STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155496	A. BUILDING 00 B. WING	02/07/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
VALLEY VIEW HEALTHCARE CENTER	333 W MISHAWAKA RD ELKHART, IN 46517

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. Survey dates: February 2, 3, 4, 5, 6 & 7, 2020 Facility number: 000523 Provider number: 155496 AIM number: 100266930 Census Bed Type: SNF/NF: 83 Total: 83 Census Payor Type: Medicare: 6 Medicaid: 68 Other: 9 Total: 83 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality Review was completed on February 12, 2020.	F 0000		
F 0585 SS=D Bldg. 00	483.10(j)(1)-(4) Grievances §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents,			

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

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	and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident. §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system; (ii) Identifying a Grievance Official who is responsible for overseeing the grievance			

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	process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations; (iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated; (iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law; (v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey			

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	Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. Based on interview and record review, the facility failed to ensure grievance decisions and summaries were communicated to the resident, for 2 of 4 grievances reviewed. (Resident 86 and 85) Findings include: During Resident Council meeting, on 2/5/2020 at 10:00 A.M., the Resident Council President indicated the facility does not act upon grievances. "...all they [the residents] do is put them in that wooden box in the front and they never hear anything... the facility never comes back to them and tells them anything...." 1. On 2/7/2020 at 9:30 A.M., a "Receipt of Grievance/Complaint" form, filed by Resident 86, was reviewed. The form indicated "Date received: 12/7/19...Initiating complaint: Resident...Individuals name: [Resident 86's name]...Documentation of grievance/complaint: She said the aide put her down at 4:30 pm because she needed changed and told her she can stay till dinner and then she got no dinner..." The portion of the form titled "Resolution of grievance/complaint" indicated "...Was the grievance/complaint resolved? [left blank]...Identify the method used to notify the resident and/or resident representative of the resolution: [left blank]...date of notification: [left blank]...." The form was signed by the facility	F 0585	**1. Corrective actions accomplished for those residents found to be affected by the alleged deficient practice** Resident Council meeting set for March 2020 to validate current concerns with appropriate follow up resolution to grievances presented. **2. Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken:** All residents are at risk to be effective. **3. Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur:** Executive Director or designee will educate the IDT team on the resident council and grievance policies and procedures. **4. How the corrective measures will be monitored to ensure the alleged deficient practice does not recur:** Resident council meeting minutes and concerns will be reviewed monthly and validate concerns are addressed and assure all concern resolutions	03/08/2020

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	Administrator. 2. On 2/7/2020 at 9:35 A.M., a "Receipt of Grievance/Complaint" form, filed by Resident 85, was reviewed. The form indicated "Date received: 1/20/2020...Initiating complaint: Resident...Individuals name: [Resident 85's name]...Documentation of grievance/complaint: [Resident 85's name] is missing a gold ring..." The portion of the form titled "Resolution of grievance/complaint" indicated "...Was the grievance/complaint resolved? [left blank]...Identify the method used to notify the resident and/or resident representative of the resolution: [left blank]...date of notification: [left blank]...." The form was signed by the facility Administrator. During an interview, on 2/7/2020 at 2:00 P.M., the facility Administrator indicated he had not been following up with residents on the resolution or decision of their grievance, but he should have been. A policy was provided by the RDCO (Regional Director of Clinical Operations) on 2/07/2020 at 2:50 P.M, titled "Grievance Process", undated, and indicated this was the policy currently used by the facility. The policy indicated "...The facility should encourage and request that staff, residents, families, visitors etc. express their concerns, complaints and grievances. The facility will review, investigate and respond to all such concerns...6. The resident or person filing the grievance and/or complaint on behalf of the resident, should be informed of the findings of the investigation within 5 days and the actions that will be taken to correct the identified problem...." 3.1-7(b)		from previous meeting have improved or resolved by resident council members by the Executive Director or designee. **The results of the audit observations will be reported, reviewed and trended for compliance thru the facility Quality Assurance Committee for a minimum of 6 months then randomly thereafter for further recommendation.**	

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F 0609 SS=E Bldg. 00	483.12(c)(1)(4) Reporting of Alleged Violations §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. Based on record review and interview, the facility failed to ensure allegations of abuse, neglect and misappropriation were reported immediately to the facility Administrator and the State Agency, for 4 of 7 allegations reviewed. (Resident 21, 86, 56 and 85)	F 0609	1. 1. **Corrective actions accomplished for those residents found to be affected by the alleged deficient practice:** Executive Director and or designee have investigated incidents for residents 21, 56, 85	03/08/2020

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	Findings include: 1. On 2/7/2020 at 9:25 A.M., a "Receipt of Grievance/Complaint" form, filed by Resident 21, was reviewed. The form indicated "Date received: 11/18/19...Initiating complaint: Resident...Individuals name: [Resident 21's name]...Documentation of grievance/complaint: a certain nurse aide (I don't know her name) always has an attitude and it seems like she wants to be intimidating whenever she comes in contact w/ [with] me..." 2. On 2/7/2020 at 9:30 A.M., a "Receipt of Grievance/Complaint" form, filed by Resident 86, was reviewed. The form indicated "Date received: 12/7/19...Initiating complaint: Resident...Individuals name: [Resident 86's name]...Documentation of grievance/complaint: She said the aide put her down at 4:30 pm because she needed changed and told her she can stay till dinner and then she got no dinner..." 3. On 2/7/2020 at 9:32 A.M., a "Receipt of Grievance/Complaint" form, filed by Resident 56, was reviewed. The form indicated "Date received: 12/17/19...Initiating complaint: Resident...Individuals name: [Resident 56's name]...Documentation of grievance/complaint: Resident states she is missing money...she states it was around $75 dollars, when asked again she states it was $175...." 4. On 2/7/2020 at 9:35 A.M., a "Receipt of Grievance/Complaint" form, filed by Resident 85, was reviewed. The form indicated "Date received: 1/20/2020...Initiating complaint: Resident...Individuals name: [Resident 85's name]...Documentation of grievance/complaint:		and 86. All incidents have been resolved and reported, if appropriate on 2/18/20. **2. Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken:** All residents have the potential to be affected by this alleged deficient practice. **An audit was completed of all residents by interviewing residents for any concerns or grievances that could constitute abuse. Any findings were investigated and followed up on by the ED and DON.** **3. Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur:** The Executive Director will educate the staff and the facility Leadership Team on the following policy: Abuse & Neglect& Misappropriation of Property 4. **How the corrective measures will be monitored to ensure the alleged deficient practice does not recur:** The following resident interviews will be completed and /or observations will be conducted by the ED or designee 5 times per week to ensure compliance. Follow up with Nursing Leadership and Social Service regarding any	

