of safety and efficacy in the provision of pharmaceutical services. The consulting pharmacist reviews the medication regimen of each resident at least monthly, and identifies resident specific irregularities and/or clinical significant risks resulting from or associated with medications, and reports to the Director of Nursing, Medical Director and/or prescribe as appropriate as individual, resident specific recommendations. The consulting pharmacist would make recommendations and the physician accepts and acts upon suggestions or rejects and, according to regulation, should provide an explanation for disagreeing. If there is a potential for serious harm and the attending prescriber does not concur, or the attending prescriber refuses to document an explanation for disagreeing, the director of nursing and the consulting pharmacist may contact the medical director.

The facility failed to continue follow up to reduce the medications Seroquel and Zoloft per pharmacist recommendations for Resident #85, placing the resident at risk for receiving medications without proper indication for use.

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- Resident #82's quarterly (MDS) Minimum Data Set assessment, dated 10/7/16, indicated the resident had a (BIMS) Brief Interview for Mental Status score of 4, indicating severe cognitive impairment, with inattention, disorganized thinking, and altered level of consciousness. The MDS stated the resident had a mood severity score of 14, indicating moderate depression, physical behavior symptoms directed toward others, and rejection of care. The MDS revealed the resident required total dependence on staff for bathing, extensive staff assistance for bed mobility, transfers, walking in corridor, toilet use, walking in room, locomotion on and off unit, dressing, eating, and personal hygiene. The MDS revealed the resident's balance was not steady, only able to stabilize with staff assistance, and used a walker and wheelchair for mobility. The MDS documented the resident had a history of falls, 2 or more non injury falls since admission, and 1 fall with minor injury since admission. The MDS revealed the resident received antipsychotic (medication to treat mental and emotional disorders), antianxiety (medication to calm and relax people with excessive nervousness or tension), antidepressant (medication used to treat mood disorder with a persistent feeling of sadness and loss of interest), and antibiotic (medication used to kill harmful infections) medications.

The 4/26/16 Psychotropic drug use (CAA) Care Area Assessment revealed the resident had a history of altered mental status, Parkinson's disease (a progressive disease of the nervous system marked by tremor, muscle rigidity, and slow imprecise movements) with dementia

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(mental disorder marked by memory disorders, personality changes, and impaired reasoning) with hallucinations (experience involving the perception of something that is not there), and agitated behaviors. The CAA documented the resident received Namenda (medication to treat dementia) for memory.

The 10/12/16 care plan indicated the resident had a potential for adverse side effects related to use of psychotropic medications, Trazodone (medication used to treat a mood disorder that causes a persistent feeling of sadness and loss of interest), and Seroquel (medication used to treat mental and emotional disorders). The care plan directed staff to monitor for adverse effects (sedation, confusion, ataxia (inability to coordinate voluntary muscle movements) , irritability, dysphoria (a state of unease or general dissatisfaction with life), psychomotor slowing), assess for and address underlying causes of target symptoms, evaluate effectiveness and adverse effects of medication. The care plan further instructed staff to request pharmacy review of drug regimen, identify or rule out environmental and psychosocial stressors, administer Lexapro (medication used to treat anxiety and depression disorders) as ordered, and report unusual behavior and report changes in physical condition.

The 8/11/16 physician's order directed staff to administer Clonazepam (medication to treat a feeling of worry, nervousness, or unease), 0.5 (mg) milligrams, (BID) twice a day for anxiety and Trazodone (antidepressant), 50 mg, daily, administered in the evening, for sleep onset

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insomnia.

The 8/12/16 physician's order directed staff to administer Trazodone, 25 mg, daily, administered in the morning, for insomnia.

The 9/6/16 physician's order directed staff to administer Seroquel (antipsychotic), 50 mg, daily for psychosis and Clonazepam (antianxiety medication), 0.5 mg, daily (PRN) as needed for anxiety, last administered 11/4/16.

The 10/8/16 physician's order directed staff to administer Lexapro (antidepressant), 10 mg, daily for (OCD) Obsessive Compulsive Disorder.

The resident's medical record documented the resident had several days with behaviors including restlessness, delusions, hallucinations, and grabbing staff.

