STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155568	A. BUILDING 00 B. WING	11/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WILLIAMSPORT NURSING AND REHABILITATION	200 SHORT ST WILLIAMSPORT, IN 47993

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. Survey dates: November 12, 13, 14, 15, and 18, 2019 Facility number: 000449 Provider number: 155568 AIM number: 100290350 Census Bed Type: SNF/NF: 59 Total: 59 Census Payor Type: Medicare: 10 Medicaid: 32 Other: 17 Total: 59 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on November 26, 2019.	F 0000		
F 0580 SS=D Bldg. 00	483.10(g)(14)(i)-(iv) Notify of Changes (Injury/Decline/Room, etc.) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention;			

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

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	(B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations			

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	under §483.15(c)(9). Based on interview and record review, the facility failed to ensure the physician was notified of insulin being held for 1 of 1 residents reviewed for insulin (Resident 112). Findings include: During an interview, on 11/12/19 at 2:31 p.m., Resident 112 indicated she believed her insulin was not being administered as she thought it should be. Resident 112's record was reviewed on 11/15/19 at 10:35 a.m. The profile indicated the resident's diagnoses included, but were not limited to, type 1 diabetes mellitus (a form of diabetes mellitus that results from autoimmune destruction of insulin-producing beta cells of the pancreas) with diabetic chronic kidney disease (a type of kidney disease caused by diabetes), type 1 diabetes mellitus with unspecified diabetic retinopathy (a complication of diabetes where blood vessels in the eye are damaged) without macular edema (a swelling of the portion of the eye that perceives central, detailed vision), and type 1 diabetes mellitus with diabetic neuropathy, unspecified (nerve damage caused due to persistently high blood sugar level [diabetes]). A care plan, dated 9/27/19, indicated the resident was at risk for adverse effects of hyperglycemia or hypoglycemia related to use of glucose lowering medication and/or diagnosis of diabetes mellitus. Interventions included, but were not limited to, medications as ordered. The November 2019 Medication Administration Record (MAR) indicated the resident's current	F 0580	**F580 – Notify of Changes** **It is the practice of this facility to notify the resident; medical doctor (MD); and the resident representative when there is a change in the resident condition and that appropriate, timely, and effective intervention takes place.** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** Resident #112 MD and resident notified that resident did not receive her insulin on 11/8/19. Resident #112 no longer resides at the facility. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** All residents with a diagnosis of diabetes have the potential to be affected. EMAR compliance report for the last 30 days will be reviewed for the last 30 days to ensure that no other residents have been affected. MD/family notification will be completed for any residents identified by 12/6/19. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:**	12/18/2019

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	Insulin/Diabetic Orders, included, but were not limited to, Humalog U-100 Insulin (fast acting insulin) solution; 100 unit/milliliter (ml), subcutaneous (SQ)(injection below the skin) per sliding scale (a physician created chart based on how the patient's body responds to insulin, their daily activity, and an agreed-upon carbohydrate intake) three times daily with meals, and Humalog U-100 Insulin solution; 100 unit/ml, 5 units SQ, three times a day, provided along with sliding scale insulin and meals. Nursing documentation on the MAR, dated 11/8/19 at 6:53 p.m., indicated the insulin had not been administered. The insulin was document as being held per precaution for poor appetite and blood sugar reading of 133. No documented evidence was observed of the physician being notified of the resident's insulin being held. During an interview, on 11/15/19 at 12:06 p.m., the Regional Director of Clinical Services (RDCS) indicated the policy of the company was to notify the physician if a medication was held. During an interview, on 11/15/19 at 1:45 p.m., the Director of Nursing Services (DNS) indicated the physician should always be notified if a medication is held. On 11/15/9 at 1:55 p.m., the DNS provided a document, with a revised date of 11/2018, titled, "Resident Change of Condition Policy," and indicated it was the policy currently being used by the facility. The policy, indicated, "POLICY: It is the policy of this facility that all changes in resident condition will be communicated to the physician...PROCEDURE: ...3...b. The nurse in charge is responsible for notification of physician...prior to the end of assigned shift when		DNS and/or designee will in-service the nursing staff on or before 12/18/19 on the facility policy related to change of condition, following MD orders and providing medications as ordered. DNS/designee will review the EMAR compliance report daily to ensure that residents receive medications as ordered. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** Ongoing compliance with this corrective action will be monitored through the facility Quality Assurance and Performance Improvement Program (QAPI). The DNS/designee will be responsible for completing the QAPI Audit tool Change of Condition weekly for 4 weeks and monthly for at least 6 months. If threshold of 95% is not met, an action plan will be developed. Findings will be submitted to the QAPI Committee for review and follow up.	

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	a significant change in the resident's condition is noted...." 3.1-5(a)(3)			
F 0584 SS=D Bldg. 00	483.10(i)(1)-(7) Safe/Clean/Comfortable/Homelike Environment §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable			

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	lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. Based on interview, and record review, the facility failed to ensure there was adequate personal space and a homelike environment in residents' room for 2 of 24 residents reviewed for homelike environment (Resident 6, and Resident 8). Findings include: During an interview, on 11/12/19 at 11:08 a.m., Resident 6 indicated he felt his bed was too close to Resident 8's and would like there to be more room between the beds. He had not said anything because Resident 8 was only in there temporary until he could be moved back to his room. During an interview, on 11/12/19 at 1:49 p.m., Resident 8 indicated he felt like his bed was too close to Resident 6's and he did not like being that close. He felt he did not have enough room and had not said anything because he had been moved into this room temporarily while his room was being remodeled. He did not have all of his belongings in the temporary room. He had been in the temporary room for approximately a week and was told it would be at least one more week. During an interview, on 11/15/19 at 2:58 p.m., the Maintenance Supervisor indicated Resident 8 had been moved to a temporary room with Resident 6 while his room was being remodeled. He was unsure how much space was between the beds	F 0584	**F584 – Safe/Clean/Comfortable/Homelike Environment** It is the practice of this facility to ensure that residents are provided a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safety. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** Resident 6 has been followed up with and has no concerns with how room is currently arranged. Resident 8 has been back to his room since renovations have been completed and has no concerns with how room is arranged. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** All residents have the potential to be affected. All residents currently residing in the facility will be asked by	12/18/2019