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	[Resident 85's name] is missing a gold ring..." During an interview, on 2/7/2020 at 2:00 P.M., the facility Administrator indicated residents were free to fill out a grievance form any time. The facility would discuss a summary of any new grievance forms every morning during their clinical meeting. He indicated the summaries did not always include all details of allegations, so he was not aware of these allegations and would consider them as allegations of abuse, neglect and misappropriation and they were not reported to the State Agency. A policy was provided by the RDCO (Regional Director of Clinical Operations) on 2/07/2020 at 2:50 P.M, titled "Indiana Abuse & Neglect & Misappropriation of Property", undated, and indicated this was the policy currently used by the facility. The policy indicated "...notify the Director of Nursing and Executive Director of the incident or allegation immediately...direct required notification of agencies, physician, family and resident representative...The Executive Director, Director of Nursing, or designee will report immediately to the appropriate agencies...." 3.1-28(c)		alleged violations noted in the 24 hour nursing report summary, ensure alleged violations have been reported to the Executive Director and then reported to the Indiana State Department of Health. The review will be conducted 5x per week on-going.	
F 0656 SS=E Bldg. 00	483.21(b)(1) Develop/Implement Comprehensive Care Plan §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the			

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	comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.			
	Based on record review and interview the facility failed to develop complete and individualized care plans for dialysis, hospice, behaviors, anticoagulant use, hypnotic medication use, psychotic disorder and psychosis on 7 of 19	F 0656	**F656- Development and implementation of Care Plans** **1. Corrective actions accomplished for those residents found to have been affected by the deficient**	03/08/2020

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	residents whose care plans were reviewed. (Residents 61, 62, 9, 46, 79, 85 and 42) Findings Include: 1. A record review was conducted, on 2/7/2020 at 3:26 P.M., for Resident 62 and indicated she was re-admitted on 7/27/19 and her diagnoses included but were not limited to hypertension, end stage renal disease, type 2 diabetes with diabetic nephropathy and dependence on renal dialysis. The quarterly MDS (Minimum Data Set) assessment indicated Resident 62 was cognitively intact and received dialysis. A care plan for dialysis did not include interventions related to how to care for the permcath (catheter placed in the chest for hemodialysis), including dressing changes, monitoring vital signs, weights, nutritional needs, fluid restriction, lab results and who to notify with concerns or in an emergency. During an interview, on 2/07/2020 at 3:32 P.M., the RDCO (Regional Director of Clinical Operations) indicated she was not aware of the required information for a dialysis care plan. 2. A record review was conducted, on 2/5/2020 at 4:21 P.M., for Resident 79 and indicated she was admitted on 8/13/19. Her diagnoses included, but were not limited to dementia without behavioral disturbance, delusional disorders, cognitive communication, history of malignant carcinoid tumor of rectum, and dysphagia. The quarterly MDS (Minimum Data Set) assessment, dated 1/17/2020, and indicated she had moderate cognitive impairment and received		**practice:** Resident 61, 62, 9, 46, 79, 85, and 42 have had their plan of care updated to reflect an individualized plan of care including but not limited to dialysis, hospice, behaviors, anticoagulant use, hypnotic medication use, psychotic disorder and psychosis as appropriate for each resident. **2. Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken:** An audit of resident care plans has been completed of all other residents that had the potential to be affected by the deficient practice. The care plans have been updated to reflect a well-developed and implemental plan of care that addresses the mental, psychosocial, behavioral, and safety needs of each resident based on diagnosis, conditions, and behaviors. **3. What measures will be put in place and what systemic changes will be made to ensure the deficient practice does not recur:** In-servicing has been completed for all nursing staff, MDS coordinator, and IDT on development of the comprehensive care plan and its accuracy to ensure resident individual needs are addressed and appropriate interventions are implemented.	