On 12/12/16 at 9:54 AM, observation revealed the resident in his/her bed sleeping. No signs or symptoms of behaviors, pain, or discomfort.

On 12/13/16 at 9:18 AM, observation revealed the resident seated in his/her wheelchair at the table outside of the nurse's station. Continued observation revealed nothing on the table, and the resident reached for things on the table that weren't there.

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On 12/12/2016 at 2:23 PM, Nurse G stated the resident has a range of behaviors, he/she has gotten upset and combative, made sexual comments, but lately, it just seems to be some restlessness and anxiety. Nurse G stated the resident has a history in the military and a lot of his/her behaviors appear to be flashbacks of his/her military time. Nurse G stated the resident spent some time at a behavioral health unit and things have improved since then, but staff are unable to tell what his/her triggers are for his/her behaviors, there doesn't seem to be a lot of consistency. Nurse Aide G stated the staff have noticed when the resident does have a behavior, it is best to just leave him/her alone, the more people involved, the more agitated the resident becomes.

On 12/13/16 at 10:20 AM, Nurse Aide H stated sometimes the resident can get very aggressive and grabby, he/she will grab staff's arm and hold on very tight. Nurse Aide H stated the resident is easily redirected, he/she likes to have a lot of options, and does well when staff keep him/her busy.

On 12/13/16 at 5:05 PM, Administrative Nurse D stated the facility communicates with the physician and the pharmacy regularly, but the resident's family prefers not to make any medication changes.

On 12/14/16 at 4:06 PM, Nurse Aide N stated the resident has some hallucinations and yells about things that aren't there. Nurse Aide N stated the resident has ripped down a portrait from his/her

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F 329	Continued From page 26 bedside, so it had to be removed, and although the resident is pretty quiet most of the time, he/she seems to have more behaviors around bedtime and overnight. The facility's 7/2000 Psychotropic Medication policy states that residents needing psychotropic medications will take the lowest effective doses to control their symptoms and be evaluated periodically by a physician, psychiatrist or (ARNP) nurse practitioner. The facility failed to ensure Resident #82 was free from psychoactive medications by failing to address the cause of his/her behaviors and to address the use of 2 concurrent antidepressant medications, placing the resident at risk for increased delusions, hallucinations, and adverse side effects.	F 329		
F 428 SS=D	483.45(c)(1)(3)-(5) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON c) Drug Regimen Review (1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. (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	F 428		

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F 428	Continued From page 27 (iv) Hypnotic. (4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. (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 had a census of 92 residents. The sample included 15 residents of which 5 were reviewed for unnecessary medications. Based on	F 428		

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observation, record review, and interview the facility's pharmacy consultant failed to identify and address 1 of 5 sampled residents, who received multiple antidepressant medications. (#82)

Findings included:

- Resident #82's quarterly (MDS) Minimum Data Set assessment, dated 10/7/16, indicated the resident had a (BIMS) Brief Interview for Mental Status score of 4, indicating severe cognitive impairment, with inattention, disorganized thinking, and altered level of consciousness. The MDS stated the resident had a mood severity score of 14, indicating moderate depression, physical behavior symptoms directed toward others, and rejection of care. The MDS revealed the resident required total dependence on staff for bathing, extensive staff assistance for bed mobility, transfers, walking in corridor, toilet use, walking in room, locomotion on and off unit, dressing, eating, and personal hygiene. The MDS revealed the resident's balance was not steady, only able to stabilize with staff assistance, and used a walker and wheelchair for mobility. The MDS documented the resident had a history of falls, 2 or more non injury falls since admission, 1 fall with minor injury since admission. The MDS revealed the resident received antipsychotic (medication to treat mental and emotional disorders), antianxiety (medication to calm and relax people with excessive nervousness or tension), antidepressant (medication used to treat mood disorder with a persistent feeling of sadness and loss of interest), and antibiotic (medication used to kill harmful infections) medications.