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	and would look into it how much space could be between the beds. The resident's room was anticipated to be completed in about one week. During an interview, on 11/18/19 at 9:23 a.m., this surveyor asked the Maintenance Supervisor if I could observe him measure the distance between Resident 6 and Resident 8's beds. At this time, he indicated he had gotten Resident 8's room completed over the weekend, on Saturday 11/16/19, and Resident 8 had returned to his room. There was not a policy for how much space should be between resident's beds but he had been told by the administrator there should be 3 feet of personal space between the resident's beds and they follow federal regulation guidelines. He had not measured the distance between the beds but felt there was more than 3 feet. During an interview, on 11/18/19 at 9:38 a.m., Qualified Medication Aide (AMA) 8 indicated Resident 8's Broda chair (wheelchairs for long term care covering tilt-in-space positioning, mobility, rehab and other care needs) would not fit in between his bed and Resident 6's bed. They had to position his chair on the other side of his bed to transfer him into bed. During an interview, on 11/18/19 at 9:50 a.m., the Administrator indicated she was unaware Resident 6 and Resident 8 had a concern with the space between their beds. A resident should have 3 feet of personal space between their beds and rooms should be homelike. During an interview, on 11/18/19 at 2:03 p.m., the Director of Nursing Services (DNS) indicated neither Resident 6 nor Resident 8 had mentioned they had concerns with how close their beds were. She was unsure how much space they had		12/13/19 if they have adequate personal space and feel that their room is a homelike environment. Any concerns will be addressed. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** All staff will be in-serviced on ensuring residents feel that they have adequate personal space in their rooms and that they feel that their room is homelike, and they have their personal belongings that they want on or before 12/18/19. During customer care rounds, residents will be asked about space in room, any concerns will be addressed immediately. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** Ongoing compliance with this corrective action will be monitored through the facility Quality Assurance and Performance Improvement Program (QAPI). The DNS/designee will be responsible for completing the QAPI Audit tool Environment weekly for 4 weeks and monthly for at least 6 months. If threshold of 95% is not met, an action plan will be developed. Findings will be submitted to the QAPI Committee for review and follow up.	

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	between the beds. Resident 8 only had some of his belongings and had not been set up with all of his belongings because he was in the room temporarily while his room was being remodeled. Resident 8's record was reviewed, on 11/15/19 at 2:52 p.m. A progress note, dated 11/5/19, indicated the family and resident had been notified of a room move due to repair. A census form, dated 11/6/19, indicated the resident had changed rooms. A quarterly Minimum Data Set (MDS) assessment, dated 8/14/19, indicated the resident was cognitively intact. On 8/14/19 at 2:00 p.m., the DNS provided a document, titled, "Admission Agreement," and indicated it was the policy currently being used by the facility. The policy indicated, "...Quality of Life and Safe Environment: A resident has a right to care in an environment that promotes maintenance or enhancement of each resident's quality of life. The resident has the right to a safe, clean, comfortable, and homelike environment, including but not limited to receiving treatment and support for daily living safely...." 3.1-19(f)(5)			
F 0641 SS=A Bldg. 00	483.20(g) Accuracy of Assessments §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. Based on record review and interview, the facility failed to ensure Minimum Data Set (MDS) assessments were completed accurately for 2 of 18 residents' MDS assessments reviewed (Residents 22 and 34).	F 0641	**F641 – Accuracy of Assessments** It is the practice of this facility to ensure accurate Minimum Data Set (MDS) Assessments are	12/18/2019

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	Findings include: 1. Resident 22's record was reviewed on 11/14/19 at 11:39 a.m. An admission Minimum Data Set (MDS) assessment, dated 8/30/19, indicated the resident's cognitive assessment was not assessed. During an interview, on 11/14/19 at 2:52 p.m., the MDS Coordinator reviewed the cognitive assessment section of the admission MDS assessment, dated 8/30/19, and indicated the section was not completed. She was not sure why it was not completed, but it should have been. 2. Resident 34's record was reviewed on 11/18/19 at 10:09 a.m. A quarterly Minimum Data Set (MDS) assessment, dated 9/10/19, indicated a Brief Interview for Mental Status (BIMS) assessment was not completed because the resident was rarely or never understood. The staff assessment of the resident's cognition was not assessed. During an interview, on 11/18/19 at 1:18 p.m., the Director of Nursing Services reviewed the cognitive assessment section of the quarterly MDS assessment, dated 9/10/19, and indicated the staff assessment of the resident's cognition was not completed. She was not sure why it was not completed, but it should have been. On 11/15/19 at 10:59 a.m., the MDS Coordinator provided a copy of Section C of the Centers for Medicare and Medicaid Services (CMS) Resident Assessment Instrument (RAI) Version 3.0 Manual, and indicated it was the policy currently being used by the facility. The manual indicated, "SECTION C: COGNITIVE PATTERNS Intent: The items in this section are intended to determine		accurately completed. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** Resident 22 MDS Assessment has been modified and resubmitted Resident 34 MDS Assessment has been modified and resubmitted **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** All residents requiring an MDS Assessment have the potential to be affected by this finding. All MDS Assessments within the last 30 days were audited to ensure the residents assessment was coded accurately for completion of the BIMS. Any inaccurate coding identified will be modified and resubmitted to ensure accuracy. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** RAI Support Specialist will in-service MDSC and other relevant team members on accuracy of assessments on or before 12/18/19. DNS/designee will ensure that BIMS interview is completed accurately before completing and submitting the	

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	the resident's attention, orientation and ability to register and recall new information. These items are crucial factors in many care-planning decisions. C0100: Should Brief Interview for Mental Status Be Conducted?...Coding Instructions Code 0, no: if the interview could not be conducted because the resident is rarely/never understood; cannot respond verbally, in writing, or using another method; or an interpreter is needed but not available. Skip to C0700, Staff Assessment of Mental Status. Code 1, yes: if the interview should be conducted because the resident is at least sometimes understood verbally, in writing, or using another method, and if an interpreter is needed, one is available...." 3.1-31(c)(12)		MDS Assessment. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** Ongoing compliance with this corrective action will be monitored through the facility Quality Assurance and Performance Improvement Program (QAPI). MDSC/MDSA will complete the QA tool labeled MDS Coding and Accuracy weekly for 4 weeks and then monthly for 6 months. If threshold of 95% is not met, an action plan will be developed. Findings will be submitted to the QAPI Committee for review and follow up.	
F 0657 SS=D Bldg. 00	483.21(b)(2)(i)-(iii) Care Plan Timing and Revision §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's			

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	representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. Based on interview and record review, the facility failed to ensure a care plan meeting was held and resident and their representative were invited (Resident 53), and care plans were revised and updated (Resident 34), for 2 of 18 residents care plans reviewed. Findings include: 1. During a resident representative interview, on 11/13/19 at 10:42 a.m., Resident 53's family representative indicated she could not remember being invited to or a care plan meeting ever being held. Resident 53's record was reviewed on 11/18/19 at 11:40 a.m. The profile indicated the resident had been admitted to the facility on 10/3/19. Review of the record's observations and progress notes, indicated no documented evidence of a care plan meeting ever being held for the resident or that invitations had been sent out to the resident and her family representative. During an interview, on 11/18/19 at 11:49 a.m., the	F 0657	**F657 – Care Plan Timing and Revision** **It is the practice of this facility to provide care plan meetings for the residents and their representatives and that care plans are revised and updated.** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** Resident 53 and their representative was invited to a care plan meeting. Resident 34 care plans have been reviewed and updated. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** All residents have the potential to be affected. Audit of all residents residing in the facility will be completed on or before 12/18/19 to ensure that	12/18/2019