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	hospice services. The care plan did not include interventions related to hospice services for provision of activities of daily living, advance directives, management of agitation, pain, nutritional and hydration needs, pressure ulcer prevention related to the coordination of care with hospice.3. A record review was conducted on 02/05/2020, at 9:57 AM, for Resident 9 and indicated an admission date of 11/10/19. Her diagnoses included, but were limited to: encephalopathy, heart failure, dementia, kidney disease, and weakness. The admission MDS assessment, dated 11/20/19, indicated a BIMS (Brief Interview for Mental Status) score of 0, severe cognitive impairment. Hospice care was indicated. The hospice care plan in place did not contain provision of ADLs (Activities of Daily Living), symptom management, or coordination of care with hospice. 4. A record review was conducted on 02/05/2020, at 9:15 AM, for Resident 46 and indicated an admission date of 08/21/19. His diagnoses included, but were not limited to: respiratory failure, heart failure, schizophrenia, and gout. The quarterly MDS assessment, dated 12/20/19, indicated a BIMS score of 14, cognitively intact. Hospice care was indicated. The hospice care plan in place did not contain provision of ADLs (Activities of Daily Living), symptom management, or coordination of care with hospice. 5. A record review was conducted on 02/06/2020,		**4. How the corrective actions will be monitored to ensure the deficient practice will not recur:** The DON/designee will audit 10 care plans weekly for 30 days, then 5 care plans weekly for 30 days, then 10 care plans monthly for 4 months or until 100% compliance is achieved. All care plans will be reviewed for appropriateness and accuracy no less then quarterly for all residents that reside in the facility. All findings will be reviewed in the monthly QAPI meeting until the determination is made that the practice to be in 100% compliance.	

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	at 9:33 AM, for Resident 42 and indicated an admission date of 10/30/13. Her diagnoses included, but were not limited to: Alzheimer's, multiple sclerosis (MS), dementia with behaviors, psychosis, psychotic disorder, mood disorder, heart failure, depression, diabetes, and hypertension (HTN). Her medications included: namenda (dementia), hydralazine, metoprolol (HTN), rivastigmine (Alzheimer's), norco, basaglar (diabetes), lexapro (depression), novolog (diabetes), and glimepiride (diabetes). The annual MDS (Minimum Data Set) assessment, dated 01/08/2020, indicated a BIMS (Brief Interview for Mental Status) score of 3, severe cognitive impairment. Anemia, coronary artery disease, heart failure, HTN, peripheral vascular disease, diabetes, Alzheimer's, dementia, MS, depression, psychotic disorder, mood disorder, and back pain were indicated as current diagnoses. Insulin, antipsychotic, antidepressant, and opioid medications were indicated as taken all 7 days of the look back period. Care plans were in place related to dementia, diabetes, depression, behaviors, psychotropic medication use, and MS. The care plan related to psychotropic medication use did not include side effects of antidepressants and the behavior care plans were not individualized. No care plan for psychotic disorder or psychosis were documented. 6. A record review was conducted on 02/05/2020, at 1:50 PM, for Resident 85 and indicated an admission date of 01/14/2020. Her diagnoses included, but were not limited to: dementia, epilepsy, hypertension (HTN), thrombosis, sciatica, and weakness. Her medications included: eliquis (anticoagulation), melatonin, amlodipine			

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	(HTN), gabapentin (nerve pain), donepezil (dementia), keppra, zyprexa (dementia), topamax, and metoprolol. The admission MDS assessment, dated 01/21/2020, indicated a BIMS score of 6, severe cognitive impairment. HTN, dementia, and epilepsy were indicated as active diagnoses. Antipsychotic medication was taken 6 of the 7 days of the look back period and anticoagulants were taken all 7 days. Care plans were in place related to dementia, impaired sleep pattern, pain, seizures, psychotropic medication use, and behaviors. The care plan related to psychotropic medication use did not include side effects of antidepressants and the behavior care plans were not individualized. No care plans related to anticoagulant use, anticonvulsant or hypnotic medication use were documented. 7. A record review was conducted on 02/05/2020, at 11:09 AM, for Resident 61 and indicated an admission date of 11/27/19. His diagnoses included, but were not limited to: pleural effusion, chronic kidney disease, colon cancer, anxiety, depression, and panic disorder. The 5-day MDS (Minimum Data Set) assessment, dated 12/04/19, indicated a BIMS (Brief Interview for Mental Status) score of 11, moderate cognitive impairment. Dialysis was indicated. The dialysis care plan in place did not contain transportation arrangements, which provider to contact for concerns or complications, assessment and care of the site, infection control measures, or advance directives.			

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	During an interview, on 02/06/2020 at 12:10 PM, the RDCO (Regional Director of Clinical Operations) indicated she would expect appropriate care plans to be in place. During an interview, on 02/07/2020 at 9:53 AM, the SSD (Social Services Director) indicated the behavior care plan was not individualized with interventions. During an interview, on 02/07/2020 at 11:00 AM, the SSD indicated she was unaware of what was required in a hospice care plan and would update after reviewing the pathway. A policy was provided by the DON (Director of Nursing) on 02/07/2020 at 4:20 PM, titled "Plan of Care Overview", dated 07/26/18, and indicated this was the policy currently used by the facility. The policy indicated "...the Plan of Care, also Care Plan is the written treatment provided for a resident that is resident-focused and provides for optimal personalized care...." 3.1-35(a)			
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.			

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	(D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. Based on record review and interview, the facility failed to ensure care plan conferences were scheduled quarterly with the interdisciplinary team, resident or resident representative for 2 of 5 residents reviewed for care plan conferences. (Resident 1 and 62) Findings include: 1. During an interview, on 2/2/2020 at 12:43 P.M., Resident 1 indicated he had not participated in any scheduled care plan conferences since admission. A clinical record review was conducted, on 2/4/2020 at 2:45 P.M., for Resident 1 and indicated he was admitted on 6/3/19 and his diagnoses included, but were not limited to, osteomyelitis of left foot and ankle, hypertension, gastro-esophageal reflux disease, anxiety, atherosclerotic heart disease, diabetes type 2 with diabetic polyneuropathy and insomnia.	F 0657	**F657- Care Plan timing and revision** **1. Corrective actions accomplished for those residents found to have been affected by the deficient practice:** Resident 1 has had a care plan conference with the interdisciplinary team that he was invited to attend. Resident 62 has had a care plan conference with the interdisciplinary team that she was invited to attend. 2. **Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken:** An audit will be conducted of all residents to ensure that a care plan meeting has been done and if	03/08/2020

