STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345277	A. BUILDING _____ B. WING _____	03/05/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
WOODLAND HILL CENTER	400 VISION DRIVE ASHEBORO, NC 27203

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0623 **Level of harm** - Potential for minimal harm **Residents Affected** - Many	**Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews with resident, family, and staff, the facility failed to notify the resident and/or Responsible Party in writing of the reason for hospital discharge for 4 of 4 sampled residents reviewed for hospitalization (Residents #10, #15, #55, and #71). The findings included: 1. Resident #55 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Resident #55 ' s medical record indicated his Responsible Party (RP) was a family member. The medical record additionally indicated Resident #55 was admitted to the hospital and discharged from the facility on 1/18/20. On 1/23/20 Resident #55 was readmitted to the facility. There was no documentation that written notice that included the reason for the hospital discharge was provided to Resident #55 and/or to his RP for this 1/18/20 hospital discharge. The quarterly Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #55 ' s cognition was intact. On 3/4/20 at 2:25 PM, Nurse #2 was interviewed. Nurse #2 stated that the RP was notified by phone when a resident was discharged to the hospital. She indicated that a Hospital Transfer Form was sent with emergency personnel for the hospital staff and this form included the reason the resident was sent to the hospital. She reported that this form was not given to the resident and/or RP. Nurse #2 stated that she was familiar with Resident #55 and she confirmed a family member was his RP. On 3/4/20 at 2:43 PM during a phone interview with Resident #55 ' s RP she indicated she had not recalled receiving any written information from the facility staff that included the reason for the hospital discharge related to the resident ' s 1/18/20 hospitalization . On 3/4/20 at 3:00 PM the Admissions Director was interviewed. She stated that she provided a follow up call to the resident ' s RP the next weekday after a hospitalization occurred. She reported that she had not provided the resident and/or RP with written notice that included the reason for the hospital discharge. An interview was conducted with the Administrator on 3/4/20 at 1:15 PM. The Administrator stated when a resident was transferred to the hospital that a Hospital Transfer Form was sent with emergency personnel for the hospital staff and this form included the reason the resident was sent to the hospital. She reported that this form was not provided to the resident and/or RP. She indicated that if a resident had an RP that a form was mailed to them that stated the date of the hospital transfer, but this form did not include the reason why the resident was transferred to the hospital. The Administrator revealed that she knew there was a regulation that required the resident and/or RP to be provided with written notice of hospital transfers/discharges, but she had not known that this written notice needed to include the reason for the hospital transfer/discharge. The Administrator indicated the form needed to be revised to include the reason for hospital transfer/discharge to meet the requirements of the regulation. 2. Resident #15 was admitted to the facility on [DATE]. The resident was discharged to a hospital on [DATE] with reentry to the facility on [DATE]. His [DIAGNOSES REDACTED]. Resident #15 ' s medical record indicated his Responsible Party (RP) was a family member. The medical record did not include documentation to indicate a written notice with the reason for his hospital discharge on 12/13/19 was provided to either Resident #15 or to his RP. Resident #15 ' s medical record included an annual Minimum Data Set (MDS) assessment dated [DATE]. This assessment reported the resident had severely impaired cognitive skills for daily decision making. On 3/4/20 at 2:25 PM, Nurse #2 was interviewed. Nurse #2 stated that the RP was notified by phone when a resident was discharged to the hospital. She indicated that a Hospital Transfer Form was sent with emergency personnel for the hospital staff and this form included the reason the resident was sent to the hospital. She reported this form was not given to the resident and/or RP. An interview was conducted on 3/4/20 at 1:15 PM with the facility ' s Administrator. The Administrator stated when a resident was transferred to the hospital, a Hospital Transfer Form was sent with emergency personnel for the hospital staff. The Hospital Transfer Form included the reason the resident was sent to the hospital. However, the Administrator reported this form was not provided to the resident or RP. She indicated that if a resident had an RP, a form was mailed to them that stated the date of the hospital transfer but this form did not include the reason why the resident was transferred to the hospital. The Administrator revealed she knew a regulation required the resident and/or RP to be provided with written notice of hospital transfers/discharges, but she did not know the written notice needed to include the reason for the hospital transfer/discharge. The Administrator indicated the form needed to be revised to include the reason for hospital transfer/discharge. A telephone interview was conducted on 3/5/20 at 9:25 AM with Resident #15 ' s RP. Upon inquiry, the RP reported she did not believe she received written notification with the reason for the resident ' s transfer to the hospital. However, the RP also stated she was out of the country at the time of his hospitalization . A follow-up interview was conducted on 3/5/20 at 12:25 PM with the facility ' s Administrator. During the interview, the Administrator reported written notification of transfer/discharge was being sent out to all residents and/or their RP, including those residents transferred to the hospital. However, she acknowledged the reason for the hospital transfer was not included on the form sent out for residents discharged to the hospital. 3. Resident #71 was admitted to the facility on [DATE]. The resident was discharged to the hospital on [DATE] with reentry to the facility on [DATE]. Her [DIAGNOSES REDACTED]. Resident #71 ' s medical record revealed she was her own Responsible Party (RP). There was no documentation to indicate a written notice with the reason for the hospital discharge (dated 1/28/20) was provided to Resident #71. Resident #71 ' s medical record included an annual Minimum Data Set (MDS) assessment dated [DATE]. This assessment reported the resident had intact cognitive skills for daily decision making. On 3/4/20 at 2:25 PM, Nurse #2 was interviewed. Nurse #2 stated that the RP was notified by phone when a resident was discharged to the hospital. She indicated that a Hospital Transfer Form was sent with emergency personnel for the hospital staff and this form included the reason the resident was sent to the hospital. She reported this form was not given to the resident and/or RP. An interview was conducted on 3/4/20 at 1:15 PM with the facility ' s Administrator. The Administrator stated when a resident was transferred to the hospital, a Hospital Transfer Form was sent with emergency personnel for the hospital staff. The Hospital Transfer Form included the reason the resident was sent to the hospital. However, the Administrator reported this form was not provided to the resident or RP. She indicated that if a resident had an RP, a form was mailed to them that stated the date of the hospital transfer but this form did not include the reason why the resident was transferred to the hospital. The Administrator revealed she knew a regulation required the resident and/or RP to be provided with written notice of hospital transfers/discharges, but she did not know the written notice needed to include the reason for the hospital transfer/discharge. The Administrator indicated the form needed to be revised to include the reason for hospital transfer/discharge. An interview was conducted on 3/5/20 at 10:00 AM with Resident #71. Upon inquiry, the resident reported she did not receive written notification of the reason for her transfer to the hospital from 1/28/20. Resident #71 confirmed she was her own Responsible Party. A follow-up interview was conducted on 3/5/20 at 12:25 PM with the facility ' s Administrator. During the interview, the Administrator reported written notification of

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 0623 **Level of harm** - Potential for minimal harm **Residents Affected** - Many	(continued... from page 1) transfer/discharge was being sent out to all residents and/or their RP, including those residents transferred to the hospital. However, she acknowledged the reason for the hospital transfer was not included on the form sent out for residents discharged to the hospital. 4) Resident #10 was originally admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Resident #10's medical record revealed she was transferred to the hospital on [DATE] and readmitted back to the facility on [DATE]. There was no documentation of a written notice of transfer was provided to the resident and/or responsible party. During an interview with the Social Worker on 3/4/2020 at 2:00pm, she stated she didn't provide any written information to the resident and/or responsible party when a resident was transferred to the hospital. On 3/4/2020 at 3:00pm the Admissions Coordinator stated she didn't provide the resident and/or responsible party with any written notice of the reason for a hospital transfer. The Administrator was interviewed on 3/4/2020 at 3:05pm and indicated she was not aware of the requirement to send written notification to the resident and/or responsible party of the reason for a hospital transfer. The Administrator revealed the facility had not provided any written information to the resident and/or responsible party when a resident was transferred from the facility to the hospital. On 3/5/2020 at 1:14pm, the Administrator and Director of Nursing stated it was their expectation for the resident and/or responsible party to be notified in writing for the reason of the hospital transfer, per the regulation.
