STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	415096	A. BUILDING _____ B. WING _____	07/09/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHANY HOME OF RHODE ISLAND	111 SOUTH ANGELL STREET PROVIDENCE, RI 02906

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F 000	INITIAL COMMENTS A Recertification Survey was conducted at Bethany Home of Rhode Island from 07/06/2021 through 07/09/2021 to determine compliance with 42 CFR Part 483 requirements for Long Term Care Facilities. A State licensure and emergency preparedness surveys were also conducted at this facility. As a result of this survey, the Facility was determined not to be in compliance with these requirements.	F 000	The filing of this Plan of Correction (POC) does not constitute that the deficiencies alleged did in fact exist, rather this POC is filed as evidence of the facility's continuing commitment to high quality resident care in full compliance with state and federal regulations. In-services have been underway and are ongoing. Completion date for optimal compliance with POC will be August 8, 2021.	
F 637 SS=D	Comprehensive Assessment After Signifcant Chg CFR(s): 483.20(b)(2)(ii) §483.20(b)(2)(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it has been determined that the facility failed to complete a Significant Change in Status Assessment within 14 days after there has been a significant change in the resident's physical or mental condition for 1 of 2 sample residents reviewed, Resident ID #4. Findings are as follows:	F 637	NR 7/28/21 RECEIVED JUL 28 2021 FACILITIES REGULATION	

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

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F 637	Continued From page 1 Record review revealed that the resident was admitted to the facility in July 2020. Record review revealed a 5/24/2021 consultant wound physician's evaluation and management summary indicating the resident has a new Stage 2 pressure wound (partial-thickness skin loss with exposed dermis) of the left, posterior, medial buttock. An additional evaluation and management summary dated 6/14/2021 revealed the pressure wound as a Stage 3 (full-thickness skin loss). Additionally, the record revealed the following decline in ADL (activities of daily living) physical functioning: 1. The 3/18/2021, quarterly MDS (Minimum Data Set) assessment revealed the resident required extensive, physical assistance of one person for locomotion on unit, locomotion off unit, and hygiene; required extensive, physical assistance of two or more persons for transfers, dressing, and toileting; and required limited assistance of one person for eating. 2. The 6/16/2021, annual MDS assessment revealed the resident required total dependence, physical assistance of two or more persons for transfers; required total dependence of one person for locomotion on unit, locomotion off unit, dressing, eating, toilet use, and hygiene. This represents a decline in seven functional areas. Further record review revealed that a Significant Change in Status Assessment was not completed	F 637	**As a POC for F 637** a) Resident ID#4 is stable and there were no negative outcomes to the resident. The MDS for Resident ID#4 was corrected, and a significant change MDS was completed and submitted immediately. b) We have since reviewed all resident MDSs to ensure all significant changes have been identified and submitted. We have not identified any further areas of concern. During the weekly RISK and Medicare meetings, if two areas of significant change are identified, a significant change MDS will be completed. **SEE EXHIBITS B-B7.** c) We conducted training for the nurses regarding systems now in place to report any change in resident condition, physically and mentally. **SEE EXHIBIT A.** A log book is now kept at the nurse's station for reporting changes. **SEE EXHIBIT B7** an internal tool used to serve as a history of areas of risk. The nurses will note in the electronic medical record any resident change in condition. d) The Director of Nursing (DNS)/designee will conduct ongoing audits of both the log book and the electronic medical record. Interventions will be made at time of detection and will be discussed at the appropriate weekly RISK meeting or Medicare meeting. **SEE EXHIBIT B 8.** Audit results will be discussed with the QAPI Committee on a monthly basis. At the end of a 3-month cycle, we will decide, as a team, if we have met our goals in this area. The indicator will be dropped if we are meeting our goals.	8/8/21