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	A quarterly MDS (Minimum Data Set) assessment, dated 11/18/19, indicated he was cognitively intact. The care plan conference sheets provided by SSD (Social Service Director) indicated Resident 1 had care plan conferences, on 6/18/19 and 1/21/2020. No care plan conferences present for review between June 2019 and January 2020. During an interview, on 2/4/2020 at 2:55 P.M., the SSD indicted Resident 1 was due for a care plan conference in October 2019, but it was missed and he did not have one. She indicated he should have a care conference quarterly. 2. A record review was conducted, on 2/7/2020 at 3:26 P.M., for Resident 62 and indicated she was re-admitted on 7/27/19 and her diagnoses included but were not limited to hypertension, end stage renal disease, type 2 diabetes with diabetic nephropathy and dependence on renal dialysis. The quarterly MDS (Minimum Data Set) assessment indicated Resident 62 was cognitively intact. The care plan conference sheets provided by the SSD indicated Resident 62 had care plan conferences 3/28/19, 10/8/19 and 1/14/2020. She did not have a care plan conference between March 2019 and October 2019. During an 2/4/2020 at 2:58 P.M., the SSD indicated Resident 62 did not have a care conference between March and October and should have. A policy was provided by the Director of Nurses, on 2/7/2020 at 4:20 P.M., titled, "Plan of Care		not it will be scheduled to include all appropriate parties. **3. What measures will be put in place and what systemic changes will be made to ensure the deficient practice does not recur:** The Social Service Director has been educated on the policy for conducting an appropriate care plan meeting for all residents no less then every 90 days and ensuring that all appropriate parties are invited to attend. **4. How the corrective actions will be monitored to ensure the deficient practice will not recur:** The DON/SSD/designee will audit 5 care plans meetings weekly for 30 days, then 10 care plans meetings monthly for 5 months or until 100% compliance is achieved to ensure a meeting was conducted with appropriate attendee's and accuracy no less then quarterly for all residents that reside in the facility. All findings will be reviewed in the monthly QAPI meeting until the determination is made that the practice to be in 100% compliance.	

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	Overview", revised 7/26/18, and indicated the policy was the one currently being used by the facility. The policy indicated "...Review care plans quarterly and/or with significant changes in care...." 3.1-35(d)(2)(B)			
F 0698 SS=D Bldg. 00	483.25(l) Dialysis §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. Based on observation, interview, and record review, the facility failed to ensure assessments were completed before and after return from dialysis for 2 of 2 residents reviewed for dialysis. (Resident 61 and 62) Findings include: 1. A record review was conducted, on 2/7/2020 at 3:26 P.M., for Resident 62 and indicated she was re-admitted on 7/27/19 and her diagnoses included but were not limited to hypertension, end stage renal disease, type 2 diabetes with diabetic nephropathy and dependence on renal dialysis. The quarterly MDS (Minimum Data Set) assessment indicated Resident 62 was cognitively intact and received dialysis. The dialysis care plan indicated to obtain vital signs and weight per protocol and report significant changes in pulse, respirations and	F 0698	**F 698- Dialysis Plan of Correction** **1. Corrective actions accomplished for those residents found to be affected by the alleged deficient practice:** Resident #61 was not harmed. Resident #62 was not harmed. Resident #61 has been assessed post dialysis and any findings reported to the physician. Resident #62 has been assessed post dialysis and any findings reported to the physician. **2. Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken:** DON or designee will audit all residents receiving hemodialysis to validate the post-dialysis evaluation upon	03/08/2020

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	blood pressure immediately. A physician's order, dated 11/29/19, indicated to complete pre dialysis assessment one time daily on Tuesday, Thursday and Saturday. A physician's order, dated 11/29/19, indicated to complete post dialysis assessment one time daily on Tuesday, Thursday and Saturday. The documentation for pre dialysis evaluation for Resident 62 was present 4 times in November 2019, 11 times in December 2019 and 5 times in January 2020. The documentation for post dialysis evaluation for Resident 62 was present 4 times in December 2019 and 1 time in January 2020. There were no documentation present for November 2019. 2. A record review was conducted on 02/05/2020, at 11:09 AM, for Resident 61 and indicated an admission date of 11/27/19. His diagnoses included, but were not limited to: pleural effusion, chronic kidney disease, colon cancer, anxiety, depression, and panic disorder. The 5-day MDS (Minimum Data Set) assessment, dated 12/04/19, indicated a BIMS (Brief Interview for Mental Status) score of 11, moderate cognitive impairment. Dialysis was indicated. The dialysis care plan in place did not contain transportation arrangements, which provider to contact for concerns or complications, assessment and care of the site, infection control measures, or advance directives. A physician order for dialysis on Monday, Wednesday, Friday and for completion of the pre and post dialysis documentation was in place.		return from dialysis center has been completed. Any findings will be reported to the physician. **3. Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur: Director of Nursing Services or designee will re-educate the Licensed Nurses on the following policy:** Hemodialysis Care and Monitoring. To include Post-Dialysis: Nurse to complete the post-dialysis evaluation upon return from the dialysis center. Any abnormal or unusual occurrence resident reports while at dialysis center will be reviewed and reported to the physician if necessary. The care of the resident receiving dialysis services will include ongoing communication, coordination and collaboration between the dialysis center and the facility. **4. How the corrective measures will be monitored to ensure the alleged deficient practice does not recur:** The following audits for 5 residents will be conducted by the Director of Nursing Services or designee 2 times per week times 8 weeks then monthly x 4 months to ensure compliance. This audit will include the pre and post dialysis assessment and communication with the dialysis center**.** **The results of the audit observations will be reported,**	