F 0657 **Level of harm** - Potential for minimal harm **Residents Affected** - Some	**Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview, the facility failed to incorporate Nursing Assistants into the care planning process for 2 of 2 residents (Residents #33 and #70) reviewed for the care plan process. The findings included: 1. Resident #33 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. The annual Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #33 ' s cognition was moderately impaired. The medical record revealed no care plan meetings were conducted for Resident #33 from 1/26/19 through 3/3/20. An interview was conducted with the Social Worker (SW) on 3/4/20 at 11:05 AM. The SW stated that care plan meetings were utilized to incorporate the resident and/or Responsible Party (RP) in the development and quarterly review of care plans for all residents. She indicated that the care plan meeting attendees were the resident and/or RP, herself, the MDS Coordinator, a Nursing Assistant (NA), and the department heads that were relevant to the resident ' s care plan such as dietary or therapy. The SW revealed that care plan meetings were only conducted if the resident and/or RP wanted to attend the meeting. She explained that when a meeting was not conducted that the department heads relevant to the resident ' s care plan were required to independently review the care plan on the electronic medical record when the quarterly and/or annual MDS assessments were due and they were required to electronically sign the document to indicate the review was completed. The SW reported that she had not known how Nursing Assistants were involved in the care plan review process if a meeting was not conducted. This interview with the SW continued. She stated that she was familiar with Resident #33. She reported that this resident and/or RP had not wished to attend a care plan meeting over the past year. She revealed that a care plan meeting had not been conducted for Resident #33 since 2018. An interview was conducted with the MDS Coordinator on 3/4/20 at 11:12 AM. She confirmed the SW interview that indicated a care plan meeting was not conducted if the resident and/or RP was not going to attend. She further confirmed that all department heads relevant to the resident ' s care plan were required to electronically sign the care plan quarterly to indicate it was reviewed. The MDS Coordinator revealed that NAs were not incorporated into the care plan review process if a meeting was not conducted. She stated that NAs had no access to the electronic medical record that contained the residents ' care plans. An interview was conducted with NA #6 on 3/4/20 at 11:10 AM. She stated that she had worked at the facility for over [AGE] years. She reported that she never reviewed the care plans for residents as the NAs had no access to the electronic medical record that contained the care plans. During an interview with the Administrator on 3/5/20 at 1:15 PM she stated that she was aware of the regulation that required NAs to be incorporated into the care planning process. She revealed she was not aware that care plan meetings were not being conducted if the resident and/or RP were not planning to attend the meeting. She stated that she expected all required staff to be incorporated into the care planning process. 2. Resident #70 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED].#70 ' s cognition was intact. The medical record revealed no care plan meetings were conducted for Resident #70 from 1/26/19 through 3/3/20. An interview was conducted with the Social Worker (SW) on 3/4/20 at 11:05 AM. The SW stated that care plan meetings were utilized to incorporate the resident and/or Responsible Party (RP) in the development and quarterly review of care plans for all residents. She indicated that the care plan meeting attendees were the resident and/or RP, herself, the MDS Coordinator, a Nursing Assistant (NA), and the department heads that were relevant to the resident ' s care plan such as dietary or therapy. The SW revealed that care plan meetings were only conducted if the resident and/or RP wanted to attend the meeting. She explained that when a meeting was not conducted that the department heads relevant to the resident ' s care plan were required to independently review the care plan on the electronic medical record when the quarterly and/or annual MDS assessments were due and they were required to electronically sign the document to indicate the review was completed. The SW reported that she had not known how Nursing Assistants were involved in the care plan review process if a meeting was not conducted. This interview with the SW continued. She stated that she was familiar with Resident #70. She reported that this resident and/or RP had not wished to attend a care plan meeting over the past year. She revealed that a care plan meeting had not been conducted for Resident #70 since 2018. An interview was conducted with the MDS Coordinator on 3/4/20 at 11:12 AM. She confirmed the SW interview that indicated a care plan meeting was not conducted if the resident and/or RP was not going to attend. She further confirmed that all department heads relevant to the resident ' s care plan were required to electronically sign the care plan quarterly to indicate it was reviewed. The MDS Coordinator revealed that NAs were not incorporated into the care plan review process if a meeting was not conducted. She stated that NAs had no access to the electronic medical record that contained the residents ' care plans. An interview was conducted with NA #6 on 3/4/20 at 11:10 AM. She stated that she had worked at the facility for over [AGE] years. She reported that she never reviewed the care plans for residents as the NAs had no access to the electronic medical record that contained the care plans. During an interview with the Administrator on 3/5/20 at 1:15 PM she stated that she was aware of the regulation that required NAs to be incorporated into the care planning process. She revealed she was not aware that care plan meetings were not being conducted if the resident and/or RP were not planning to attend the meeting. She stated that she expected all required staff to be incorporated into the care planning process.
F 0658 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure services provided by the nursing facility meet professional standards of quality.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews, observation, staff interviews and Nurse Practitioner interview, the facility failed to transcribe physician orders [REDACTED].#389 and #55). The findings included: 1) Resident #389 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. The February 2020 and (NAME)2020 Medication Administration Records (MAR) indicated to give 25 units of [MED] [MED] by mouth two times a day. On 3/4/2020 at 10:05am an interview occurred with Nurse #3 who was working on the medication cart for Resident #389's hall. She stated she was familiar with the resident and had provided his [MED] [MED] subcutaneously. Nurse #3 acknowledged the MAR indicated [REDACTED]. At 1:54pm on 3/4/2020 a phone interview was held with Nurse #4 who had transcribed the order for [MED] [MED] on 2/21/2020. She stated it was error and should have read to administer the medication subcutaneously. An interview was held with Nurse Practitioner #1 on 3/5/2020 at 9:50am. She reviewed the physician orders [REDACTED]. She further stated she expected medication routes to be transcribed correctly for [MED]. The Director of Nursing was interviewed on 3/5/2020 at 1:14pm and stated she expected all medication administration routes to be transcribed correctly when the order was received and/or reviewed. 2. Resident #55 was admitted to the facility on [DATE] and most recently readmitted on [DATE] with [DIAGNOSES REDACTED]. The quarterly Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #55 ' s cognition was intact. A physician's order [REDACTED]. The stop date of this order was 1/31/20. A nursing note dated 2/3/20 indicated Resident #55 had recently completed an antibiotic and was removed from contact precautions. On 3/4/20 a review of the active orders for Resident #55 indicated a physician's order [REDACTED]. This order was entered into the electronic medical record by Nurse #5. An observation was conducted of Resident #55 on 3/4/20 at 1:50 PM. The resident was in bed in his room and contact

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F 0658 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 2) precautions were not in place. An interview was conducted with Nurse #2 on 3/4/20 at 1:55 PM. She stated that Resident #55 ' s contact precautions were only in place until his antibiotic was completed on 1/31/20. Nurse #2 reviewed Resident #55 ' s active orders and confirmed the contact precautions order was still active. She stated that the nurse who entered the order should have included a stop date that coincided with the antibiotic stop date. Nurse #2 went on to explain that this contact precautions order was placed under the category of other which meant that it was not showing up on the Medication Administration Record [REDACTED]. An interview was conducted with Nurse #5 on 3/4/20 at 4:05 PM. The active order for contact precautions for Resident #55 was reviewed with Nurse #5. Nurse #5 confirmed she entered this order into the electronic record and should have transcribed the order with a stop date that coincided with the stop date of the antibiotic. She revealed that this was a transcription error. During an interview with Nurse Practitioner #1 on 3/5/20 at 9:50 AM she stated that Resident #55 ' s stop date for contact precautions should have coincided with the stop date for his antibiotic. She reported that she expected orders to be transcribed correctly. An interview was conducted with the Administrator and Director of Nursing on 3/4/20 at 1:15 PM. The both indicated they expected physician's order [REDACTED].