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F 637	Continued From page 2 when the resident was identified with a new Stage 2 or higher pressure ulcer and decline in ADL physical functioning. During a surveyor interview with the MDS Nurse Coordinator on 7/8/2021 at 2:45 PM, she could not provide evidence that a Significant Change in Status Assessment was completed for the resident with a decline in two or more areas.	F 637		8/8/21
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review, and staff interview, it has been determined that the facility assessments failed to accurately reflect the resident's status for 2 of 12 sample residents, Resident ID #s 4 and 16. Findings are as follows: 1. Record review for Resident ID #4 revealed s/he was admitted to the facility in July of 2020. Record review revealed a 6/14/2021 consultant wound physician's evaluation and management summary indicating the resident has a Stage 3 pressure wound (full-thickness skin loss) of the left, posterior, medial buttock measuring 0.7 x 0.8 x 0.1 centimeters (cm). Record review revealed an annual Minimum Data Set (MDS) assessment dated 6/16/2021, with an ARD (assessment reference date) of 6/16/2021.	F 641	**As a POC for F 641** a) Resident ID#4 and Resident ID#16 are stable without any negative outcomes. Corrections were made to the MDS with appropriate coding. b) MDS RN reviewed all patient MDSs for accurate coding. No other issues were identified. Nursing to be educated on the importance of RN documentation in conjunction with MDS coding. c) A mandatory RN meeting was held on July 21, 2021to review expectations of accurate assessments and documentation specifically in regards to wound assessments and medication orders. **SEE EXHIBIT A.** The DNS/designee will monitor any significant changes, quarterly assessments, and documentation assessments upon admission. **SEE EXHIBIT C.** d) The Director of Nursing (DNS)/designee will conduct ongoing audits specifically, in regard to assessments and documentation on wound care and review MDS to ensure all areas are captured. Audit findings will be shared with the QAPI Committee on a monthly basis. At the end of a 3-month cycle, we will decide, as a team, if we have met our goals in this area. The indicator will be dropped if we are meeting our goals.	

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F 641	Continued From page 3 Section M0210, Unhealed Pressure Ulcers/Injuries, of the assessment revealed that the resident was inaccurately coded as having no unhealed pressure ulcers/injuries during the 7-day look back period. 2. Record review for Resident ID #16 revealed s/he was admitted to the facility in February of 2020. Record review revealed a 2/26/2021 physician's order for Sertraline (an antidepressant) 50 milligrams once daily, with an order to hold from 5/26/2021 at 5:50 PM to 5/27/2021 at 5:49 PM. Further review revealed an additional order dated 5/27/2021 for Sertraline 50 mg one time only at 5:00 AM. Further review of the Medication Administration Record from 5/21/2021 to 5/27/2021 revealed that the resident received Sertraline 7 days. Record review revealed a significant change MDS dated 5/27/2021, with an ARD of 5/27/2021. Section N0410, Medications Received, of the assessment revealed that the resident was inaccurately coded as not receiving antidepressants during the 7-day look back period. During surveyor interviews with the MDS Nurse Coordinator on 7/8/2021 at 12:51 PM and 7/9/2021 at 11:37 AM, she acknowledged that the assessments were inaccurately coded.	F 641		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity	F 686		