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	Regional Director of Clinical Services (RDCS) indicated documentation of care plan meetings would be in the record under observations and a progress note would be put into the record for the meeting. She was not able to locate any documented evidence of a care plan meeting being held, in the resident's record. On 11/18/19 at 1:17 p.m., the Director of Nursing Services (DNS) provided a document, with a revised date of 10/19, titled, "IDT (Interdisciplinary Team) Care Plan Review Guidelines," and indicated it was the policy currently being used by the facility. The policy indicated, "1. Prior to the Meeting: IDT members must ensure the following: ...Care Plan invitation has been mailed to the resident's representative (Social Services [SS]), Care Plan invitation has been given to the resident prior to the meeting time (SS)...2...all IDT members...meet with the resident and/or representative...."2. Resident 34's record was reviewed on 11/18/19 at 10:09 a.m. A quarterly Minimum Data Set (MDS) assessment, dated 9/10/19, indicated the resident was rarely or never understood. Resident 34 had care plans, last reviewed and revised on 7/8/19 with goal target dates of 10/8/19, for the following concerns: risk for adverse side effects related to the use of an anticonvulsant medication, life story and social information, refused to have his picture taken for the medical record, memory deficit and impaired decision making ability, difficulty making himself understood, risk for complications related to tube feeding, risk for bleeding and bruising, risk for ineffective tissue perfusion, impaired gas exchange, caries (cavities) or missing teeth, constipation, risk for pain, risk for fluid imbalance, incontinent, not able to return to the community		they have had a care plan meeting within the last 90 days. All residents residing in the facility have had their care plans reviewed to ensure that they are up to date. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** SS/IDT will be in-serviced on ensuring residents and their representatives are invited to a care plan meeting at least quarterly. MDSC/IDT will be in-serviced on ensuring care plans are reviewed and updated with each MDS assessment. Social Service Designee will ensure care resident and families are invited to care plan meeting through verification of MDS schedule and care plan invitation. ED/designee will ensure care plan held and reviewed weekly through verification through the MDS schedule. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** Ongoing compliance with this corrective action will be monitored through the facility Quality Assurance and Performance Improvement Program (QAPI).	

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	and required 24 hour care, a full code status (initiate cardiopulmonary resuscitation of found not breathing and pulseless), risk for skin breakdown, and risk for falls. A care plan, last reviewed and revised on 7/19/19, goal target dated 10/8/19, indicated the resident had an indwelling urinary catheter (a tube inserted into the bladder to drain urine). A care plan, last reviewed and revised on 8/1/19, goal target dated 11/1/19, indicated the resident did not wish to participate in group activities. A care plan, last reviewed and revised on 8/8/19, goal target dated 10/8/19, indicated the resident's family was supportive and the resident would communicate needs. A care plan, last reviewed and revised on 8/26/19, goal target dated 10/8/19, indicated the resident required assistance and monitoring with activities of daily living (ADL) care. A care plan, last reviewed and revised on 9/18/19, goal target dated 10/8/19, indicated the resident was at risk for aspiration. A care plan, last reviewed and revised on 10/3/19, goal target dated 10/8/19, indicated the resident resisted care and became agitated. During an interview, on 11/18/19 at 1:18 p.m., the Director of Nursing Services (DNS) reviewed the resident's care plans, and indicated the goal target dates should have been future dates. Care plans should have been reviewed and revised with the MDS assessments, at least quarterly. The last MDS assessment was 9/10/19, and the care plans should have been reviewed and revised at that		MDSC/designee will complete the QA tool labeled Care Plan Review weekly for 4 weeks and then monthly for 6 months. If threshold of 95% is not met, an action plan will be developed. Findings will be submitted to the QAPI Committee for review and follow up.	

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	time. On 11/18/19 at 1:18 p.m., the DNS provided a document titled, "IDT Comprehensive Care Plan Policy," and indicated it was the policy currently being used by the facility. The policy indicated, "Policy: It is the policy of this facility that each resident will have a comprehensive person-centered care plan developed based on comprehensive assessment. The care plan will include measurable goals and resident specific interventions based on resident needs and preferences to promote the resident's highest level of functioning including medical, nursing, mental, and psychosocial needs...Procedure: ...Care plan problems, goals, and interventions will be updated based on changes in resident assessment/condition, resident preferences or family input...." 3.1-35(d)(2)(B)			
F 0692 SS=D Bldg. 00	483.25(g)(1)-(3) Nutrition/Hydration Status Maintenance §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise;			

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	§483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. Based on record review, observation, and interview, the facility failed to ensure accuracy of a resident's weights, communication of swallowing difficulties, and to provide a resident assistance to eat in a timely manner for 1 of 3 residents reviewed for nutrition (Resident 57). Findings include: Resident 57's record was reviewed on 11/13/19 at 2:18 p.m. An admission Minimum Data Set (MDS) assessment, dated 10/27/19, indicated the resident had a severe cognitive impairment and required extensive assistance of one staff member with eating. Diagnoses on the resident's profile included, but were not limited to, hemiplegia (paralysis on one side of the body) and hemiparesis (muscle weakness or partial paralysis on one side of the body) following cerebral infarction (an area of necrotic tissue in the brain as a result of obstructed blood flow) affecting the right dominant side, dysphagia (difficulty swallowing) following cerebral infarction, and aphasia (loss of the ability to understand or express speech caused by brain damage) following cerebral infarction. A weight in the resident's electronic medical record, dated 10/21/19, indicated 149 pounds. A Physician's Order, dated 10/23/19, indicated Speech Therapy (ST) to treat aphasia and	F 0692	F692 – Nutrition/Hydration Status Maintenance It is the practice of this facility to ensure accuracy of a resident's weight, to communicate any swallowing difficulties and aid to residents to eat in a timely manner. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: Resident 57 weight remains stable. MD/family are aware of current weight. Speech therapist recommendations were implemented on 11/14/19. Her food preferences were obtained, and a dietary assessment has been completed. Resident 57 receives assistance in the restorative dining room for meals as needed. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: All residents have the potential to	12/18/2019