F 0690 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observations and staff interviews, the facility failed to secure the indwelling urinary catheter for 1 of 3 residents reviewed for urinary catheter use. (Resident #10) The findings included: Resident #10 was originally admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. The quarterly Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #10 had moderately impaired cognition. She required extensive assistance from staff for toileting and had an indwelling urinary catheter. Review of Resident #10's care plan dated 12/18/19 revealed a problem area for an indwelling urinary catheter due to [MEDICAL CONDITION]. On 3/3/2020 at 2:30pm Nurse Aide #1 (NA) was observed providing catheter care to Resident #10. A catheter securement device was not present. NA #1 stated residents with indwelling urinary catheters should have a securement device but could not explain why Resident #10 did not have one. She further stated she would let the nurse know so a securement device could be applied. On 3/4/2020 at 8:55am Resident #10 was observed having urinary catheter care by Nurse Aide #2. A catheter securement device was not present. NA #2 stated residents with urinary catheters should have a securement device and the NA's should let the nurses know when one wasn't present. She could not explain why Resident #10 did not have a securement device. Nurse #1 was interviewed on 3/4/2020 at 10:15am and explained residents with indwelling urinary catheters should have a securement device to prevent pulling on the catheter and accidental dislodgement. She further stated the nurse aides should have reported if there was not a catheter securement device present and had been unaware Resident #10's catheter tubing was not secured to her leg. An interview occurred with the Unit Manger #1 on 3/4/2020 at 4:15pm and stated all residents with indwelling urinary catheters are expected to have a securement device and Resident #10 had one placed earlier today. The Director of Nursing was interviewed on 3/5/2020 at 1:14pm and stated it was her expectation for indwelling urinary catheter tubing's to be secured or properly anchored to the resident's thigh to prevent accidental pulling.
F 0744 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observation, and interviews with resident, staff, Psychiatric Mental Health Nurse Practitioner, and Nurse Practitioner, the facility failed to provide the care planned intervention of a psychiatric consultation for a resident with a [DIAGNOSES REDACTED].#70) reviewed for dementia care. The findings included: Resident #70 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED].#70 had a care plan developed with the focus area of impaired/decline in cognitive function or impaired thought processes related to dementia. The interventions included, in part, evaluate need for psychiatric/behavioral health consultation. A physician's order [REDACTED].#70 dated 3/4/19 indicated the nurse was to document each shift if the resident was behavior free and if behaviors were present the nurse was to document the behavior in a nursing note. A physician's order [REDACTED]. On 3/25/19 Resident #70 ' s care plan related to impaired/decline in cognitive function was updated with the intervention of 2 nurses to verify medication administration for resident ' s reassurance. On 3/27/19 Resident #70 had a care plan developed with the focus area of the occurrence of refusing care related to cognitive loss/dementia. The interventions included, in part, evaluate need for psychiatric/behavioral health consultation and postpone care/activity if resident becomes combative or resistive. The quarterly Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #70 ' s cognition was moderately impaired. The resident reported no mood issues. She was assessed with [REDACTED]. Resident #70 had verbal behaviors and rejection of care on 1 to 3 days during the 7-day review period. Her active [DIAGNOSES REDACTED]. Resident #70 received antidepressant medication on 6 of 7 days and antianxiety medication on 3 of 7 days. A physician's order [REDACTED]. On 4/15/19 Resident #70 had a care plan developed with the focus area of exhibiting symptoms of [MEDICAL CONDITION] related to perceptual disturbances such as delusions. Resident #70 was noted to believe someone had stolen her cushions, believe her teeth were not hers, and believe she had not been given the correct medication. The goal of this focus area was for Resident #70 to remain free of signs/symptoms of [MEDICAL CONDITION] with no unexplained or rapid changes in cognition, mental status, mood, behavior, motor function, sleep patterns and/or communication ability. The interventions included, in part, evaluate need for psychiatric/behavioral health consultation, cue and supervise as needed, redirect in a calm/quiet/comforting manner, and reassure as necessary. A Psychiatric Mental Health Nurse Practitioner (PMHNP) note dated 4/16/19 indicated Resident #70 was seen for an initial psychiatric evaluation. She was noted with a history of depression, anxiety, and dementia. The Social Worker (SW) reported to the PMHNP that Resident #70 had been experiencing increased delusional thoughts that included accusing people of stealing her things, refusing medication because she believed they were poison, and thinking that someone had been coming into her room and unplugging her phone/tv/refrigerator. The PMHNP noted that paranoia/delusions were present during evaluation. The [DIAGNOSES REDACTED]. The plan was to reassess in 4 weeks to determine the need for initiation of medication such as low dose [MEDICATION NAME] (antipsychotic medication) or [MEDICATION NAME] (antipsychotic medication) for Resident #70 ' s paranoia/delusions. A PMHNP note dated 5/16/19 indicated Resident #70 was seen for a follow up visit. She was noted to experience paranoia/delusions during the visit stating that someone had taken her teeth from her. Resident #70 ' s teeth were observed by the PMHNP to be in the resident ' s mouth. Staff reported to PMHNP that resident believed staff were poisoning her, stealing her teeth, and giving her medications to cause arthritis. Resident #70 was noted with worsening dementia with behaviors, major [MEDICAL CONDITION], and anxiety disorder. The plan was to add [MEDICATION NAME] 0.25 mg at night, continue [MEDICATION NAME] 5 mg twice daily, and continue [MEDICATION NAME] (antidepressant medication) 50 mg daily. Resident #70 was to have a follow up visit in 4 to 8 weeks for assessment. A physician's order [REDACTED]. A Status Change Notification note completed by the Customer Service Advocate (CSA) from the psychiatric provider dated 5/16/19 indicated that Resident #70 was discontinued from all psychiatric services as she was discharged from the facility. The medical record indicated Resident #70 was not discharged from the facility on 5/16/19. The record also indicated that 5/16/19 was the last time Resident #70 was seen by a psychiatric provider. A nursing note dated 5/19/19 indicated Resident #70 was argumentative stating that she had not received her morning medication and she was unable to be re-directed or convinced otherwise. A note completed by the Administrator dated 5/21/19 indicated that Resident #70 continued to exhibit paranoia/delusions revolving around believing items of hers were stolen or broken when the items were observed in proper working condition in the resident ' s room. Nursing notes dated 5/25/19 and 6/24/19 indicated Resident #70 believed she had not been given her medications and when she was assured that she received them she became verbally aggressive with staff. Two nursing staff continued to be present for medication administration. A nursing quarterly review note dated 6/25/19 indicated Resident #70 was alert with behaviors. She was noted with physical behaviors and verbal behaviors directed toward others up to 5 days a week. She was also noted with agitation, restlessness, and frustration. The annual MDS assessment dated [DATE] indicated Resident #70 ' s cognition was intact. The resident reported trouble falling asleep/staying asleep/sleeping too much and feeling tired/having little energy on 2-6 days out of the 7-day MDS review period. She was coded with no delusions and no rejection of care. Resident #70 had verbal behaviors on 1 to 3 days