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F 686	Continued From page 4 §483.25(b)(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: Based on surveyor observation, record review and staff interview, it has been determined that the facility failed to ensure that residents with pressure ulcers receive necessary treatment and services, consistent with professional standards of practice, to promote healing and prevent infection for 2 of 2 residents with actual or at risk for pressure ulcers, Resident ID #s 4 and 10. Findings are as follows: The facility's policy entitled, "Skin Care Program," states in part: "We...understand that intact skin is the body's first line of defense and to that end will make every attempt to maintain and/or restore out [sic] residents' skin integrity through preventative skin care and individualized wound care... 2. Upon residents' admission, the nurse will also complete the braden scale to identify those at risk for skin breakdown. The braden scale [will] be repeated on a quarterly basis. 3. Weekly skin assessments will be done for every resident with pressure wounds and results	F 686	**As a POC for F 686:** a) Resident ID#4 is stable and there were no negative outcomes to the resident. An updated and corrected wound assessment and treatment were put into place immediately. b) We have since reviewed all the residents with wounds, to ensure that the wound assessment and documentation are both comprehensive and accurate. No other issues were identified. c) RNs were in-serviced on July 21, 2021, **SEE EXHIBT A,** on properly and comprehensively assessing wounds (per regulation) and performing and documenting weekly skin assessments. The wound RN works together with the wound physician to assess patients with wounds or at risk for wounds and then documents all areas identified in the electronic medical record. The Director of Nursing (DNS)/designee will ensure these notes are reflected in the RISK and Medicare Meetings as a double check to ensure nothing goes undetected. **SEE EXHIBIT D.** d) The Director of Nursing (DNS)/designee will conduct audits of weekly skin check assessments to ensure documentation is comprehensive and accurate. These findings will be shared with the QAPI Committee on a monthly basis. At the end of a 3-month cycle, we will decide, as a team, if we have met our goals in this area. The indicator will be dropped if we are meeting our goals.	8/8/21

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F 686	Continued From page 5 documented on the wound log and in the resident progress notes. 4. Residents identified with a potential for skin breakdown or an existing skin breakdown will have a care plan established with resident specific interventions geared toward prevention and/or wound healing. Wound Care Documentation 1. Pressure wounds will be measured every week. 2. Measurements will be recorded in the progress notes of the medical record..." 1. Record review revealed that Resident ID #4 was admitted to the facility in July of 2020 and has diagnoses including, but not limited to, dementia, Alzheimer's disease, and stage 3 pressure ulcer (full-thickness skin loss). Review of a 6/21/2021 "Braden Scale For Predicting Pressure Sore Risk" indicates that the resident is at risk for developing a pressure ulcer. Review of a care plan initiated on 7/17/2020, revised on 7/6/2021, revealed that the resident "has a small superficial area on right buttock Resolved" and "is at risk for pressure ulcers r/t [related to] impaired mobility." Further review revealed interventions to "Follow facility protocols for treatment of injury...Nursing do skin assessment weekly and PRN [as needed]..." Review of progress notes revealed a 5/24/2021 Skin/Wound note stating, "Seen by Wound MD [medical doctor] for stage 2 pressure wound (partial-thickness skin loss with exposed dermis) on right buttocks. Measure at 0.8 x 0.9 x 0.1 cm [centimeter]..."	F 686	MR 7/28/21	

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F 686	Continued From page 6 Review of weekly Skin Observation Tools from 5/25/2021 to 7/6/2021 revealed the following: 5/25/2021, "Area on right buttocks healing" 6/1/2021, "Area on right buttocks healing. Tx [treatment] in place..." 6/8/2021, "Area on right buttocks healing. Tx in place..." 6/15/2021, "Area on right buttocks healing. Tx in place..." 6/22/2021, "Area on right buttocks resolved with barrier cream in place. No other issues." 6/29/2021, "Area on right buttocks resolved with barrier cream in place. Skin c/d/i [clean/dry/intact]." 7/6/2021, "Skin c/d/i" Review of the consultant wound physician's notes from 5/24/2021 to 6/28/2021 revealed the following: 5/24/2021, "Stage 2 Pressure Wound to the Left, Posterior, Medial Buttock...Wound size (L x W x D): 0.8 x 0.9 x Not Measurable cm...Exudate [drainage]: Moderate Serous [thin and clear drainage]" 6/1/2021, "The patient's visit has been rescheduled." 6/7/2021, "Stage 3 Pressure Wound to the Left, Posterior, Medial Buttock...Wound size (L x W x D): 0.9 x 0.8 x 0.1 cm...Exudate: Moderate	F 686	NR 7/29/21	