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The 4/26/16 Psychotropic drug use (CAA) Care Area Assessment revealed the resident had a history of altered mental status, Parkinson's disease (a progressive disease of the nervous system marked by tremor, muscle rigidity, and slow imprecise movements) with dementia (mental disorder marked by memory disorders, personality changes, and impaired reasoning) with agitated behaviors/hallucinations (experience involving the perception of something that is not there), and agitated behaviors. The CAA documented the resident received Namenda (medication to treat dementia) for memory.

The 10/12/16 care plan indicated the resident had a potential for adverse side effects related to use of psychotropic medications, Trazodone (medication used to treat a mood disorder that causes a persistent feeling of sadness and loss of interest), and Seroquel (medication used to treat mental and emotional disorders). The care plan directed staff to monitor for adverse effects (sedation, confusion, ataxia (inability to coordinate voluntary muscle movements) , irritability, dysphoria, psychomotor slowing), assess for and address underlying causes of target symptoms, evaluate effectiveness and adverse effects of medication. The care plan further instructed staff to request pharmacy review of drug regimen, identify or rule out environmental and psychosocial stressors, administer Lexapro (medication used to treat anxiety and depression disorders) as ordered, and report unusual behavior and report changes in physical condition.

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The 8/11/16 physician's order directed staff to administer Clonazepam (medication to treat a feeling of worry, nervousness, or unease), 0.5 (mg) milligrams, (BID) twice a day for anxiety and Trazodone (antidepressant), 50 mg, daily, administered in the evening, for sleep onset insomnia.

The 8/12/16 physician's order directed staff to administer Trazodone, 25 mg, daily, administered in the morning, for insomnia.

The 9/6/16 physician's order directed staff to administer Seroquel (antipsychotic), 50 mg, daily for psychosis and Clonazepam (antianxiety medication), 0.5 mg, daily (PRN) as needed for anxiety, last administered 11/4/16.

The 10/8/16 physician's order directed staff to administer Lexapro (antidepressant), 10 mg, daily for (OCD) Obsessive Compulsive Disorder.

The resident's medical record documented the resident had several days with behaviors including restlessness, delusions, hallucinations, and grabbing staff.

The facility's pharmacist consultant review reported the following:

7/13/16 (BBW) Black Box Warning for Seroquel, no other concerns

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F 428	Continued From page 31 8/11/16 BBW for Lovenox, no other concerns 10/6/16 BBW for Lexapro, no other concerns 11/3/16 BBW for Metformin, no other concerns 11/7/16 BBW for Cipro, no other concerns On 12/12/16 at 9:54 AM, observation revealed the resident in his/her bed with eyes closed. No signs or symptoms of behaviors, pain, or discomfort. On 12/13/16 at 9:18 AM, observation revealed the resident seated in his/her wheelchair at the table outside of the nurse's station. Continued observation revealed nothing on the table, and the resident reached out as to grab something off the table that was not there. On 12/12/2016 at 2:23 PM, Nurse G stated the resident has a range of behaviors, he/she has gotten upset and combative, made sexual comments, but lately, it just seems to be some restlessness and anxiety. Nurse G stated the resident has a history in the military and a lot of his/her behaviors appear to be flashbacks of his/her military time. Nurse G stated the resident spent some time at a behavioral health unit and things have improved since then, but staff are unable to tell what his/her triggers are for his/her behaviors, there doesn't seem to be a lot of consistency. Nurse Aide G stated the staff have noticed when the resident does have a behavior, it is best to just leave him/her alone, the more people involved, the more agitated the resident becomes.	F 428		

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On 12/13/16 at 10:20 AM, Nurse Aide H stated sometimes the resident can get very aggressive and grabby, he/she will grab staff's arm and hold on very tight. Nurse Aide H stated the resident is easily redirected, he/she likes to have a lot of options, and does well when staff keep him/her busy.

On 12/13/16 at 5:05 PM, Administrative Nurse D stated the facility communicates with the physician and the pharmacy regularly, but the resident's family prefers not to make any medication changes.

On 12/14/16 at 4:06 PM, Nurse Aide N stated the resident has some hallucinations and yells about things that aren't there. Nurse Aide N stated the resident has ripped down a portrait from his/her bedside, so it had to be removed, and although the resident is pretty quiet most of the time, he/she seems to have more behaviors around bedtime and overnight.