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F 0744 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 3) during the 7-day review period and the behaviors were noted to significantly impact others by disrupting care or the living environment. Resident #70 received antipsychotic medication, antianxiety medication, and antidepressant medication on 7 of 7 days. A nursing note dated 7/1/19 indicated Resident #70 believed she had not been given her medications and when she was assured that she received them she became verbally aggressive with staff. Notes completed by the Administrator dated 7/2/19 and 7/5/19 indicated Resident #70 continued to have paranoia/delusions that related to her medications being taken and/or changed by the Administrator herself. She was noted to be verbally aggressive and physically aggressive with the Administrator and was unable to be redirected or reassured. A nursing note dated 7/11/19 indicated Resident #70 repeatedly asked for her medications that had already been provided. She was verbally aggressive and physically aggressive with staff. A nursing note dated 7/13/19 indicated Resident #70 continued to periodically have behaviors related to her medication. She accused staff of not giving her the correct medication. A nursing note dated 7/14/19 indicated Resident #70 was argumentative with staff stating that she had not received her medications after they had been administered. A note completed by the Director of Nursing (DON) dated 7/17/19 indicated Resident #70 continued to have behaviors and was refusing medications at times. A nursing note dated 7/22/19 indicated Resident #70 believed she had been not been administered the correct medication. Two nursing staff were present during medication administration. A nursing notes dated 7/23/19 indicated Resident #70 requested medications that had already been given. The resident became verbally and physical aggressive with staff when she was assured her medications had already been given. The quarterly MDS assessment dated [DATE] indicated Resident #70 ' s cognition was moderately impaired. The resident reported no mood issues. She was assessed with [REDACTED].#70 was noted to have verbal behaviors daily and rejection of care 1 -3 days out of the 7-day MDS review period. She received antipsychotic medication, antianxiety medication, and antidepressant medication on 7 of 7 days. Nursing notes dated 7/24/19, 7/30/19, and 8/1/19 indicated Resident #70 requested medications that had already been given. The resident became verbally and/or physical aggressive with staff when she was assured her medications had already been given. On 8/6/19 the physician's order [REDACTED].#70 ' s behavior monitoring was revised to include the specific target behaviors of refusing medication, calling staff names, accusing staff of taking/moving her things, and accusing staff and providers that medication was poison. On 8/7/19 Resident #70 had a care plan developed with the focus area of exhibiting physical/verbal behaviors related to cognitive loss/dementia and ineffective coping skills. Resident #70 was noted to curse and kick at staff when agitated. The goal of this focus area was for Resident #70 substitute acceptable ways of expressing frustration/impatience/anger and to demonstrate the ability to seek out staff/caregiver support when feeling frustrated or provoked. The interventions included, in part, allow resident to verbalize her frustration and postpone care/activity if resident became combative or resistive. A nursing note dated 8/8/19 indicated Resident #70 was verbally aggressive with staff. Nursing notes dated 9/6/19, 9/10/19, 9/12/19, and 9/30/19 indicated Resident #70 requested medications that had already been given. The resident became verbally and/or physical aggressive with staff when she was assured her medications had already been given. A nursing note dated 10/2/19 indicated Resident #70 was reviewed in the At-Risk Meeting and was noted with continued behaviors of accusing staff of stealing things from her room and not giving her medications. Resident #70 was indicated to be followed by psychiatric services. Nursing notes dated 10/8/19, 10/18/19, 10/20/19, and 10/21/19, indicated Resident #70 requested medications that had already been given. The resident became verbally and/or physical aggressive with staff when she was told her medications had already been given. The quarterly MDS assessment dated [DATE] indicated Resident #70 ' s cognition was moderately impaired. The resident reported feeling tired/having little energy on 2-6 days out of 7. She was assessed with [REDACTED]. Resident #70 was noted to have verbal behaviors 1 -3 days out of the 7-day MDS review period. She received antipsychotic medication, antianxiety medication, and antidepressant medication on 7 of 7 days. A nursing note dated 11/2/19 indicated Resident #70 requested medications that had already been given. The resident became verbally aggressive with staff when she was told her medications had already been given. The quarterly MDS assessment dated [DATE] indicated Resident #70 ' s cognition was moderately impaired. The resident reported no mood issues. She was assessed with [REDACTED]. Resident #70 received antipsychotic medication, antianxiety medication, and antidepressant medication on 7 of 7 days. Nursing notes dated 11/20/19, 11/22/19, 11/23/19, and 12/17/19 indicated Resident #70 requested medications that had already been given. The resident became verbally aggressive with staff when she was told her medications had already been given. A nursing note dated 1/15/20 indicated Resident #70 believed someone was trying to poison her. A nursing note dated 1/26/20 indicated Resident #70 stated that she either got the wrong pills or didn ' t get the pills at all. She was noted to be verbally aggressive with staff and redirection was minimally successful. A nursing note dated 1/30/20 indicated Resident #70 had physical behaviors toward her Nursing Assistant (NA). The annual MDS assessment dated [DATE] indicated Resident #70 ' s cognition was intact. The resident reported trouble falling asleep/staying asleep/sleeping too much and feeling tired/having little energy on 2-6 days out of the 7-day MDS review period. She was coded with no delusions and no rejection of care. Resident #70 had verbal behaviors on 1 to 3 days during the 7-day review period and the behaviors were noted to significantly impact others by disrupting care or the living environment. Resident #70 received antipsychotic medication, antianxiety medication, and antidepressant medication on 7 of 7 days. Nursing notes dated 2/12/20, 2/13/20, and 2/16/20 indicated Resident #70 requested medications that had already been given. The resident became verbally and/or physical aggressive with staff when she was told her medications had already been given. A Bi-annual comprehensive assessment dated [DATE] completed by Nurse Practitioner (NP) #2 indicated Resident #70 had worsening cognition, depression, anxiety, disorientation, and paranoia. She was assessed with [REDACTED]. Resident #70 also was assessed with [REDACTED]. NP #2 indicated that psychiatry and psychotherapy collaboration was to continue. A nursing note dated 3/1/20 indicated Resident #70 was asking questions about her medications and when she was given answers she became verbally aggressive with staff. The NA care guide was reviewed on 3/2/20 and indicated Resident #70 had physical and verbal behaviors and would benefit from reminders to accommodate cognitive limitations. Resident #70 ' s (NAME)2020 physician's order [REDACTED]. An interview was conducted with Resident #70 on 3/2/20 at 10:30 AM. The resident was observed to be calm and pleasant and she was alert and oriented to person and place with noted confusion to time and situation. Resident #70 inaccurately reported that she had never seen any psychiatric provider, nor had she seen any other type of doctor since she had been at the facility. She was unable to state how long she had resided at the facility. An interview was conducted with NA #3 on 3/4/20 at 9:45 AM. She stated that she regularly worked with Resident #70. She reported that the resident frequently had verbal behaviors and physical behaviors directed toward staff. She indicated that she always attempted to calm Resident #70 with reassuring words. She stated that if this intervention was ineffective she reported to the nurse and postponed care until the resident calmed down. An interview was conducted with Nurse #2 on 3/3/20 at 11:10 AM. She stated that she regularly worked with Resident #70. She confirmed NA #3 ' s interview that Resident #70 frequently had verbal behaviors and physical behaviors