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	The pre dialysis documentation was completed routinely. Only three post dialysis evaluations were completed on 12/11/19, 12/14/19, and 02/03/2020. During a interview, on 02/06/2020 at 11:22 PM, the RDCO (Regional Director of Clinical Operations) indicated staff are expected to complete the pre and post dialysis documentation for each appointment. A policy was provided by the DON (Director of Nursing) on 02/07/2020 at 4:20 PM, titled "Hemodialysis Care and Monitoring", dated 03/23/18, and indicated this was the policy currently used by the facility. The policy indicated "...Pre-Dialysis a. Evaluation completed within four (4) hours of transportation to dialysis to...Post-Dialysis...b. Nurse to complete the post-dialysis evaluation upon return from dialysis center...." 3.1-37(a)		**reviewed and trended for compliance thru the facility Quality Assurance Committee for a minimum of 6 months then randomly thereafter for further recommendation.**	
F 0727 SS=D Bldg. 00	483.35(b)(1)-(3) RN 8 Hrs/7 days/Wk, Full Time DON §483.35(b) Registered nurse §483.35(b)(1) Except when waived under paragraph (e) or (f) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. §483.35(b)(2) Except when waived under paragraph (e) or (f) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. §483.35(b)(3) The director of nursing may serve as a charge nurse only when the facility			

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	has an average daily occupancy of 60 or fewer residents. Based on record review and interview, the facility failed to ensure there was at least 8 hours of RN (Registered Nurse) coverage in a 24 hour period for 1 of 7 days reviewed for staffing. (2/2/2020) Finding includes: The Staff Posting, dated 2/2/2020, indciated there was no RN coverage scheduled for the 24 hour day schedule. During an interview, on 2/7/2020 at 3:30 P.M., CNA (certified nurse aide) 7 indicated she was responsible for updating Nurse Staff Posting sheets and she indicated there was no RN coverage for 2/2/2020. A policy on RN coverage was requested, but no policy was provided. 3.1-17(b)(3)	F 0727	**F 727- RN Coverage** **1. Corrective actions accomplished for those residents found to be affected by the alleged deficient practice:** No residents were harmed **2. Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken**: All residents have the potential to be affected by alleged deficient practice. DON will ensure that 8 hr/7 day a week RN coverage and contract staffing has been secured. **3. Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur:** RDCO/RDO to educate Administration and Director of Nursing on 8hr/7 day a week RN coverage. **4. How the corrective measures will be monitored to ensure the alleged deficient practice does not recur**: ED and DON to complete daily staffing meeting to be completed to ensure that RN coverage is in place for 8 hours a day 7 days a week. **The results of the audit observations will be reported,**	03/08/2020

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			reviewed and trended for compliance thru the facility Quality Assurance Committee for a minimum of 6 months then randomly thereafter for further recommendation.	
F 0732 SS=D Bldg. 00	483.35(g)(1)-(4) Posted Nurse Staffing Information §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not			

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	to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. Based on record review and interview, the facility failed to ensure the Nurse Staff Posting sheets contained correct data for scheduled and actual hours worked by staff for 7 of 7 days reviewed for nurse staff posting. (1/28, 1/31, 2/2, 2/4, 2/5, 2/6 & 2/7/2020) Findings include: 1. The nurse staff posting, dated 1/28/2020, indicated the hours scheduled, but did not contain the actual hours worked. 2. The nurse staff posting, dated 1/31/2020, indicated the hours scheduled, but did not contain the actual hours worked. 3. The nurse staff posting, dated 2/2/2020, indicated the hours scheduled, but did not contain the actual hours worked. 4. The nurse staff posting, dated 2/4/2020, indicated the hours scheduled, but did not contain the actual hours worked. It indicated there was only 1.50 LPN (Licensed Practical Nurse) hours scheduled for day shift. 5. The nurse staff posting, dated 2/5/2020, indicated the hours scheduled, but did not contain the actual hours worked. 6. The nurse staff posting, dated 2/6/2020, indicated the hours scheduled, but did not	F 0732	**F732- Posted Staffing Information** 1. **Corrective actions accomplished for those residents found to be affected by the alleged deficient practice:** Executive Director corrected the Daily Nurse Staffing Data for 2/6/20 and 2/7/20 upon identification of inaccuracy on 2/7/20. 2. **Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken**: Executive Director will educate Staffing Scheduler on the process for posting Daily Nurse Staffing Data. This will include; posting on a daily basis at the beginning of each shift, which must be in clear and readable format. Which must be in a prominent place readily accessible to residents and visitors by 3/8/20. 3. **Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur:** Executive Director and or	03/08/2020

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	contain the actual hours worked. 7. The nurse staff posting, dated 2/7/2020, indicated the hours scheduled, but did not contain the actual hours worked. During an interview, on 2/7/2020 at 3:30 P.M., CNA (certified nurse aide) 7 indicated the nursing staff posting form was wrong on 2/4/2020 and she was unaware the facility was required to post actual worked hours for public viewing. On 2/7/2020 at 3:45 P.M., the Regional Clinical Director provided the "Nurse Staff Information" policy, dated 6/9/2017, and indicated this was the policy currently being used by the facility. The policy indicated the staff information included the total number and the actual hours worked by nurse staffing employees that are directly responsible for resident care per shift.... The facility will post daily nurse staff information for public viewing and maintain the data for a minimum of 18 months....		designee will spot check Daily Nurse Staffing data posting three times a week for the next 60 days to ensure Staffing Scheduler is posting the Daily Nurse Staffing Data appropriately. 3/8/20 4. **How the corrective measures will be monitored to ensure the alleged deficient practice does not recur**: The Executive Director will report to QAPI monthly the findings of the audit. The QAPI committee will determine when compliance is achieved or if ongoing monitoring is required for the next 60 days.	
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			