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F 686	Continued From page 7 Serous...Slough [dead tissue, usually cream or yellow in color]: 30%...Granulation tissue [new, healthy tissue]: 30%...Other viable tissues: 40%...Wound progress: Deteriorated..." 6/14/2021, "Stage 3 Pressure Wound to the Left, Posterior, Medial Buttock...Wound size (L x W x D): 0.7 x 0.8 x 0.1 cm...Exudate: Moderate Serous...Slough: 40%...Granulation tissue: 30%...Other viable tissues: 30%...Wound progress: Improved..." 6/21/2021, "Stage 3 Pressure Wound to the Left, Posterior, Medial Buttock...Wound size (L x W x D): 0.1 x 0.1 x 0.1 cm...Exudate: None...Other viable tissues: 100%...Wound progress: Improved..." 6/29/2021, "Stage 3 Pressure Wound to the Left, Posterior, Medial Buttock...Wound size (L x W x D): 0.2 x 0.3 x 0.1 cm...Exudate: None...Other viable tissues: 100%...Wound progress: No change..." Review of the "Wound Monitoring" binder provided by the facility revealed that on 6/1/2021 "rescheduled" is documented. Further record review failed to reveal evidence of full, weekly wound assessments on 6/1/2021 and 7/5/2021, including staging, measurements, exudate (if present), pain (if present), wound bed, and a description of wound edges and surrounding tissue. During a surveyor observation of the resident's skin in the presence of Nurse, Staff A, on 7/8/2021 at 9:19 AM, revealed a small open area on the resident's right buttock.	F 686	IMK 7/28/21	

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F 686	Continued From page 8 During a surveyor interview with Staff A immediately following the observation she acknowledged that the pressure ulcer was on the right buttock and not the left as documented on the wound physician notes. Additionally, she revealed that this was the same area that has been undergoing treatment. During a surveyor interview with the Director of Nursing Services (DNS) on 7/8/2021 at 3:10 PM, he revealed that the nurse completing the weekly skin checks should document a full, weekly wound assessment. Further, he failed to provide evidence of a full wound assessment on 6/1/2021 and 7/5/2021. 2. Record review revealed Resident ID #10 was admitted to the facility in July of 2020 and has diagnoses including, but not limited to, vascular dementia. Review of the Minimum Data Set (MDS) assessment, dated 4/16/2021, revealed that the resident is at risk for pressure ulcers. Review of a care plan, initiated 7/17/2020, revealed that the resident has potential impairment to skin integrity related to fragile skin. Further review revealed an intervention which states, "Follow facility protocols for treatment of injury...Nursing to do weekly skin checks and PRN." Review of progress notes revealed a 6/1/2021 Skin/Wound note stating, "Late Entry: Note Text: During AM [morning] care small opening found on right side of coccyx. Measured at 1.25 x 1.0 cm; stage 2 [pressure ulcer] N.O. [new order] for Triad [wound cream] to open area."	F 686		

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F 686	Continued From page 9 Record review revealed a physician's order dated 6/3/2021 stating, "Apply Triad to open area on coccyx every shift for wound care until resolved." The order was discontinued on 6/28/2021. Record review of weekly skin observation tools 6/1/2021 through 7/6/2021 revealed the following: 6/1/2021, "Site Sacrum...Type Pressure...Length 1.25...Width 1.0...Stage II...pressure area to coccyx with tx..." 6/8/2021, "Site Sacrum...Type Pressure...Length 1.25...Width 1.0...Stage II ...pressure area to coccyx with tx..." 6/15/2021, "Site Sacrum...Type Pressure...Length 1.25...Width 1.0...Stage II...pressure area to coccyx with tx..." 6/22/2021,"pressure area to coccyx resolving with tx..." 6/29/2021, "pressure area to coccyx resolving with tx..." 7/6/2021, "Skin c/d/i" Further record review from 6/1/2021 to 7/6/2021 failed to reveal evidence of full, weekly wound assessments, including staging, measurements, exudate (if present), pain (if present), wound bed, and a description of wound edges and surrounding tissue. Additionally, the record failed to reveal evidence of when the wound healed. The physician's treatment order was discontinued on 6/28/2021 and the 6/29/2021 skin observation indicates "pressure area resolving with	F 686 MR 7/24/21		