directed toward staff. She explained that Resident #70 had delusions and paranoia which tended to revolve around medication and this was what normally led to the behaviors. She further explained that Resident #70 either believed she had not been given her medication or that the medication she was given was not hers. Nurse #2 reported that the delusions/paranoia tended to cycle with multiple occurrences for several days in a row with a period in between where the resident had no issues. She indicated that there had been no increase in frequency of the cycle nor an increase in the level/extent of the delusions/paranoia and/or behaviors over the past several months. Nurse #2 reported that 2 nurses were always present to administer medications to provide resident reassurance and attempt to alleviate any of her concerns. She stated that the staff tried not to argue with the resident as her beliefs about her medication were generally fixed and were unable to be changed in that moment. Nurse #2 reported that Resident #70 was on [MEDICATION NAME] to target the delusions and paranoia. She indicated she believed Resident #70 was followed by the facility ' s psychiatric provider. During an interview with the Administrator on 3/3/20 at 1:10 PM she stated that she reviewed the Status Change Notification note dated 5/16/19 that indicated Resident #70 was discharged from psychiatric services due to facility discharge. She revealed that Resident #70 had not been discharged from the facility and that she was unsure why this happened. The Administrator stated that she had not realized until today (3/3/20) that Resident #70 had not been seen by psychiatric services since 5/16/19. This interview with the Administrator continued. She stated she was very familiar with Resident #70. She indicated that she herself seemed to be a trigger to the resident as the resident frequently had delusions and paranoia that involved her. She explained that Resident #70 had accused her of stealing her teeth, stealing her dentures, breaking her phone, and changing her medications. The Administrator indicated that she made a concerted effort to avoid the resident to refrain from causing her unnecessary distress. An interview was conducted with the SW on 3/3/20 at 3:10 PM. She stated that the normal facility process was for all residents on [MEDICAL CONDITION] medications to be followed by the psychiatric provider unless the resident and/or Responsible Party (RP) declined services. She reported

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0744 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 4) that the psychiatric provider came to the facility twice per month. The SW revealed that she had not known Resident #70 was discharged from psychiatric services in May 2019 until the Administrator told her this afternoon (3/3/20). She reported she spoke with office staff from the psychiatric provider and they confirmed Resident #70 had not been seen since 5/16/19. She indicated they were unable to say for certain why this occurred, but they believed there was a mix up with residents and the wrong resident was discharged from their services. The SW stated that Resident #70 would be seen by the psychiatric provider on their next visit to the facility. This interview with the SW continued. She stated that Resident #70 had verbal and physical behaviors directed toward staff. She indicated that the behaviors generally revolved around medications or believing someone had taken items of hers such as her cushions, dentures and/or teeth. She reported that Resident #70 was appropriate for psychiatric services and she should have been regularly seen by the provider. A phone interview was conducted with the CSA from the psychiatric provider on 3/4/20 at 8:45 AM. The Status Change Notification note dated 5/16/19 that indicated Resident #70 was discharged from psychiatric services due to facility discharge was reviewed with the CSA. The CSA stated that she was unable to say for certain why Resident #70 was discharged from services, but she assumed it may have been human error. She explained that it could have been this resident was mixed up with another resident. She confirmed that Resident #70 had not been seen by the psychiatric provider since 5/16/19, but she was placed on the list to be seen on the providers next visit to the facility. A phone interview was conducted with the PMHNP on 3/4/20 at 9:25 AM. She confirmed that she had not seen Resident #70 since 5/16/19. She stated that she had not realized the resident was not her caseload until her office staff notified her on 3/3/20. She reported that she reviewed her note from her 5/16/19 visit with Resident #70 and indicated that she had planned for a follow up assessment in 4-8 weeks to assess the resident after the initiation of [MEDICATION NAME]. An interview was conducted with NP #2 on 3/4/20 at 11:18 AM. She reported that Resident #70 had paranoia and delusions which tended to lead to behavioral issues. She explained that Resident #70 ' s paranoia and delusions included believing someone had stolen her medication or had given her the wrong medication. She further explained that these beliefs caused behaviors that included agitation, combativeness, and profanity. NP #2 reported that she previously wrote an order for [REDACTED].#2 indicated that Resident #70 was appropriate for psychiatric services due to her [DIAGNOSES REDACTED]. A phone interview was attempted with Resident #70 ' s physician on 3/4/20 at 11:45 AM. The physician was unable to be reached. During an interview with the Administrator and DON on 3/5/20 at 1:15 PM they both confirmed they thought Resident #70 was being routinely seen by the psychiatric provider until the 5/16/19 discharge note was reviewed on 3/3/20. They stated that Resident #70 ' s [DIAGNOSES REDACTED].
F 0755 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interviews and record reviews, the facility failed to maintain an accurate accounting of a controlled medication for 1 of 2 residents reviewed for pain (Resident #6). The findings included: Resident #6 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Resident #6 ' s (NAME)2019 physician's order [REDACTED].#6 ' s cognition was intact. She was administered opioid medication on 7 of 7 days. A nursing note dated 6/13/19 at 4:29 PM completed by Nurse #6 indicated 1 missing dose of [MEDICATION NAME] 7.5 mg was identified for Resident #6. A review of the controlled medication record for Resident #6 indicated [MEDICATION NAME] 7.5 mg was signed out 5 times rather than the 4 times the medication was ordered for on 6/13/19. The additional 7.5 mg of [MEDICATION NAME] was signed out by Nurse #6 and an illegible time was handwritten on the form. A phone interview was conducted with Nurse #6 on 3/5/20 at 4:35 PM. Nurse #6 stated that she no longer worked at the facility. The 6/13/19 nursing note that indicated a missing dose of 7.5 mg of [MEDICATION NAME] was identified for Resident #6 as well as the controlled medication record that indicated [MEDICATION NAME] 7.5 mg was signed out by Nurse #6 on 1 additional time than ordered by the physician were reviewed with Nurse #6. Nurse #6 stated that she was unable to recall anything about this incident that occurred on 6/13/19. She reported that she had not recalled anything about this incident. She further reported that she had not recalled any incident in which a 7.5 mg dose of [MEDICATION NAME] went missing nor any incident when Resident #6 was mistakenly administered 1 more dose than ordered. An interview was conducted with the Director of Nursing (DON) on 3/5/20 at 10:20 AM. The (NAME)2019 controlled medication record and the 6/13/19 nursing note completed by Nurse #6 were reviewed with the DON. The DON stated that she had not recalled anything about this missing dose of [MEDICATION NAME] for Resident #6. She indicated that according to the Nurse #6 ' s note, she wrote that the medication was missing, but signed the controlled medication record as if the medication was administered 1 additional time than it was ordered for. She reported that Nurse #6 no longer worked at the facility. The DON was unable to provide any additional explanation. During a follow up interview with the DON on 3/5/20 at 1:15 PM she indicated that she expected staff to implement their system to ensure all controlled medications were accounted for. The DON reported that she was supposed to be informed of any discrepancies with controlled medications and that she had not been informed of this incident.