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	§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 interview and record review, the facility failed to ensure medications ordered had an appropriate indication for use, and failed to monitor side effects for anticonvulsant and anticoagulant medications for 2 of 5 residents reviewed for unnecessary medications. (Residents 42 & 85) Findings Included: 1. A record review was conducted on 02/06/2020, at 9:33 AM, for Resident 42 and indicated an admission date of 10/30/13. Her diagnoses included, but were not limited to: Alzheimer's, multiple sclerosis (MS), dementia with behaviors, psychosis, psychotic disorder, mood disorder, heart failure, depression, diabetes, and hypertension (HTN). Her medications included: namenda (dementia), hydralazine, metoprolol (HTN), rivastigmine (Alzheimer's), norco, basaglar (diabetes), lexapro (depression), novolog (diabetes), and glimepiride (diabetes). The annual MDS (Minimum Data Set) assessment, dated 01/08/2020, indicated a BIMS (Brief Interview for Mental Status) score of 3, severe cognitive impairment. Anemia, coronary artery disease, heart failure, HTN, peripheral vascular disease, diabetes, Alzheimer's, dementia, MS, depression, psychotic disorder, mood disorder,	F 0757	F 757- Drug Regimen is Free from Unnecessary Drugs **1. Corrective actions accomplished for those residents found to be affected by the alleged deficient practice:** Resident #42 was not harmed. Resident # 85 was not harmed. Side effect monitoring was initiated for resident # 42 and resident # 85 **2. Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken:** DON or designee will audit all anticonvulsant and anticoagulant medication orders to validate there is side effect monitoring in place. **3. Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur: How the corrective measures will be monitored to ensure the alleged deficient practice does not recur:** Director of Nursing	03/08/2020

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	and back pain were indicated as current diagnoses. Insulin, antipsychotic, antidepressant, and opioid medications were indicated as taken all 7 days of the look back period. Care plans were in place related to dementia, diabetes, depression, behaviors, psychotropic medication use, and MS. The care plan related to psychotropic medication use did not include side effects of antidepressants and the behavior care plans were not individualized. No care plan for psychotic disorder or psychosis were documented. 2. A record review was conducted on 02/05/2020, at 1:50 PM, for Resident 85 and indicated an admission date of 01/14/2020. Her diagnoses included, but were not limited to: dementia, epilepsy, hypertension (HTN), thrombosis, sciatica, and weakness. Her medications included: eliquis (anticoagulation), melatonin, amlodipine (HTN), gabapentin (nerve pain), donepezil (dementia), keppra, zyprexa (dementia), topamax, and metoprolol. The admission MDS assessment, dated 01/21/2020, indicated a BIMS score of 6, severe cognitive impairment. HTN, dementia, and epilepsy were indicated as active diagnoses. Antipsychotic medication was taken 6 of the 7 days of the look back period and anticoagulants were taken all 7 days. Care plans related to dementia, impaired sleep pattern, pain, seizures, psychotropic medication use, and behaviors. The care plan related to psychotropic medication use did not include side effects of antidepressants and the behavior care plans were not individualized. No care plans related to anticoagulant use, anticonvulsant or		Services or designee will re-educate the Licensed Nurses on the following policy: Physician orders guidelines, to include the following: 1. Side effect monitoring upon implementation of anticoagulant or anticonvulsant medications **4. How the corrective measures will be monitored to ensure the alleged deficient practice does not recur:** The following audits and /or observations for 5 residents will be conducted by the Director of Nursing Services or designee 2 times per week times 8 weeks then monthly x 4 months to ensure compliance. **The results of the audit observations will be reported, reviewed and trended for compliance thru the facility Quality Assurance Committee for a minimum of 6 months then randomly thereafter for further recommendation.**	

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	155496	A. BUILDING 00 B. WING	02/07/2020

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	hypnotic medication use were documented. No side effect monitoring related to anticonvulsant and anticoagulant medications use was documented. During an interview, on 02/06/20 at 12:10 PM, the RDCO (Regional Director of Clinical Operations) indicated she would expect side effects to be monitored and all medications should have a documented indication for use. On 02/07/2020, at 10:50 AM, a policy related to side effect monitoring was requested, but one was not available. 3.1-48(a)(3) 3.1-48(a)(4)			
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			

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	documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. Based on interview and record review, the facility failed to monitor and document medication side effects and individualized behaviors and symptoms for 4 of 5 residents reviewed for unnecessary medications. (Resident 42, 85, 23 and 239) Findings Include: 1. A record review was conducted, on 2/6/2020 at 11:07 A.M., for Resident 23 and indicated her	F 0758	F758- Free From Unnecessary Psychotropic Meds/PRN Use **1. Corrective actions accomplished for those residents found to be affected by the alleged deficient practice:** Resident #23 was not harmed. Side effect monitoring was implemented for resident #23. Care plans were reviewed for	03/08/2020