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	dysphagia secondary to cerebral infarction. A Physician's Order, dated 10/29/19, discontinued on 11/14/19, indicated regular diet, Kennedy cups (a lightweight, spill proof cup) for liquids, and finger foods. A weight in the resident's electronic medical record, dated 10/31/19, indicated 138 pounds. A second weight, obtained the same day, indicated 138 pounds. The electronic medical record lacked documentation of any further weights. A weight review observation, dated 11/1/19, indicated the resident's weight was stable. A Physician's Order, dated 11/14/19, indicated pureed diet with Kennedy cups for liquids. A care plan, goal target dated 1/21/20, indicated the resident was at risk for altered nutritional status related to newly admitted to the facility. Interventions included Kennedy cups for liquids due to tremors, provide finger foods at meals, food and diet preferences, notify physician and family of significant weight changes, offer a substitute of less than half of any meal is consumed, and regular diet. The resident's record lacked documentation the resident's dietary preferences were assessed, a dietitian had completed a dietary assessment, and any action was taken to verify the accuracy of the resident's weights, or address weight loss if the weights were accurate. During an interview, on 11/14/19 at 10:57 a.m., the Director of Nursing Services (DNS) indicated there was a Nutrition at Risk (NAR) program to monitor residents' nutritional status and weights.		be affected. Weight Variance report for all residents currently residing in the facility has been reviewed to ensure weights are accurate. Audit completed to ensure all residents have had dietary preferences obtained and that a dietary assessment has been completed. Therapy/IDT has completed dining room observations to ensure that no resident has any swallowing or chewing difficulty by 12/13/19 What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: Nursing staff will be in-serviced on ensuring accuracy of resident weight before entering into electronic record on or before 12/18/19. Nursing staff will be in-serviced on completing therapy referral form for any resident with a noted change in their baseline on or before 12/18/19. Nursing staff will be in-serviced on providing cueing and assistance in the dining room on or before 12/18/19.	

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	All residents newly admitted to the facility should have been weighed weekly for four weeks. At the same time, the DNS reviewed the resident's weights in the electronic record and indicated there were not weekly weights for four weeks recorded. During an interview, on 11/14/19 at 11:08 a.m., Speech Language Pathologist (SLP) 14 indicated the Occupational Therapist (OT) recommended the Kennedy cups and finger foods because of the resident's self feeding abilities. Weight losses should have been communicated with the SLP, and she was not aware this resident had lost weight. Nursing reported to her the resident had increased difficulty swallowing this morning. She already had the resident on case load, but was seeing her more for cognitive issues than swallowing. The resident just started to exhibit increased swallowing difficulty today. During an interview, on 11/14/19 at 11:13 a.m., Occupational Therapist (OT) 15 indicated she was not sure if the resident had lost weight. She was normally notified of weight losses. During an interview, on 11/14/19 at 11:15 a.m., Licensed Practical Nurse (LPN) 12 indicated weekly weights were obtained by the floor staff, given to the DNS, and the DNS should have put them in the electronic record. She reviewed the resident's weights, and indicated four weekly weights were not included in the resident's record. She was unable to find any documentation from the dietitian in the resident's record. During an interview, on 11/14/19 at 11:25 a.m., the Dietary Manager indicated he completed dietary preferences with the residents upon admission. At the same time, he was unable to find any dietary		DNS/designee will review all residents weight variance reports weekly to ensure there are no variances, if variance is identified, the resident will be reweighed and appropriate action taken. All new residents, and residents during their quarterly review have dietary preferences completed and will be place in observation initial nutritional review within 72 hours of admission b y dietitian/designee. DNS/designee will make referral to therapy for a screen for any resident identified as having a significant weight loss, having difficulty swallowing or having difficulty in feeding self. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: Ongoing compliance with this corrective action will be monitored through the facility Quality Assurance and Performance Improvement Program (QAPI). The DNS/designee will be responsible for completing the QAPI Audit tool Meal Observation weekly for 4 weeks and monthly for at least 6 months. If threshold of 95% is not met, an action plan will be developed. Findings will be submitted to the QAPI Committee for review and follow up.	

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	preferences completed in the system for this resident. During an interview, on 11/14/19 at 11:50 a.m., the DNS indicated the resident's food preferences should have been completed. She was not sure about when the dietitian's assessment should have been completed. She found the resident's weight for the previous week written on a piece of paper on her desk, and it was 140 pounds. She should have entered this weight in the electronic record, but had not done so yet. She did not think the admission weight was correct, but had not reached out to the previous facility to verify this until requested. On 11/14/19 at 12:12 p.m., LPN 13 was observed assisting the resident to eat. LPN 13 indicated the resident had increased difficulty swallowing over the previous weekend. During an interview, on 11/14/19 at 1:23 p.m., SLP 14 indicated she was not notified of the resident having increased swallowing difficulty until today, Thursday. She was not aware the resident had increased swallowing difficulty over the previous weekend. If a resident had difficulty swallowing over the weekend, it should have been reported to therapy the following Monday. Nursing should have used nursing measures until that time. During an interview, on 11/14/19 at 1:26 p.m., LPN 13 indicated the resident had increased swallowing difficulty over the previous weekend while eating a grilled cheese. She had not reported this to therapy. On 11/15/19 at 10:00 a.m., the DNS provided documentation from the resident's previous			

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	facility, the resident weighed 133.5 pounds on 10/7/19. At the same time, the DNS indicated she had not obtained this information previously. On 11/15/19 at 11:39 a.m., the resident was observed in the restorative dining room, served a pureed diet with Kennedy cups. The plate was placed in front of the resident, with spoons placed in pureed spaghetti and applesauce. The resident made no attempt to feed herself. At 11:56 a.m., LPN 13 assisted the resident to start eating. Prior to that, the resident was not assisted or cued to eat. During an interview, on 11/15/19 at 11:56 a.m., LPN 14 indicated there should have been enough staff members to assist all of the residents, but there were not enough people helping in the dining room today. During an interview, on 11/15/19 at 12:04 p.m., the Regional Director of Clinical Services (RDCS) indicated residents should not have waited 15 minutes for assistance to eat, while food was in front of them. On 11/14/19 at 1:44 p.m., the DNS provided a document titled, "Resident Weight Monitoring," and indicated it was the policy currently being used by the facility. The policy indicated, "POLICY: It is the policy of this facility to have resident weights reviewed routinely by the Registered Dietitian and The Nursing Department. An interdisciplinary team will review any resident who has weight or nutritional concerns. PROCEDURE: 1. The interdisciplinary team will place the following residents on weekly weights. New admission or readmission for a minimum of 4 weeks...."			