The facility's 7/2000 Psychotropic Medication policy states that residents needing psychotropic medications will take the lowest effective doses to control their symptoms and be evaluated periodically by a physician, psychiatrist or (ARNP) nurse practitioner.

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F 428	Continued From page 33 The facility's pharmacy consultant failed to ensure Resident #82 was free from use of multiple psychoactive medications in the same drug classification, Trazadone and Lexapro placing the resident in the facility at risk for adverse side effects.	F 428		
F 441 SS=E	483.80(a)(1)(2)(4)(e)(f) INFECTION CONTROL, PREVENT SPREAD, LINENS (a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: (1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards (facility assessment implementation is Phase 2); (2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported;	F 441		

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(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;

(iv) When and how isolation should be used for a resident; including but not limited to:

(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.

(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and

(vi) The hand hygiene procedures to be followed by staff involved in direct resident contact.

(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.

(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.

(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary.
This REQUIREMENT is not met as evidenced by:
The facility had a census of 92 residents. The sample included 15 residents. Based on observation, record review, and interview the facility failed provide a sanitary environment to

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prevent the development and transmission of disease and infection on 1 of 4 halls of the facility.

Findings included:

- On 12/8/16 at 10:34 AM, observation revealed Housekeeping Staff A prepared to clean a resident's room on Pioneer Hall. Housekeeping Staff A parked the housekeeping cart, in the hall, across from the resident's room. Housekeeping Staff A applied gloves, gathered the toilet bowl cleaner and brush, Clorox bleach germicidal (disinfectant deodorizer cleaner) in a spray bottle and Clorox wipes. Housekeeping Staff A entered the resident's bathroom, sprayed the Clorox bleach germicidal on the sink, pushed the toilet lid back with his/her gloved hand, to spray underneath it, the toilet riser, and the rest of the toilet. Housekeeping Staff A, with the same soiled gloves, took the premoistened Clorox wipe, wiped the window sill, after picking up the resident's urinal (a container used for urination) in the window, then wiped off the sink, and top of the toilet. Housekeeping Staff A squeezed the toilet bowl cleaner into the toilet bowl, brushed the inside of the toilet bowl, then with the contaminated toilet brush, brushed the toilet riser, underneath, top of the toilet seat, and around the bottom of the toilet. Housekeeping Staff A, with the same soiled gloves, took a roll of paper towels, touching the roll with the soiled gloves, tore off a paper towel, wiped off the toilet seat, and removed and discarded his/her gloves into the plastic trash bag in the trash can in the bathroom. Continued observation revealed Housekeeping Staff A tied the trash bag, placed a new trash bag in the trash can, and returned to the housekeeping cart in the hall, then placed the cleaning supplies in a locked compartment on the

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cart.

On 12/8/16 at 10:45 AM, Housekeeping Staff A verified the above observation is the way he/she normally cleaned a resident's room.

On 12/8/16 at 1:09 PM, Housekeeping Supervisor B stated staff should change gloves after contacting a contaminated surface and should not use a contaminated toilet brush to clean surfaces of the toilet, toilet riser, and toilet seat.

On 12/13/16 at 4:04 PM, Administrative Nurse D stated it was inappropriate for staff, when cleaning a resident's room, to clean the toilet bowl with a brush, then use the same brush to clean the toilet riser, and outside of the toilet, including the seat of the toilet. Administrative Nurse D stated he/she would expect staff to change gloves between cleaning dirty surfaces and clean surfaces.

The facility's 7/16 Housekeeping policy stated gloves should be changed after contact with contaminated surfaces and wash hands after removing gloves. Repeat as necessary. The policy stated scrub the toilet bowl with a brush and use pumice (a porous or spongy form of volcanic glass, used as an abrasive) bar when needed and wipe down all surfaces and sides of toilet and around bolts with disinfectant, if there is a high rise take off and disinfect all sides.

The facility failed to use proper necessary infection control practices, while cleaning an unsampled resident's room, in 1 of 4 halls of the facility, placing residents in the facility at risk for infections.