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F 686	Continued From page 10 treatment." Review of the "Wound Monitoring" binder, provided by the facility, failed to reveal evidence of a wound monitoring form for this resident with full, weekly assessments. During a surveyor observation of the resident's right coccyx in the presence of Staff A, on 7/8/2021 at 9:33 AM, revealed the resident's skin without a pressure ulcer. During a surveyor interview with the DNS on 7/8/2021 at 1:55 PM, he could not provide evidence of a full, weekly wound assessments being completed while the resident had an active pressure ulcer.	F 686		
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 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: Based on surveyor observation, record review, and staff interview, it has been determined that the facility failed to provide respiratory care consistent with professional standards of practice for 1 of 1 resident reviewed for oxygen therapy, Resident ID #131.	F 695		

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F 695	Continued From page 11 According to Brunner and Sudarth's textbook, Medical and Surgical Nursing, 7th Edition, 1992, p.524, "as with other medications, oxygen is administered with care, and its effects on each patient are carefully assessed. Oxygen is a drug and except in emergency situations is prescribed by a physician." Findings are as follows: Record review revealed the resident was admitted to the facility in July of 2021 with diagnoses which include, but are not limited to, acute respiratory failure with hypoxia (reduced oxygen in body tissues), heart failure, and dependence on supplemental oxygen. Review of the record revealed a 7/1/2021 physician's order for "O2 [oxygen] via nasal cannula to maintain P/ox [pulse oximetry, oxygen level of the blood] greater than 92%." The record failed to reveal evidence of a physician ordered liter flow for the oxygen. During surveyor observations made on 7/6/2021 at 12:00 PM, 7/7/2021 at 8:15 AM, 10:45 AM, and 1:57 PM revealed the resident was receiving oxygen via nasal cannula at 2 liters per minute. During a surveyor interview with Nurse, Staff A, on 7/7/2021 at 2:02 PM, she acknowledged that the resident has been using oxygen since admission and could not provide evidence of a compete physician's order indicating liter flow for the oxygen therapy	F 695	**As a POC for F 695** a) Resident ID#131 is stable and there were no negative outcomes to the resident. A corrected order was put in place to reflect oxygen therapy of 1-3 liters. b) We have since reviewed the charts of current residents on oxygen to ensure that the orders are accurate. We have not identified any further issues. c) RNs were in-serviced on July 21, 2021, **SEE EXHIBT A,** on properly reviewing and verifying all medication, including oxygen orders. Daily, all new orders are reviewed and verified with the physician. The second shift nurse prints the new orders and the third shift nurse reviews the orders for accuracy. The DNS/designee will serve as a triple check to review these orders for assurances they are accurately transcribed. d) The Director of Nursing (DNS)/designee will conduct ongoing audits of new orders. **SEE EXHIBIT E.** Audit findings will be shared with the QAPI Committee on a monthly basis. At the end of a 3-month cycle, we will decide, as a team, if we have met our goals in this area. The indicator will be dropped if we are meeting our goals.	8/8/21
F 756 SS=E	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5)	F 756		

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F 756	Continued From page 12 §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §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:	F 756	**As a POC for F 756:** a) Residents ID #12, 14, and 16, are stable without any negative outcome as a result. All pharmacy recommendations have since been responded to and MD orders followed accordingly. b) We have since reviewed additional pharmacy recommendations. There are no outstanding recommendations at this time. MR 7/28/21 c) RNs were in-serviced on July 21, 2021, **SEE EXHIBTS A**, on the importance of following through with pharmacy recommendations in a timely manner per regulatory guidelines. The DNS/designee will review pharmacy recommendations once they are provided by the Pharmacist Consultant. All recommendations will be addressed by second shift RN via telephone with the physician on the same day. Physicians will sign all recommendations during their next visit. d) The Director of Nursing (DNS)/designee will conduct ongoing audits to ensure the pharmacy recommendations are completed timely. **SEE EXHIBITS F and F1.** Audit findings will be shared with the QAPI Committee on a monthly basis. At the end of a 3-month cycle, we will decide, as a team, if we have met our goals in this area. The indicator will be dropped if we are meeting our goals.	8/8/21