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	On 11/15/19 at 1:35 p.m., the RDCS provided a document titled, "Delivery and Documentation of Meal Service and Between Meal Nourishments," and indicated it was the policy currently being used by the facility. The policy indicated, "POLICY: It is the policy of this facility that residents receive their meals and nourishments in a timely, courteous, and helpful manner...PROCEDURE: Delivery: ...Assist residents in eating as needed...." 3.1-46(a)(1)			
F 0695 SS=D Bldg. 00	483.25(i) Respiratory/Tracheostomy Care and Suctioning § 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. Based on observation, interview, and record review, the facility failed to ensure a Licensed Nurse stayed with a resident during an entire nebulizer treatment (drug delivery device used to administer medication in the form of a mist inhaled into the lungs) for 1 of 1 residents reviewed for respiratory care (Resident 37). Findings include: During a random observation, on 11/12/19 at 1:45 p.m., Resident 37 was observed upright in his bed receiving a nebulizer treatment, there was liquid in	F 0695	**F695 – Respiratory/Tracheostomy Care and Suctioning** It is the practice of this facility to ensure that a Licensed Nurse stay with a resident while they are receiving a nebulizer treatment. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** Resident 37 lungs have been assessed and has had no	12/18/2019

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	the nebulizer medicine cup and mist coming from the mouthpiece. There was no licensed nurse observed to be in the room during this time. At 1:53 p.m., the mist was no longer present and only droplets of liquid were noted in the nebulizer medicine cup. The resident placed the mouthpiece on his bedside table, the nebulizer machine was still on. At this time, the resident indicated a nurse would not always stay with him during his nebulizer treatment. There was no observation of an assessment that included pulse and respirations performed during the procedure, or a post assessment that included pulse, respiration, and breath sounds. At 2:04 p.m., Certified Nursing Assistant (CNA) 30 was observed to turn off the nebulizer compressor. At this time, CNA 30 indicated a nurse would often set up the resident's nebulizer machine and the resident would self-administer the treatment when he wanted. A nurse would not always stay with the resident during the entire procedure and she had not observed a nurse with the resident prior to turning the nebulizer machine off. During an interview, on 11/12/19 at 2:20 p.m., Registered Nurse (RN) 6 indicated her shift started at 2:00 p.m. and she had not administered Resident 37's nebulizer treatment, it would have been the nurse on the prior shift. The nursing staff would not always stay with a resident who was alert and oriented and could perform it themselves. She would assess the residents lung sounds, respirations, pulse, and how they tolerated the breathing treatment prior to, at least once during, and after the treatment was completed. A treatment usually took 10-15 minutes and she would go back in with the resident around that time frame after a treatment had been started.		identified issues with administering his nebulizer treatment on 11/12/19. RN #6, LPN #9, LPN #10 were educated on 11/12/19 when deficient practice was identified and completed a return demonstration for competency on providing a nebulizer treatment. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** Resident 37 lungs have been assessed and has had no identified issues with administering his nebulizer treatment on 11/12/19. RN #6, LPN #9, LPN #10 were educated on 11/12/19 when deficient practice was identified and completed a return demonstration for competency on providing a nebulizer treatment. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** DNS/designee will complete random nebulizer treatment skills competencies on all shifts daily for one week to ensure that nebulizer treatments are being administered correctly. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality**	

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	During an interview, on 11/12/19 at 2:34 p.m., Licensed Practical Nurse (LPN) 9 indicated she could not remember what time the resident had received his breathing treatment, but was sure she had completed a post assessment of the resident after his treatment. She could not remember if she had turned off the nebulizer machine or if it was off when she went into his room. Resident 37 was alert and oriented and she would not always stay with him during the entire procedure and had not done so with his treatment today. During an interview, on 11/12/19 at 3:00 p.m., the Director of Nursing Services (DNS) indicated Resident 37 would not administer his own nebulizer treatment and a nurse should stay with the resident during the entire procedure. A nurse would be expected to complete a pre-assessment, an assessment during, and a post-assessment of pulse, respirations, and breathe sounds. During an interview, on 11/12/19 at 3:03 p.m., LPN 10 indicated if a resident was alert and oriented should would not always stay with the resident during a nebulizer treatment. Resident 37's record was reviewed on 11/13/19 at 2:14 p.m. The profile indicated the resident's diagnoses included, but were not limited to, chronic obstructive pulmonary disease (COPD) (a group of lung diseases that block airflow and make it difficult to breathe), and obstructive sleep apnea (intermittent airflow blockage during sleep). A physician's order, start date 7/24/19, indicated ipratropium-albuterol (solution for nebulization) 0.5 milligrams (mg)-3 mg/3 milliliters (ml) to be inhaled four times a day at 9:00 a.m., 1:00 p.m., 5:00 p.m., and 9:00 p.m.		**assurance program will be put into place:** Ongoing compliance with this corrective action will be monitored through the facility Quality Assurance and Performance Improvement Program (QAPI). The DNS/designee will be responsible for completing the Skills Competency Nebulizer Treatment weekly for 4 weeks and monthly for at least 6 months. If threshold of 95% is not met, an action plan will be developed. Findings will be submitted to the QAPI Committee for review and follow up.	

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	A physician's order, start date 7/24/19, indicated observe pulse, respirations and breath sounds after each nebulizer treatment four times a day. A care plan, revised 10/14/19, indicated the resident was at risk for impaired gas exchange related to COPD, and sleep apnea. Interventions included, but were not limited to, administer medications as ordered, and nebulizer treatments as ordered. On 11/13/19 at 10:17 a.m., the DNS provided a document, last reviewed 01/2015, and titled, "Nebulizer Treatment," and indicated it was the policy currently being used by the facility. The policy indicated, "Procedure Steps: ...10. Instruct and remind resident to breathe "slow and deep" through their mouth for the duration of the therapy. 11. Stay with resident during entire procedure. 12. Encourage the resident to occasionally take an "extra deep" breath to promote deep penetration of the medication into the lungs. 13. During procedure perform assessment including pulse and respiration. 14. Treatment is complete when medication ceases to be aerosolized and the mist is no longer present. 15. Have resident take a deep breath and cough after therapy. Encourage resident to expectorate any secretions...." 3.1-47(a)(6)			
F 0755 SS=D Bldg. 00	483.45(a)(b)(1)-(3) Pharmacy Srvcs/Procedures/Pharmacist/Records §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may			

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	permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.			
	Based on record review and interview, the facility failed to obtain antibiotic eye drops to treat a resident's eye infection for 1 of 1 residents reviewed for infection (Resident 35). Findings include: Resident 35's record was reviewed on 11/15/19 at 2:42 p.m. A quarterly Minimum Data Set (MDS) assessment, dated 9/13/19, indicated the resident had a severe cognitive impairment and received hospice care.	F 0755	**F755 – Pharmacy Services/Procedures/Pharmacist/Records** It is the practice of this facility to provide routine and emergency drugs and biologicals to our residents or obtain them. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:**	12/18/2019