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	diagnoses included, but were not limited to, major depressive disorder, delusions, seizures, insomnia and encephalopathy. A quarterly MDS (Minimum Data Set) assessment, dated 1/29/2020, indicated Resident 23 had moderate cognitive impairment. A medication list, dated 2/6/2020, included, but were not limited to, mirtazapine 7.5 mg (milligrams) at bedtime for major depressive disorder, sertraline 50 mg daily for depression and Seroquel 50 mg daily for delusions. A care plan, dated 12/4/19, indicated the use of psychotropic drugs placed Resident 23 at risk for drug related effects. The interventions included, but were not limited to, monitor for side effects and monitor for effectiveness. There were no specific targeted behaviors listed. A care plan, dated 9/16/19, indicated Resident 23 had depression. The interventions included, but were not limited to, monitor/document for side effects and effectiveness. The MAR (Medication Administration Record), for December 2019 and January 2020, indicated to monitor Resident 23's behavior every shift related to use of antipsychotic agents, no specific behaviors listed. There was no behavior monitoring present for review prior to December 2019. There was no anti-depressant side effect monitoring present for review. 2. A record review was conducted, on 2/7/2020 at 2:22 P.M. for Resident 239 and indicated he was		resident #23 and specific behavioral interventions implemented. Anti-Depressant side effect monitoring was implemented for resident #23. Resident #239 was not harmed. Behavior monitoring was implemented for resident #239. Side effect monitoring for antidepressant and antipsychotic medications were implemented for resident #239. Resident #42 was not harmed. Care plans were reviewed and care plan for psychosis and psychotic disorder was implemented. Antidepressant medication side effect monitoring was implemented for resident #42. Resident #85 was not harmed. Behavior monitoring and side effect monitoring were implemented for resident #85. Care Plans updated to include anticoagulant and anticonvulsant use for resident #85. **2. Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken:** DON or designee will audit all antidepressant and antipsychotic medications orders to validate there is side effect monitoring in place. All residents with psychotic disorders/psychosis to be reviewed to ensure care plans in place. All residents on antidepressant or antipsychotic medications will be reviewed to	

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	admitted on 1/24/2020 and his diagnoses included, but were not limited to, insomnia, restlessness and agitation, dementia without behavioral disturbance and altered mental status. An admission MDS, dated 1/31/19, indicated Resident 239 had severely impaired cognitive skills, and had a memory problem and had a behavior of wandering, and physical abusive behavior symptoms toward others and received an anti-depressant and anti-psychotic medication 7 days of the look back period. A medication list, dated 2/7/2020, included, but were not limited to, Seroquel 100 mg at bedtime for dementia without behavioral disturbance, Seroquel 25 mg give 75mg daily for dementia without behavior disturbance and trazodone 50 mg at bedtime for insomnia. There were no behavior monitoring present for review. There were no side effect monitoring present for the use of anti-depressant and anti-psychotic for review. 3. A record review was conducted on 02/06/2020, at 9:33 AM, for Resident 42 and indicated an admission date of 10/30/13. Her diagnoses included, but were not limited to: Alzheimer's, multiple sclerosis (MS), dementia with behaviors, psychosis, psychotic disorder, mood disorder, heart failure, depression, diabetes, and hypertension (HTN). Her medications included: namenda (dementia), hydralazine, metoprolol (HTN), rivastigmine (Alzheimer's), norco, basaglar (diabetes), lexapro (depression), novolog (diabetes), and glimepiride (diabetes). The annual MDS (Minimum Data Set) assessment,		ensure behavior monitoring in place. **3. Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur: How the corrective measures will be monitored to ensure the alleged deficient practice does not recur:** Director of Nursing Services or designee will re-educate the Licensed Nurses on the following policy: Physician orders guidelines, to include the following implementation of side effect monitoring upon initiation of antidepressant or antipsychotic. SSD/MDS to be educated by RDCO on implementation of care plans and behavior monitoring. **4. How the corrective measures will be monitored to ensure the alleged deficient practice does not recur:** The following audits and /or observations for 5 residents will be conducted by the Director of Nursing Services or designee 2 times per week times 8 weeks then monthly x 4 months to ensure compliance. **The results of the audit observations will be reported, reviewed and trended for compliance thru the facility Quality Assurance Committee for a minimum of 6 months then randomly thereafter for further recommendation.**	

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	dated 01/08/2020, indicated a BIMS (Brief Interview for Mental Status) score of 3, severe cognitive impairment. Anemia, coronary artery disease, heart failure, HTN, peripheral vascular disease, diabetes, Alzheimer's, dementia, MS, depression, psychotic disorder, mood disorder, and back pain were indicated as current diagnoses. Insulin, antipsychotic, antidepressant, and opioid medications were indicated as taken all 7 days of the look back period. Care plans were in place related to dementia, diabetes, depression, behaviors, psychotropic medication use, and MS. The care plan related to psychotropic medication use did not include side effects of antidepressants and the behavior care plans were not individualized. No care plan for psychotic disorder or psychosis were documented. Only one care planned behavior was documented as being monitored. Antidepressant medication side effects were not monitored as ordered. 4. A record review was conducted on 02/05/2020, at 1:50 PM, for Resident 85 and indicated an admission date of 01/14/2020. Her diagnoses included, but were not limited to: dementia, epilepsy, hypertension (HTN), thrombosis, sciatica, and weakness. Her medications included: eliquis (anticoagulation), melatonin, amlodipine (HTN), gabapentin (nerve pain), donepezil (dementia), keppra, zyprexa (dementia), topamax, and metoprolol. The admission MDS assessment, dated 01/21/2020, indicated a BIMS score of 6, severe cognitive impairment. HTN, dementia, and epilepsy were indicated as active diagnoses. Antipsychotic medication was taken 6 of the 7			