F 0756 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews, and staff, consultant pharmacist, Nurse Practitioner, Psychiatric Mental Health Nurse Practitioner, and physician interviews, the consultant pharmacist failed to identify and report medication irregularities (Residents #71, #76, #24 and #389), failed to complete a monthly medication regimen review (Resident #71), the facility failed to act upon pharmacy recommendations in a timely manner (Residents #71, #14, and #70), and also failed to retain pharmacy consultation reports (Resident #71). This was for 6 of 6 residents reviewed for unnecessary medications. The findings included: 1-a) Resident #71 was admitted to the facility on [DATE]. Her cumulative [DIAGNOSES REDACTED]. Necrotizing pneumonia is a rare complication of pneumonia in which tissue death (necrosis) begins to occur in the lung. Resident #71 ' s medical record revealed she was discharged to the hospital on [DATE] with a [DIAGNOSES REDACTED]. Her hospital discharge summary reported the resident underwent [REDACTED]. She was started on antibiotics and 200 milligrams (mg) voriconazole (an oral antifungal medication) to be given twice daily for 3 months. The resident was discharged from the hospital back to the facility on [DATE]. A review of the admission orders [REDACTED]. On 5/17/19, the consulting pulmonologist recommended changing voriconazole to itraconazole 200 mg daily (another antifungal medication). He also indicated an infectious disease consultation would need to be arranged for Resident #71. The resident ' s Medication Administration Records (MARs) for May, June, July, and (NAME)2019 documented itraconazole was initiated on 5/18/19 as one-100 mg capsule provided twice daily and was continued through 8/20/19. Resident #71 was seen for a consultation with her infectious disease (ID) physician on 8/15/19. He noted the resident had [MEDICATION NAME] [DIAGNOSES REDACTED] (an infection, usually of the lungs, caused by the fungus Aspergillus) and recommended to stop the itraconazole and initiate the use of voriconazole to provide better activity for Aspergillus. Resident #71 ' s paper chart included a hard copy of the prescription written by her ID physician on 8/15/19 for 200 mg voriconazole to be given as one tablet (200 mg dose) by mouth two times daily. The prescription was written for 60 tablets (30 days of treatment) with two additional refills. The written prescription included a notation indicating the start date for voriconazole was 8/15/19 and the end date was 11/13/19. Resident #71 ' s physician orders [REDACTED]. The first order entered into the facility ' s electronic medical record on 8/16/19 initiated 200 mg voriconazole for the resident to be given twice daily; no end date was specified for on this order entry. However, the order was revised on 8/16/19 to indicate voriconazole would be provided for 60 days (versus 3 months as the ID physician recommended). The (NAME)2019 MAR indicated [REDACTED]. Based on documentation from the resident ' s September and October MARs, the resident received voriconazole up until the morning of 10/15/19 (60 days after it had been initiated). A Medication Regimen Review was conducted by the facility ' s Consultant Pharmacist on 10/26/19. Documentation on that date referred to his report for comments and recommendation(s) noted. A review of the Pharmacy Consultation Report (also dated 10/26/19) revealed no reference to the discontinuation of voriconazole was made by the pharmacist in the report. No irregularity related to the discontinuation of voriconazole was documented by the pharmacist. On 11/12/19, the ID physician ' s office was notified Resident #71 was no longer receiving voriconazole. A recommendation was made by the ID physician to resume administration of 200 mg voriconazole twice daily and an order was written by the facility ' s NP for re-initiation of the medication. Documentation on Resident #71 ' s October and November 2019 MARs

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F 0756 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 5) indicated the resident did not receive voriconazole from 10/15/19 to 11/14/19. An interview was conducted on 3/4/20 at 10:15 AM with Unit Manager #2. During the interview, Resident #71 ' s consultation visits with the ID physician and implementation of his recommendations were discussed. The unit manager recalled when the resident returned from her consult appointment in August, she had a prescription for the voriconazole and she thought the prescription had a 60-day stop date on it. When asked how it was recognized the voriconazole was discontinued after 60 days of administration, Unit Manager #2 thought one of the nurses alerted her to it. Upon inquiry as to whether or not the pharmacy consultant alerted the facility voriconazole had been discontinued, the Unit Manager stated, Not that I remember. A telephone interview was conducted on 3/4/20 at 2:31 PM with the facility's consultant pharmacist. During the interview, the pharmacist reported he was unable to recall any details in regards to the 30-day lapse of voriconazole treatment for [REDACTED]. An interview was conducted on 3/5/20 at 11:15 AM with the facility ' s Director of Nursing (DON). During the interview, concern was shared regarding the lapse of voriconazole administered to Resident #71 for approximately 1 month from mid-October to mid-November. When shown the script sent back with the resident from the ID consult on 8/15/19, the DON stated this should have at least raised questions about the 60-day duration input into the computer orders for voriconazole. The prescription from the ID physician explicitly indicated the medication had a start date of 8/15/19 and an end date of 11/13/19. 1-b) Resident #71 was admitted to the facility on [DATE]. Her cumulative [DIAGNOSES REDACTED]. Necrotizing pneumonia is a rare complication of pneumonia in which tissue death (necrosis) begins to occur in the lung. The Consultant Pharmacist ' s monthly Medication Regimen Reviews (MRRs) documented in Resident #71 ' s electronic medical record were reviewed and noted to include the following: --4/4/19 A medication regimen review was performed see report for comments / recommendation(s) noted. --4/29/19 No irregularities found. --5/30/19 No irregularities found. --6/30/19 No irregularities found. --7/16/19 No irregularities found. --8/22/19 No irregularities found. --9/25/19 A medication regimen review was performed see report for comments / recommendation(s) noted. --10/26/19 A medication regimen review was performed see report for comments / recommendation(s) noted. --11/22/19 A medication regimen review appeared to have been initiated in the resident ' s electronic medication record. However, one of two radial buttons were required to be checked to indicate whether or not irregularities were found and recommendations were made as a result of the review. It could not be determined whether or not the MRR was completed. --12/31/19 A medication regimen review was performed see report for comments / recommendation(s) noted. --[DATE] (late entry) No irregularities found. --2//27/20 No irregularities found. A telephone interview was conducted on 3/4/20 at 2:31 PM with the facility's consultant pharmacist. During the interview, the pharmacist reported he did not have access to the resident ' s medical records or his monthly notes at the time of the interview. He was unable to recall any details in regards to Resident #71 ' s medication regimen reviews but stated he was not aware the documentation for the 11/22/19 MRR was incomplete. An interview was conducted on 3/5/20 at 11:15 AM with the facility ' s Director of Nursing (DON). During the interview, concern regarding the Consultant Pharmacist ' s MRR from 11/22/19 was discussed. The DON reported she would expect the monthly MRRs to be completed and available for review. 1-c) Resident #71 was admitted to the facility on [DATE]. Her cumulative [DIAGNOSES REDACTED]. Necrotizing pneumonia is a rare complication of pneumonia in which tissue death (necrosis) begins to occur in the lung. On 10/24/19, an order for [REDACTED]. The resident ' s MAR indicated [REDACTED] 10/31/19. A Medication Regimen Review (MRR) was conducted by the facility ' s Consultant Pharmacist on 10/26/19. Documentation on that date referred to his report for comments and recommendation(s) noted. A review of the Pharmacy Consultation Report (also dated 10/26/19) included the following comment: (Resident #71) has a PRN order for an anxiolytic without a stop date: [MEDICATION NAME] (brand name for [MEDICATION NAME]) 7.5 mg. A recommendation was made to, Please discontinue PRN [MEDICATION NAME]. If the medication cannot be discontinued at this time, current regulations require that the prescriber document the indication for use, the intended duration of therapy, and the rationale for the extended time period. Resident #71 ' s MARs revealed she received PRN [MEDICATION NAME] 19 times in November 2019, 19 times in December 2019, and 12 times in January 2020. On 1/14/20, the resident ' s nurse practitioner (NP #1) responded to the Consultant Pharmacist ' s recommendations made on 10/26/19. NP #1 was identified by nursing staff from her handwriting and signature on the 10/26/19 consult form. NP #1 checked a response to indicate, I decline the recommendation above and do not wish to implement any changes due to the reasons below. She handwrote, Change [MEDICATION NAME] 7.5 mg po (by mouth) q (every) HS (hour of sleep) to scheduled. The notation was dated 1/14/20. A telephone interview was conducted on 3/4/20 at 2:31 PM with the facility's consultant pharmacist. During the interview, the pharmacist reported he did not have access to the resident ' s medical records or his monthly notes at the time of the interview. Upon further inquiry, the pharmacist reported he emailed his recommendations to the facility ' s Director of Nursing (DON) either before leaving the facility or sometimes within a few days after his consultation visits. The pharmacist also reported if he made a recommendation about a PRN [MEDICAL CONDITION] medication, he would generally regenerate the recommendation or ask the facility about it if he had not received a response back from the provider by his next monthly visit. Multiple unsuccessful telephone attempts were made to contact the resident ' s physician (who was also the facility ' s Medical Director) for an interview. An interview was conducted on 3/5/20 at 11:15 AM with the facility ' s Director of Nursing (DON). During the interview, the DON reported the facility recently changed the process for physician/Nurse Practitioner (NP) review when they identified a delay in the responses to the pharmacy recommendations. However, she also reported this process was still being reviewed and needing to be adjusted. The DON stated the process for pharmacy consults to be reviewed by the provider with recommendations implemented (as deemed appropriate by the provider) should be completed within 30 days of the Consultant Pharmacist ' s report. A telephone interview was conducted on 3/5/20 at 1:25 PM with NP #1. Upon inquiry, the nurse practitioner reported she came to the facility twice a week. While at the facility, she checked her folder for any Pharmacist Consultant Reports, reviewed them, and signed the reports as they became available to her. NP #1 was hesitant to say how much time would be reasonable for the Pharmacist Consultant Reports to be made available for review and the recommendations implemented as deemed appropriate by the provider. When asked, however, the NP agreed 2 and months was a long delay between when the Pharmacist Consultant Report was submitted and when it was reviewed by the provider. 