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	A face sheet indicated the resident's allergies included, but were not limited to, amoxicillin (an antibiotic). A nursing note, dated 11/8/19, indicated the resident's eye was swollen and red. Hospice was notified and would evaluate the next day. A Physician's progress note, dated 11/9/19, indicated the resident had bacterial conjunctivitis (a common type of eye infection) of the left eye and was placed on gentamicin eye drops by hospice. An infection event, dated 11/9/19, indicated the resident had bacterial conjunctivitis. Augmentin (an antibiotic) was ordered by mouth and gentamicin eye drops. A nursing note, dated 11/9/19, indicated augmentin and gentamicin eye drops were ordered by hospice. The augmentin was discontinued related to allergies. A Medication Administration Record (MAR), dated November 2019, indicated gentamicin eye drops, 0.3%, one drop to left eye four times a day was initially ordered to start on 11/10/19. The medication was then held until 11/13/19 related to waiting for the pharmacy to deliver the medication. The medication was first administered on 11/13/19. A Treatment Administration Record, dated November 2019, indicated the resident was on contact isolation (precautions taken to prevent the spread of infection, caregivers should wear gown and gloves) related to an infection in the eye until 24 hours after the eye drops were		Resident 35 did receive eye drops. Resident 35 has been assessed and eyes are clear and without any redness or drainage. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** All residents have the potential to be affected. EMAR compliance report has been reviewed for the last 30 days to ensure that medications were received. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** Licensed Nurses have been in-serviced on medication shortages/unavailable medications policy and what medications are available in the facility emergency drug supply kit and the steps they are to complete if a medication is not available to administer on or before 12/18/19. DNS/designee will review EMAR compliance report daily to ensure that medications are available to be given to the resident as ordered. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:**	

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	initiated. The isolation was initiated on 11/11/19, and discontinued on 11/14/19. A care plan goal target dated 1/11/20, indicated the resident had an infection in the left eye. Interventions included, but were not limited to, administer medications as ordered. During an interview, on 11/15/19 at 2:54 p.m., the Director of Nursing Services (DNS) indicated the resident had to be kept on contact isolation for 24 hours after treatment was started. During an interview, on 11/18/19 at 11:36 a.m., the DNS indicated the antibiotic eye drops were not started on 11/10/19, as ordered by the physician, because they had not been delivered by the pharmacy. She was not sure why it took until 11/13/19 to get the eye drops to the facility. They were not available in the emergency drug kit (EDK). On 11/18/19 at 11:21 a.m., Licensed Practical Nurse (LPN) 34 provided a document titled, "Medication Shortages/Unavailable Medications," and indicated it was the policy currently being used by the facility. The policy indicated, "Applicability: This Policy...sets forth procedures related to medication shortages and unavailable medications. Procedure: 1. Upon discovery that Facility has an inadequate supply of medication to administer to a resident, Facility staff should immediately initiate action to obtain the medication from Pharmacy...3. If a medication shortage is discovered after normal Pharmacy hours: 3.1 A licensed Facility nurse should obtain the ordered medication from the Emergency Medication Supply. 3.2. If the ordered medication is not available in the Emergency Medication Supply, the licensed Facility nurse should call the		Ongoing compliance with this corrective action will be monitored through the facility Quality Assurance and Performance Improvement Program (QAPI). The DNS/designee will be responsible for completing the QAPI Audit tool Change of Condition weekly for 4 weeks and monthly for at least 6 months. If threshold of 95% is not met, an action plan will be developed. Findings will be submitted to the QAPI Committee for review and follow up.	

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	Pharmacy's emergency answering service and request to speak with the registered pharmacist on duty to manage the plan of action. Action may include: 3.2.1 Emergency delivery; or, 3.2.2 Use of an emergency (back-up) Third Party Pharmacy...." 3.1-25(a)			
F 0757 SS=D Bldg. 00	483.45(d)(1)-(6) Drug Regimen is Free from Unnecessary Drugs §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. Based on record review and interview, the facility failed to obtain laboratory tests in a timely manner for 1 of 5 residents reviewed for unnecessary medications (Resident 20). Findings include:	F 0757	**F757 – Drug Regimen is Free from Unnecessary Drugs** It is the practice of this facility to ensure that laboratory tests are obtained in a timely manner. **What corrective action(s) will**	12/18/2019

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	Resident 20's record was reviewed on 11/13/19 at 2:31 p.m. A physician's progress note, dated 7/18/19 at 4:03 p.m., indicated to check comprehensive metabolic panel (CMP) (measures bloods sugar levels, electrolyte and fluid balance, kidney function, and liver function) and hemoglobin A1C (measures average blood glucose level over the past 3 months) for diabetes type II (a chronic condition that affects the way the body processes blood sugar), vitamin B12 (nutrient that helps keep body's nerve and blood cells healthy) level for vitamin B12 deficiency, and vitamin D (fat-soluble vitamin) level for vitamin D deficiency. A review of physician's orders, dated July 2019, lacked documentation an order had been transcribed for the laboratory tests the physician indicated to check on 7/18/19. A review of laboratory results lacked documentation a CMP had been obtained. A routine laboratory test for a basic metabolic panel (BMP) (measures bloods sugar levels, electrolyte and fluid balance, kidney function) was obtained on 8/26/19. A review of laboratory results lacked documentation a hemoglobin A1C, vitamin B12, and vitamin D level had been obtained until 10/10/19. A physician's order, start date 1/16/19, indicated vitamin D3 2,000 units, give 1 tablet once a day for vitamin D deficiency. A care plan, revised 9/26/19, indicated the resident was at risk for adverse effects of hyperglycemia or hypoglycemia related to use of glucose lowering		**be accomplished for those residents found to have been affected by the deficient practice:** MD notified of labs not obtained on 7/18/19 no new orders received. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** All residents have the potential to be affected. Audit of all labs ordered for the last 30 days will be completed by 12/13/19 to ensure they have been obtained. Audit of Physician Progress notes for the last 30 days have been reviewed to ensure that any needed follow up will be completed by 12/13/19. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** Licensed nurses will be educated on reviewing FAR for any new documented Physician Progress notes to ensure that there is no needed follow up and reviewing the facility Lab Due Report daily. DNS/designee in addition will review the Lab Due Report daily to ensure labs are being obtained as ordered. DNS/designee will review FAR daily to ensure that follow up has been completed for any	

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	medication and diagnosis of diabetes mellitus. Interventions included, but were not limited to, labs as ordered. A care plan, revised 9/26/19, indicated the resident was at risk for skin breakdown due to vitamin D deficiency. A care plan, revised 9/26/19, indicated the resident was at risk for falls due to vitamin D deficiency. During an interview, on 11/14/19 at 11:01 a.m., the Director of Nursing Services (DNS) indicated the physician typically wrote his own orders, and she was unsure why he had not wrote orders for the laboratory tests on 7/18/19. All progress notes were reviewed by management the next day, but she could find where the physician's progress note had been followed up on. On 11/14/19 at 11:55 a.m., the Regional Director of Clinical Services (RDCS) provided a policy, dated 11/2017, and titled, "Labs and Diagnostics," and indicated it was the policy currently being used by the facility. The policy indicated, "Policy: It is the policy of American Senior Communities to provide or obtain laboratory and diagnostic services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services...." On 11/14/19 at 11:55 a.m., the RDCS provided a policy, revised on 11/2018, and titled, "Matrix Physician Orders," and indicated it was the policy currently being used by the facility. The policy indicated, "Matrix Physician Orders: All new orders will into Matrix Physician Orders by the Nurse receiving the order...." 3.1-48(a)(3)		documented Physician's progress notes. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** Ongoing compliance with this corrective action will be monitored through the facility Quality Assurance and Performance Improvement Program (QAPI). The DNS/designee will be responsible for completing the QAPI Audit tool Labs/Diagnostics weekly for 4 weeks and monthly for at least 6 months. If threshold of 95% is not met, an action plan will be developed. Findings will be submitted to the QAPI Committee for review and follow up.	