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F 756	Continued From page 13 Based on record review and staff interview, it has been determined that the facility failed to ensure that the residents' drug regimen reviews were acted upon after irregularities were found and recommendations were made by the pharmacist for 3 of 7 Medication Regimen Reviews (MRR), Resident ID #s 12, 14, and 16. Findings are as follows: Review of the facility's policy titled, "Medication Monitoring, Medication Regimen Review and Reporting" states in part, "...Recommendations shall be acted upon within 30 calendar days. For those issues that require physician intervention, the attending physician either accepts and acts upon the report..." 1. A review of Resident ID #12's monthly consultant pharmacist report dated 4/28/2021 states in part, "...BP [blood pressure]-please review and repeat today. Yesterday was 174/98 hx [history] of ICH [intracerebral brain hemorrhage] likely due to HTN [hypertension] on 4/11/21- goal SBP [systolic blood pressure] < [less than] 160. Suggest review orders-parameter to call MD/RNP [Medical Doctor/Registered Nurse Practitioner] if SBP > [greater than] 160...Suggest change to Synthroid [medication used to treat low thyroid hormone] 62.5 mcg [microgram] and if no recent TSH [Thyroid stimulating hormone] done, suggest add to labs in one month..." Additionally, monthly consultant pharmacist report dated 5/27/2021 states in part, "...See signed rec from last month-add TSH in June... Physician/Prescriber Response...I agree with the above recommendations..."	F 756	MR 7/28/21	

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F 756	Continued From page 14 2. A review of Resident ID #14's monthly consultant pharmacist report dated 5/18/2021 states in part " ...Suggest change Ergocalciferol [Vitamin D2, use to treat and prevent bone disorders] to Cholecalciferol [Vitamin D3, used to treat and prevent bone disorders] when current supply is gone...Resident on Clonidine [a medication used to treat high blood pressure] 0.1 mg [milligram] q [every] hs [bedtime]. Clonidine is usually dosed BID [twice a day]. BP [blood pressure] on high side since admission 150/70 today- suggest trial increase to 0.1 mg BID...Ambien [a medication used to treat insomnia/sleeping disorder] prn [as needed] is required to have a stop date of initially 14 days...add dx [diagnosis] Asthma from hospital records for use of Proair [a medication used to prevent and treat shortness of breath] prn...On Flonase [a medication used to treat symptoms of allergies] daily- no dx found...add dx of Glaucoma from hospital dx list...Currently on Dorzolamide [a medication used to treat Glaucoma] with dx for HTN...Hospital stated stop taking dorzolamide...Note from hospital states was recently started on timolol [a medication used to treat Glaucoma and high blood pressure in the eyes] eye drops...Suggest clarifying eye drops with patient or family or ophthalmologist [eye doctor]." 3. A review of Resident ID #16's monthly consultant pharmacist report dated 2/26/2021 states in part, "BP last night 185/69 meds changed including a one x [time] dose of lisinopril [a medication used to treat high blood pressure] 10 mg last night. No further BP noted. Suggest check BP TID [three times a day] until controlled...Physician/Prescriber Response...I	F 756		