1-d) Resident #71 was admitted to the facility on [DATE]. Her cumulative [DIAGNOSES REDACTED]. Necrotizing pneumonia is a rare complication of pneumonia in which tissue death (necrosis) begins to occur in the lung. The Consultant Pharmacist ' s monthly Medication Regimen Reviews (MRRs) documented in Resident #71 ' s electronic medical record were reviewed and noted to include the following: --4/4/19 A medication regimen review was performed see report for comments / recommendation(s) noted. --4/29/19 No irregularities found. --5/30/19 No irregularities found. --6/30/19 No irregularities found. --7/16/19 No irregularities found. --8/22/19 No irregularities found. --9/25/19 A medication regimen review was performed see report for comments / recommendation(s) noted. --10/26/19 A medication regimen review was performed see report for comments / recommendation(s) noted. --11/22/19 An incomplete medication regimen review was initiated in the resident ' s electronic medication record. --12/31/19 A medication regimen review was performed see report for comments / recommendation(s) noted. --[DATE] (late entry) No irregularities found. --2/27/20 No irregularities found. The facility provided copies of the Consultant Pharmacist ' s recommendations made on 9/25/19 and 10/26/19 as a result of the monthly reviews conducted for Resident #71. A request was made at that time to also review the Consultant Pharmacist ' s recommendations made on 4/4/19 and 12/31/19. A telephone interview was conducted on 3/4/20 at 2:31 PM with the facility's consultant pharmacist. During the interview, the pharmacist reported he did not have access to the resident ' s medical records or his monthly notes at the time of the interview. He was unable to provide any additional information regarding Resident #71 ' s MRRs or recommendations made on 4/4/19 or 12/31/19. Upon further inquiry, the pharmacist reported he emailed his recommendations to the facility ' s Director of Nursing (DON) either before leaving the facility or sometimes within a few days after his consultation visits. On 3/4/20 at 2:46 PM, the facility ' s Administrator reported they could not find the two missing recommendations (dated 4/4/19 and 12/31/19) from the Consultant Pharmacist. An interview was conducted on 3/4/20 at 4:15 PM with the Medical Records clerk. Upon inquiry, she reported no additional Pharmacy Consultation Reports had been found. An interview was conducted on 3/5/20 at 11:15 AM with the facility ' s Director of Nursing (DON). During the interview, the DON reported she would expect the monthly MRRs to be completed and available for review. 2) Resident #389 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of the baseline care plan dated [DATE]20 revealed a problem area for a [DIAGNOSES REDACTED]. Resident #389's medical record revealed a monthly medication review was completed by the consultant pharmacist on 2/26/2020 and no irregularities were found. On 3/4/2020 at 10:05am an interview occurred with Nurse #3 who was working on the medication cart for Resident #389's hall. She stated she was familiar with the resident and had provided his [MED] [MED] subcutaneously. Nurse #3 acknowledged the MAR indicated

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F 0756

Level of harm - Minimal harm or potential for actual harm

Residents Affected - Some

(continued... from page 6)

[REDACTED]. On 3/4/2020 at 3:05pm, a phone interview was conducted with the facility's consultant pharmacist. The pharmacist stated the error in the administration route of the resident's [MED] [MED] should have been identified as an irregularity on the resident's monthly medication review completed on 2/26/20 and was most likely an oversight. The Administrator and Director of Nursing were interviewed on 3/5/2020 at 1:14pm and stated they expected the facility's consultant pharmacist to alert staff to errors in administration routes during his monthly medication reviews.

3. Resident #76 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Resident #76 had a physician's orders [REDACTED]. Resident #76's February 2020 Medication Administration Record [REDACTED]. The MAR indicated [REDACTED]. The resident's MAR for February 8th 2020 was blank, indicating the labs were not drawn. During a record review, laboratory results could not be found for hemoglobin A1C level during the month of February 2020. The most recent hemoglobin A1C level for Resident #76 was drawn on 11/8/2019. Record review indicated the consult pharmacist completed a monthly review of Resident #76's medications on 2/26/2020 and noted no irregularities and no new recommendations. On 03/04/2020 at 10:27am an interview was conducted with the Director of Nursing (DON) regarding results of the hemoglobin A1C that was ordered to be drawn in February 2020. She stated she could not find any results that would indicate the lab was drawn and was not sure why it was not drawn. On 03/05/2020 at 9:59am during an interview with the facility's Nurse Practitioner, (NP) she stated Quetiapine [MEDICATION NAME] or [MEDICATION NAME] is known to cause [MEDICAL CONDITION] in patients, both those with diabetes and those without diabetes so recommendations suggest checking hemoglobin A1C levels to monitor for this. She did not feel that missing the labs had endangered the resident as he had no signs or symptoms of [MEDICAL CONDITION] reported while in the facility. She further stated she had given the nurses an order to draw the missed lab that day. During an interview with the consultant pharmacist on 03/04/2020 at 3:03pm he stated he did not recommend checking hemoglobin A1C levels with the use of Quetiapine [MEDICATION NAME], that was not a typical order. The consultant pharmacist stated he did not review the physician orders [REDACTED]. 4. Resident #24 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Record review revealed a physician's orders [REDACTED]. The resident's January 2020 Medication Administration Record [REDACTED]. The MAR indicated [REDACTED]. The January 2020 MAR indicated [REDACTED]. Laboratory results for Resident #24 did not reveal results for a hemoglobin A1C in January 2020. The consultant pharmacist conducted a monthly review of Resident #24's medications on 1/31/2020 and indicated no irregularities and no new recommendations. The consultant pharmacist completed a monthly review of the resident's medications on 2/27/2020 with the only recommendations being a gradual dose reduction of [MEDICATION NAME]. On 03/04/2020 at 10:27am an interview was conducted with the Director of Nursing (DON) regarding results of the hemoglobin A1C that should have been drawn in January 2020. She stated she could not find any results that would indicate the lab was drawn. 03/05/20 12:35 PM a phone interview was conducted with Physician #2. He stated the resident had diabetes type 2 and was on [MEDICATION NAME]. The recommendations are to monitor hemoglobin A1C in these patients due to the side effect of [MEDICAL CONDITION]. He further stated he did not feel the resident suffered any harm from not having the lab completed as ordered. During an interview with the consultant pharmacist on 03/04/2020 at 3:03pm he stated he did not recommend checking hemoglobin A1C levels with the use of Quetiapine [MEDICATION NAME] or [MEDICATION NAME], that was not a typical order. The consultant pharmacist stated he did not review the physician orders [REDACTED]. 5. Resident #14 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Resident #14s May 2019 Medication Administration Record [REDACTED]. The monthly medication review by the pharmacist completed on 5/30/2019 recommended discontinuing the order for as needed [MEDICATION NAME] or adding a stop date that did not exceed 14 days. The monthly medication review completed by the consult pharmacist on 6/30/2019 also recommended discontinuing the order for as needed [MEDICATION NAME] and [MEDICATION NAME] or adding a stop date that did not exceed 14 days. The monthly medication review for Resident #14 completed by the consultant pharmacist on 7/16/2019 indicated no irregularities and no new recommendations. The (NAME)2019 medication review on 8/16/2019 recommended an Abnormal Involuntary Movement Scale (AIMS) be completed with the use of [MEDICATION NAME]. The September 2019 medication review dated 9/25/2019 for Resident #14 completed by the consultant pharmacist read, repeated recommendation to discontinue as needed orders for [MEDICATION NAME] and [MEDICATION NAME] or place a stop date that did not exceed 14 days. This order was acknowledged/signed by the NP on 9/25/2019. Resident #14's monthly MARs from (NAME)2019 through September 25, 2019 indicated the as needed orders for both the [MEDICATION NAME] and [MEDICATION NAME] without stop dates remained on the resident's medication administration record. The MARs indicted the resident was not administered any of the as needed orders of the [MEDICATION NAME] or [MEDICATION NAME]. On 3/4/2020 at 12:23pm an interview was conducted with Nurse Practitioner (NP) #2 who signed the and acknowledged the September 25th pharmacy recommendation. She stated she acted on the recommendation as soon as she was made aware. She stated she did not receive the 5/30/2019 or the 6/30/2019 pharmacy recommendations to stop the as needed orders for [MEDICATION NAME] and [MEDICATION NAME] until 9/25/2019. She explained that the recommendation were being put into a folder in the physician's box and were not getting to her or the physician. She stated she was made aware of the issue in September 2019 and it had been corrected. She further stated she was aware when [MEDICATION NAME] or [MEDICATION NAME] were written as needed, they would require a stop date of no more than 14 days. A phone interview with Physician #2 was conducted on 03/05/20 12:35pm in which he stated the facility had been told to fax pharmacy recommendations to him if the NP was not in the building to address them on the day the recommendation was received by the facility. He stated he was not aware of the delay in acknowledging and acting on the pharmacy recommendations from May 2019 and (NAME)2019 and is not sure why that would have occurred. On 03/04/2020 at 3:03pm at phone interview was conducted with the consult pharmacist in which he stated if the as needed orders for [MEDICATION NAME] and [MEDICATION NAME] remained on the resident's MAR indicated [REDACTED].