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	days of the look back period and anticoagulants were taken all 7 days. Care plans related to dementia, impaired sleep pattern, pain, seizures, psychotropic medication use, and behaviors. The care plan related to psychotropic medication use did not include side effects of antidepressants and the behavior care plans were not individualized. No care plans related to anticoagulant use, anticonvulsant or hypnotic medication use were documented. No behavior monitoring or side effect monitoring for melatonin and antidepressant use was documented. During an interview, on 02/06/2020 at 12:10 PM, the RDCO (Regional Director of Clinical Operations) indicated she would expect appropriate care plans to be in place with side effects and behaviors monitored. She also indicated all medications should have a documented indication for use. During an interview, on 02/07/2020 at 9:53 AM, the SSD (Social Services Director) indicated not all behaviors were being monitored and should have been. She also indicated the behavior care plan was not individualized with interventions. On 02/07/2020, at 10:50 AM, a policy related to side effect monitoring was requested, but one was not available. A policy was provided by the DON (Director of Nursing) on 02/07/2020 at 4:20 PM, titled "Behavior Management General", dated 04/08/16, and indicated this was the policy currently used by the facility. The policy indicated "...policy of this facility to identify and safely manage			

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	residents who are exhibiting behaviors related to psychiatric diagnoses...Residents will be provided with a resident centered behavior management plan...Assess for problematic/dangerous behaviors...Document the assessment of the behavior in electronic medical records...Complete a care plan...." 3.1-48(a)(3) 3.1-48(a)(4)			
F 0761 SS=D Bldg. 00	483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals §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 be readily detected.			

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	Based on observation and interview the facility failed to maintain proper temperature control of the medication storage refrigerator for 1 of 1 refrigerators reviewed. (Medication room refridgerator) Finding Includes: During a medication storage observation, on 2/7/2020 at 2:00 P.M., the UM (Unit Manager) indicated the temperature of the medication refrigerator was 32 degrees. The temperature log indicated the temperature had been between 30 to 35 degrees between February 1 through February 7 2020. The medication room refrigerator had 8 boxes of influenza afluria quadrivalent that indicated it should be stored between 36 to 46 degrees and 6 boxes of tuberculin test solution that indicated it should be stored between 36 to 46 degrees. During an interview, on 2/7/2020 at 2:05 P.M., the UM indicated the refrigerator temperature should be kept between 36 to 46 degrees and maintenance should be notified when the temperature is out of range. A policy was provided by the Director of Nurses, on 2/7/2020 at 4:20 P.M., titled, "Storage of Medications", no date, and indicated the policy was the one currently being used by the facility. The policy indicated "...Medications requiring refrigeration are kept in a refrigerator at temperatures between...36 degrees Fahrenheit and 46 degrees Fahrenheit...." 3.1-25(m)	F 0761	F761- Label/Storage Drugs and Biologicals **1. Corrective actions accomplished for those residents found to be affected by the alleged deficient practice:** Director of Nursing immediately disposed of the Influenza Afluria Quadrivelent and Tuberculin Test Solution found in refrigerator with inaccurate temperatures on 2/7/20. **2. Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken:** Director of Nursing will educate nurses on the process for monitoring refrigerator temperatures and adjusting temperature as appropriate. **3. Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur: How the corrective measures will be monitored to ensure the alleged deficient practice does not recur:** The following audits and /or observations for 5 residents will be conducted by the Director of Nursing Services or designee 2 times per week times 8 weeks then monthly x 4 months to ensure compliance	03/08/2020

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			4. How the corrective measures will be monitored to ensure the alleged deficient practice does not recur: The Executive Director will report to QAPI monthly the findings of the audit. The QAPI committee will determine when compliance is achieved or if ongoing monitoring is required for the next 60 days.	
F 0881 SS=E Bldg. 00	483.80(a)(3) Antibiotic Stewardship Program §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(3) An antibiotic stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use. Based on record review and interview, the facility failed to monitor antibiotic use for appropriate diagnoses, dose or duration that was reviewed with the Pharmacy Consultant and physicians, for 4 of 15 residents reviewed for infection and antibiotic use. Finding includes: The Infection Control Surveillance book was reviewed on 2/7/2020 at 10:00 A.M. The Infection Log, dated 1/2020, had missing tracking of antibiotic use and missed doses of antibiotics to the following residents:	F 0881	F881- Antibodic Stewardship 1. **Corrective actions accomplished for those residents found to be affected by the alleged deficient practice:** No residents were harmed by this deficient practice. 2. **Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken:** All residents receiving an antibiotic have the potential to be affected. An audit of all residents receiving	03/08/2020

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	A resident was started on antibiotics for signs and symptoms of urinary tract infection on 1/2/2020 that was not documented. An order for cephalexin 500 mg (milligrams) for 30 days had a stop date of 2/13/2020, which was over 30 days since the start on 1/8/2020. A resident had an order for Vancomycin IV, Cefepime IV and Flagyl orally. Only the vancomycin was documented on the infection control log. A resident was ordered Cipro 500 mg for urinary tract infection for 7 days and documentation indicated resident had received only antibiotics on 4 of the 7 days. During an interview, on 2/07/2020 at 10:39 A.M., the Infection Control Nurse indicated the that the missing information should be documented. On 2/7/2020 at 3:00 P.M. a policy on Antibiotic Stewardship was requested but one was not provided.		an antibiotic will be completed to validate they are being monitored for appropriate diagnoses and are reviewed with the pharmacy consultant and physicians. All findings will be reviewed with the Physician. 3. **Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur: How the corrective measures will be monitored to ensure the alleged deficient practice does not recur:** The DON and SDC will be educated on the antibiotic stewardship program and the Infection Prevention and Control program. 4. **How the corrective measures will be monitored to ensure the alleged deficient practice does not recur:** The DON or designee will complete an audit weekly of the infection control and prevention program to include the antibiotic stewardship for 6 months to validate any resident with an order for an antibiotic is monitored for diagnosis, dose, duration and reviewed with the Pharmacy Consultant and physician. Any findings will be reported in the monthly QAPI meeting by the SDC/DON. The QAPI committee will determine if ongoing monitoring is required or if compliance is met.	

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