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F 756	Continued From page 15 agree with the above recommendations 3/2/21..." Record review failed to reveal evidence that the above-mentioned monthly consultant pharmacist reports were acted upon by the facility. During a surveyor interview with the Director of Nursing Services (DNS) on 7/8/2021 at 10:49 AM, he revealed that the physician was not made aware of Resident ID #14's monthly consultant pharmacist report. During additional interviews with the DNS on 7/8/2021 at 1:18 PM and 1:31 PM, he revealed that the monthly consultant pharmacist reports for Resident ID #'s 12 and 16 were not implemented after they were approved by the physician. During a surveyor telephone interview with the physician on 7/9/2021 at 10:15 AM, she indicated that she approved the pharmacy recommendations for Resident ID #'s 12 and 16 and would have expected them to be implemented.	F 756	MR 7/29/21	
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:	F 758		

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F 758	Continued From page 16 (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that— §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or	F 758	**, a POC for F758:** a) Stop dates for PRN psychotropic medications for Resident ID#14 and Resident ID #133 were put into place immediately. All stop dates for PRN psychotropic medications are now place. There were no negative outcomes. b) We have reviewed all orders for a PRN psychotropic medication to ensure there is a stop date associated with each order. We are (re) educating the nursing team and physicians regarding the regulations associated with PRN psychotropic medication usage. When a new psychotropic drug or PRN (for anti-psychotic, anti-depressant, anti-anxiety, and hypnotics) is ordered, the following information: name of patient, medication, and stop date will be listed in the psychotropic/PRN log book and will be reviewed for accuracy by the day nurse. c) RNs were in-serviced on July 21, 2021, **SEE EXHIBIT A.** The DNS/designee will routinely review these orders to ensure stop dates are in place and ensure a MD note regarding use of the medication is in the chart. **SEE EXHIBITS G and G1.** We have also requested that our Pharmacist consultant review these orders as well during the monthly visits. d) The DNS/designee will conduct ongoing audits of PRN psychotropic medications to verify all orders have an appropriate stop date. Audit findings will be shared with the QAPI Committee on a monthly basis. At the end of a 3-month cycle, we will decide, as a team, if we have met our goals in this area. The indicator will be dropped if we are meeting our goals.	8/8/21

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F 758	Continued From page 17 prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview it has been determined that the facility failed to ensure the residents' drug regimen is free from unnecessary psychotropic drugs related to as needed drugs extended beyond 14 days without an intended duration of therapy and in excessive dose for 2 of 4 residents with physician orders for PRN (as needed) psychotropic medications, Resident ID #s 14 and 133. Findings are as follows: Review of the facility's pharmacy policy titled, "CMS Prescribing Limits for PRN Psychotropics" states in part, "...Therapy Duration limit-14 days...If no rationale provided: order should be discontinued, and provider contacted..." 1. Record review for Resident ID #14 revealed a current physician's order dated 5/17/2021 for Zolpidem (Ambien, a medication use to treat insomnia/sleeping problem) 5 mg (milligram), by mouth every 24 hours as needed for insomnia. This order had no stop date. Record review of the Medication Administration Record (MAR) from 6/1/2021 through 7/7/2021 revealed that the resident received the above ordered Zolpidem on 6/6, 6/7, 6/8, 6/9, 6/10, 6/12, 6/13, 6/15, 6/16, 6/18, 6/19, 6/21, 6/22, 6/23, 6/24, 6/26, 6/28, 6/29, 6/30, 7/1, 7/2, 7/4, 7/5, 7/6 and 7/7. 2. Record review for Resident ID #133 revealed a current physician's order dated 6/17/2021 for	F 758	MR 7/25/21	