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F 0758 SS=D Bldg. 00	483.45(c)(3)(e)(1)-(5) Free from Unnec Psychotropic Meds/PRN Use §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used 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			

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	extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. Based on record review and interview, the facility failed ensure physician written documentation of the declination for a pharmacy recommended gradual dose reduction (GDR) and to address the recommendation in a timely manner (Resident 18), failed to attempt a GDR per pharmacy recommendation and to document a rationale (Resident 20), and failed to transcribe a GDR in a timely manner (Resident 36), for 3 of 5 residents reviewed for unnecessary medications. Findings include: 1. Resident 18's record was reviewed on 11/13/19 at 2:21 p.m. The profile indicated the resident's diagnoses included, but were not limited to, other specified depressive episodes (presentations in which symptoms characteristic of a depressive disorder that cause clinically significant distress or impairment in social, occupational, or other important areas of functioning predominate but do not meet the full criteria for any of the disorders in the depressive disorders diagnostic class). The November 2018 Medication Administration Record (MAR) indicated the resident received Celexa (antidepressant medication) 10 milligrams (mg), by mouth, once daily.	F 0758	**F758 – Free from Unnecessary Psychotropic Meds/PRN Use** **It is the practice of this facility to ensure the physician provides documentation and rationale for declining a pharmacy recommendation for gradual dose reductions (GDR) and to transcribe the GDR timely.** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** Resident 20 will have psychotropic medications reviewed by physician and a new ASC GDR form completed. Resident 36 will have medications reviewed by physician and a new ASC GDR form completed. Resident 18 physician reviewed for GDR with appropriate rationale. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** All resident receiving psychotropic	12/18/2019

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	A significant change Minimum Data Set (MDS) assessment, dated 12/31/18, indicated the resident had moderate cognitive deficit, had a mood severity score of 3 (none to minimal depression), and received an antidepressant medication. A care plan, dated 8/13/18, indicated the resident was at risk for adverse side effects related to use of psychotropic medication (anti-depressant). Interventions included, but were not limited to, administer medications as ordered, interdisciplinary team (IDT) to review routinely to attempt gradual dose reductions, unless contraindicated by the physician. A Pharmacy Consultation Report, dated 11/29/18, indicated the resident received Celexa for management of depressive symptoms since 11/10/17. The currently dose was 10 mg daily, which was a successful dose reduction in April 2018. IDT recommended no changes at this time. A recommendation was made that if therapy was to be continued, provide resident specific rationale describing why a dose reduction is contraindicated. A check mark was observed written on the document. No documented physician rationale for the declination was observed. A Pharmacy Consultation Report, dated 1/22/19, indicated the resident received Celexa for management of depressive symptoms since 11/10/17. The currently dose was 10 mg daily, which was a successful dose reduction in April 2018. IDT recommended no changes at this time. A recommendation was made that if therapy was to be continued, provide resident specific rationale describing why a dose reduction is contraindicated. The document was marked with an "X," on the response, "I decline the		medications have the potential to be affected. All residents currently receiving psychotropic medications will be reviewed to ensure that pharmacy recommendations have been completed and GDR's have rationale for any declination. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** SS/IDT will be in-serviced on the ASC GDR form and ensuring the physician has documented rationale for any declinations. Licensed nurses will be educated on timely transcription of physician orders. Pharmacy recommendations to be provided to DNS to ensure appropriate communication and resolution to the physician. Completed GDR to be reviewed by the IDT for appropriate rationale and transcription. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** Ongoing compliance with this corrective action will be monitored through the facility Quality Assurance and Performance Improvement Program (QAPI). The DNS/designee will be responsible for completing the	

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	recommendation above because GDR is clinically contraindicated for this individual as indicated below." The documented rationale did not address the Celexa, but stated, "Resident with in creased anxiety regarding medical issues, start Buspar today." A Psychiatry Initial Consult document, dated 1/23/19, indicated continue citaloproam (Celexa) 10 mg PO daily and that the GDR was clinically contraindicated related to the resident's increased anxiety and need for additional medication to treat. During an interview, on 11/14/19 at 10:20 a.m., the Regional Director of Clinical Services (RDCS) indicated she was unable to locate a documented rationale written which addressed the recommendation made on the 11/29/18 consultation report. If a physician declined a recommendation, a documented rationale must be included to justify the declination. The recommendation made on the 11/29/18 consultation report, had not been address in a timely manner. 2. Resident 20's record was reviewed on 11/13/19 at 2:31 p.m. The profile indicated the resident's diagnoses included, but were not limited to, anxiety disorder unspecified (characterized by excessive, uncontrollable and often irrational worry). A document, dated 7/23/19, and titled, "Pharmacy Consultation Report," indicated for the initial attempt at a gradual dose reduction (GDR), please reduce to clonazepam 0.5 milligrams (mg) at bedtime while concurrently monitoring for reemergence of target behaviors and/or withdrawal symptoms. The rationale for the recommendation: Within the first year after the		QAPI Audit tool Psychoactive Management and QAPI Audit tool MatrixCare Physicians Orders weekly for 4 weeks and monthly for at least 6 months. If threshold of 95% is not met, an action plan will be developed. Findings will be submitted to the QAPI Committee for review and follow up.	