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F 758	Continued From page 18 Alprazolam (Xanax, an antianxiety medication) 1 mg, every 24 hours as needed for anxiety. This order had no stop date. During surveyor interviews with the Director of Nursing Services on 7/8/2021 at 8:49 AM and at 10:49 AM, he revealed that the PRN Zolpidem did not have a stop date and further indicated that the resident had received this medication after the 14 day time frame. Additionally, he revealed that the PRN Alprazolam did not have a 14 day stop date.	F 758		
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can	F 761	**As a POC for F 761 Part 1** a) The expired insulin pen was discarded and a new insulin pen was put into place the same day. No negative outcomes occurred. b) We have since reviewed all medication carts. We have not identified any further areas of concern regarding expired medications. c) Nurses and Med techs were in-serviced on July 21, 2021, **SEE EXHIBIT A,** on procedures to ensure compliance. Assignments have been given to various individuals to check expiration dates on all types of medications. d) The Director of Nursing (DNS)/designee will conduct ongoing audits of the medication carts and medication refrigerator. **SEE EXHIBIT H-H4.** Audit findings will be shared with the QAPI Committee on a monthly basis. At the end of a 3-month cycle, we will decide, as a team, if we have met our goals in this area. The indicator will be dropped if we are meeting our goals.	8/8/21

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F 761	Continued From page 19 be readily detected. This REQUIREMENT is not met as evidenced by: Based on surveyor observation and staff interview, it has been determined that the facility failed to store and label drugs and biologicals in accordance with currently acceptable professional principles for 2 of 2 medication carts observed, Nurse Medication Cart and Certified Medication Technician (CMT) Cart. Findings are as follows: Review of the facility policy tilted "Medication Storage" states in part "...Medication rooms, cabinets and medication supplies should remain locked when not in use or attended by persons with authorized access...Outdated medications are immediately removed from stock, disposed of according to procedures for medication disposal and reordered from the pharmacy..." 1. Surveyor observation of the Nurse Medication Cart in the presence of Nurse, Staff A, on 7/8/2021 at 7:40 AM revealed an insulin Lispro (medication use to treat diabetes) 1 unit dial solution pen 100 units/milliliter with an opened date of 5/18/2021 and discard date of 6/18/2021. Manufacturer instructions states in part "...Open or in-use pens should be kept at room temperature for a maximum of 28 days After 28 days, throw away..." During an interview immediately following this observation with Staff A she acknowledged that the insulin was expired and should have been discarded. She further revealed that the insulin was the only one in the facility and is in use.	F 761	MR 7/29/21	

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F 761	Continued From page 20 2. Surveyor observation of the CMT cart revealed the following: a. 7/8/2021 at 8:26 AM to 8:29 AM revealed the medication cart unlocked with a bottle of acetaminophen stored on the top of the medication cart unattended. b. 7/8/2021 at 8:39 AM to 8:41 AM revealed a bottle of multi vitamin tablets, a bottle of Biotech D3 (Vitamin D3) and a bottle of acetaminophen stored on the top of the medication cart unattended. c. 7/9/2021 at 8:14 AM revealed a bottle of acetaminophen stored on the top of the medication cart unattended. During an interview on 7/8/2021 at approximately 8:41 AM with CMT, Staff B, she acknowledged that the medications were left unattended and that the medication cart was left unlocked and unattended. She further acknowledged that she stores the acetaminophen on the top of the medication cart unattended and stated, "because I use it a lot." During an additional interview on 7/9/2021 at 8:18 AM with Staff A, she acknowledged that the acetaminophen was left on the top of the medication cart unattended. During an interview on 7/8/2021 at 11:54 AM with the Director of Nursing Services, he indicted that the insulin should have been discarded and not available for use. He further indicated that he would expect that the staff store medications securely.	F 761	**As a POC for F 761 Part 2** a) The medication carts were immediately secured and medications were properly stored. No negative outcomes occurred. b) We have since reviewed, one-on-one with med techs and RNs, on proper procedures of regulation 483.45 (h). c) Nurses and Med techs will have frequent and random evaluations done by the Director of Nursing/designee to ensure they are following regulation 483.45 (h): Storage of Drugs and Biologicals. d) The Director of Nursing (DNS)/designee will conduct ongoing audits of all medication carts. All findings will be shared with the QAPI Committee on a monthly basis. At the end of a 3-month cycle, we will decide, as a team, if we have met our goals in this area. The indicator will be dropped if we are meeting our goals. MR 7/28/21	8/8/21