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	facility had initiated such medication, the facility must attempt a GDR in two separate quarters. If this therapy was to continue, it was recommended the prescriber document an assessment of risk versus benefit that indicated it would continue to be a valid therapeutic intervention for this individual. The physician's response, dated 8/7/19, indicated he declined the recommendation because the resident would probably exacerbate anxiety. A review of the resident's clinical record, dated June and July 2019, lacked documentation the resident had anxiety symtpoms of worries, isolating behaviors, or tearfulness. A physician's order, start date 1/16/19, indicated clonazepam (antianxiety) 1 mg, give 1 tablet by mouth at bedtime for anxiety disorder. A care plan, revised 9/27/19, indicated the resident had anxiety symptoms such as worries, isolating behaviors, and tearfulness. During an interview, on 11/14/19 at 1:21 p.m., the Social Services float indicated she could not find where the resident had any occurrences of anxiety prior to the GDR recommendation and the GDR should have been attempted or a clear rationale documented by the physician of risk versus benefit. 3. Resident 36's record was reviewed on 11/14/19 at 10:27 a.m. The profile indicated the resident's diagnoses included, but were not limited to, insomnia (sleep disorder). A document, dated 7/23/19, and titled, "Pharmacy Consultation Report," indicated to consider discontinuing Remeron (antidepressant) 7.5			

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WILLIAMSPORT NURSING AND REHABILITATION	200 SHORT ST WILLIAMSPORT, IN 47993

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	milligrams (mg) at bedtime for insomnia. The rationale for the recommendation: Within the first year after the prescribing practionitioner has initiated a psychotropic medication, the facility must attempt a gradual dose reduction (GDR) in two separate quarters. The physician's response, dated 7/25/19, indicated the recommendation was accepted and to implement as written. A progress note, dated 7/25/19 at 11:23 a.m., indicated to discontinue Remeron 7.5 mg today per GDR recommendation. A progress note, dated 7/29/19 at 1:51 p.m., indicated the resident had a sleep disorder and Remeron 7.5 mg at bedtime was discontinued today per GDR recommendation. A review of physician's order lacked documentation Remeron had been discontinued from 7/25/19 through 8/9/19. A physician's order, dated 8/10/19, indicated to discontinue Remeron 7.5 mg at bedtime for sleep disorders. A care plan, revised 11/14/19, indicated the resident had a diagnosis of insomnia. During an interview, on 11/14/19 at 11:05 a.m., the Director of Nursing Services (DNS) indicated the Remeron should have been discontinued on 7/25/19 when the nurse documented a progress note that indicated it had been discontinued per GDR recommendation. She was unsure why it was not done. On 11/14/19 at 11:55 a.m., the Regional Director of Clinical Services (RDCS) provided a policy, revised 9/2017, and titled, "Psychotropic			

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	Management Policy," and indicated it was the policy currently being used by the facility. The policy indicated, "Policy: It is the policy of American Senior Communities to ensure that a resident's psychotropic medication regimen helps promote the resident's highest practicable mental, physical and psychosocial well-being with person centered intervention and assessment. These medications are managed in collaboration with the attending physician, pharmacist and facility staff to include non-pharmacological interventions, assessment and reduction as applicable. Definition: 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: Anti-psychotic, Anti-depressant, Anti-anxiety, and Hypnotic. Procedure: ...4. Periodic re-evaluation of the medication regimen is necessary to determine whether prolonged or indefinite use of a medication is indicated. The clinical rationale for continued use of a medication(s) may have been demonstrated in the clinical record, or the staff and prescriber may present pertinent clinical reasons for duration of use. The facility will initiate a request for a GDR at least on the following schedule for each drug. a. For residents who use antipsychotic medication a GDR must be initiated per following guidelines: During the first year that the resident is admitted to the facility on antipsychotic or after the facility has initiated an antipsychotic, a GDR must be attempted in two separate quarters with at least one month in between attempts, unless clinically contraindicated by the physician. After the first year, a GDR must be attempted annually unless clinically contraindicated by the physician. b. For residents who use anxiolytic medications a GDR must be initiated per the following guidelines: ...During the first year...after the facility has			

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	initiated an antipsychotic, a GDR must be attempted in two separate quarters with at least one month in between attempts, unless clinically contraindicated by the physician...d. For resident who use antidepressant medications a GDR must be initiated per the following guidelines: ...During the first year...after the facility has initiated an antipsychotic, a GDR must be attempted in two separate quarters with at least one month in between attempts, unless clinically contraindicated by the physician...." 3.1-48(a)(3)			
F 0812 SS=F Bldg. 00	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. Based on observation, interview, and record	F 0812	**F812 – Food Procurement,**	12/18/2019

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	review, the facility failed to ensure food was removed from refrigerators by the use by date and personal drinks were not kept in food preparation areas during 2 of 3 random kitchen observations which had the potential to affect 57 of 59 residents who received meals from the kitchen. Findings include: On 11/12/19 at 10:39 a.m., during an initial kitchen tour with the Dietary Manager a half filled container of egg salad was observed in the walk in refrigerator, with a use by date of 11/9/19. A container of mixed peanut butter and jelly was observed in the reach in cooler, with a use by date of 11/11/19. During an interview, on 11/15/19 at 9:35 a.m., Cook 17 indicated food should not have been in the refrigerators past the use by date on the label. The coolers were usually cleaned out each week, on Tuesdays. On 11/15/19 at 10:47 a.m., Cook 17 was observed preparing pureed food with a personal drink cup within reach of the food preparation area. At the same time, Cook 17 indicated the drink was hers, and she would not normally have kept it in the food preparation area. She removed the drink from the area. During an interview, on 11/15/19 at 10:54 a.m., the Executive Director (ED) indicated staff should not have kept personal drink in the food preparation areas. On 11/15/19 at 9:48 a.m., the Dietary Manager provided a document titled, "Labeling and Dating," and indicated it was the policy currently being used by the facility. The policy indicated, "3		**Store/prepare/serve – Sanitary** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** Peanut butter, egg salad and jelly were destroyed immediately. Audit completed and no foods found past use by date. Staff have been educated that no personal drinks are to be in the kitchen. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** All residents have the potential to be affected. Audits will be completed to ensure policies and procedures are corrected. An audit was completed to ensure no food was past die by culinary manager. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** Education to all dietary staff will be completed by 12-5-19 on removing food from refrigerators by the use by date and also on no personal drinks in food prep areas. Culinary manager will review the food walk in refrigerator to ensure properly labeled, and to ensure personal drinks are not in food prep area. **How the corrective action(s)**	

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	days: Processed meats and any item that has been cooked and cooled should be kept no longer than 3 days. Label with date of storage and date of discard...7 days: Any refrigerated opened item that has not been cooked can be stored for 7 days. Label with the date item is placed in storage and the date of discard...." On 11/15/19 at 1:35 p.m., the Regional Director of Clinical Services (RDCS) provided a document titled, "Infection Control," and indicated it was the policy currently being used by the facility. The policy indicated, "POLICY: All local, state and federal standards and regulations are followed in order to assure a safe and sanitary dietary department. PROCEDURE: ...2. Employees...g. Personal items should not be stored on food preparation equipment or in food storage areas...." 3.1-21(i)(3)		**will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** Dietary Manager/ Executive Director will do audits on the refrigerators and in kitchen for personal drinks three times a week for 3 weeks. Then two times a week for 3 weeks, then monthly for 3 months. Dietary manager will report findings to QAPI committee monthly.	