6. Resident #70 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED].#70 ' s cognition was moderately impaired. She was assessed with [REDACTED]. Resident #70 received antipsychotic medication, antianxiety medication, and antidepressant medication on 7 of 7 days. A pharmacy recommendation dated 10/26/19 indicated Resident #70 had received [MEDICATION NAME] (antipsychotic medication) 0.25 milligrams (mg) at bed time since 5/16/19 and a Gradual Dose Reduction (GDR) was recommended to change [MEDICATION NAME] to 0.125 mg at bed time. Nurse Practitioner (NP) #2 signed the recommendation as declined on 1/3/20. A pharmacy recommendation dated 1/31/20 indicated Resident #70 had received [MEDICATION NAME] (antianxiety medication) 5 mg twice daily since 4/6/19 and a GDR was recommended to change [MEDICATION NAME] to 7.5 mg once daily. The Psychiatric Mental Health Nurse Practitioner (PMHNP) signed her acceptance of this recommendation on [DATE]. A review of the physician's order [REDACTED].#70 ' s [MEDICATION NAME] remained at 5 mg twice daily until 3/2/20 when it was reduced to 7.5 mg once daily. A phone interview was conducted with the Pharmacy Consultant on 3/4/20 at 3:00 PM. He reported that he expected his recommendations to be reviewed, responded to, and acted upon (if applicable) by the time of his next monthly Medication Regimen Review (MRR). An interview was conducted with the Director of Nursing (DON) on 3/4/20 at 11:30 AM. She stated that she received the pharmacy recommendations by fax from the Pharmacy Consultant. She indicated that they recently changed the normal process for physician/Nurse Practitioner (NP) review when they identified a delay in the responses to the pharmacy recommendations. She explained that prior to the change, the previous process was for the recommendations to be placed in the physicians ' folders that were kept at each nurse ' s station. The DON stated that the physicians (2 primary physicians who came to the facility) were not in the facility weekly as their NPs (2 NPs came to the facility) were in the facility multiple times per week. She further stated that when the physicians were in the facility they were not always reviewing the recommendations that were in their folders. She revealed that this was why some of the recommendations were not responded to for 2 or more months. She stated that sometime after the beginning of 2020 the process was changed so that all pharmacy recommendations not related to [MEDICAL CONDITION] medications were given to the Unit Managers (UMs) to put directly into the NPs ' folders rather than the physicians ' folders. She reported that all pharmacy recommendations for [MEDICAL CONDITION] medications were given to the Social Worker (SW) to provide to the PMHNP for her review, the PMHNP then gave them back to the SW, and the SW gave the recommendations to the UMs to place in the appropriate NP folder for final review prior to implementing any changes. The DON revealed that although the process had been changed, it had not completely resolved the problem as there were still recommendations that were taking over a month to be reviewed, responded to, and/or acted upon. A phone interview was attempted with Resident #70 ' s physician on 3/4/20 at 11:45 AM. The physician was unable to be reached. A phone interview was conducted with the PMHNP on 3/4/20 at 9:25 AM. The pharmacy recommendation dated 1/31/20 related to Resident #70 ' s [MEDICATION NAME] signed by the PMHNP on [DATE] and the [MEDICATION NAME] GDR implemented on 3/2/20 in accordance with the recommendation were reviewed with the PMNHP. She stated that she normally reviewed pharmacy recommendations while she was at the facility, but

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	345277	A. BUILDING _____ B. WING _____	03/05/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
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For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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F 0756 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 7) on [DATE], there was a problem with the electronic medical records system due to a storm, so she took the recommendations with her and she brought them back on her next visit to the facility on [DATE] and gave them to the SW. The PMHNP was unable to say why the recommendation was not implemented until 3/2/20. An interview was conducted with the SW on 3/4/20 at 9:49 AM. The pharmacy recommendation dated 1/31/20 related to Resident #70 ' s [MEDICATION NAME] signed by the PMHNP on [DATE] and the [MEDICATION NAME] GDR implemented in accordance with the recommendation on 3/2/20 were reviewed with the SW. The SW reported that she recalled the PMHNP had to take the recommendations out of the facility for review as there was a problem with the electronic medical records system on [DATE]. She stated that the PMHNP returned the recommendations to her on 2/20/20. She was unable to recall for certain when she gave the recommendations to the UMs, but she believed it would have been 2/25/20 at the latest. The SW was unable say why the recommendation was not implemented until 3/2/20. An interview was conducted with UM #2 on 3/3/20 at 3:30 PM. The pharmacy recommendation dated 1/31/20 related to Resident #70 ' s [MEDICATION NAME] signed by the PMHNP on [DATE] and the GDR implemented on 3/2/20 in accordance with the recommendation were reviewed with UM #2. UM #2 stated that she first saw the recommendation on 2/28/20 and she put it in NP #2 ' s folder that afternoon. She explained that NP #2 requested a final review of all pharmacy recommendations prior to the implementation of any changes. She indicated that since the form was not in NP #2 ' s folder until the afternoon of 2/28/20, it was not seen by NP #2 until the following weekday, 3/2/20. An interview was conducted with NP #2 on 3/4/20 at 11:18 AM. She stated that she was at the facility 3 times a week and she reviewed, responded to, and acted upon (if applicable) pharmacy recommendations that were placed in her folder every time she was in the facility. The pharmacy recommendation dated 10/26/19 related to Resident #70 ' s [MEDICATION NAME] that was signed by NP #2 on 1/3/20 was reviewed. She reported that when she signed this recommendation on 1/3/20 she had just received it in her folder. The pharmacy recommendation dated 1/31/20 related to Resident #70 ' s [MEDICATION NAME] signed by the PMHNP on [DATE] and the 3/2/20 [MEDICATION NAME] GDR implemented in accordance with the recommendation were reviewed with NP #2. NP #2 indicated that she received this recommendation for review on 3/2/20. She explained that the PMHNP was given this recommendation for initial review and she completed a final review prior to implementation of any changes. She stated that once she reviewed the recommendation on 3/2/20 she agreed with the change and she gave the order to GDR [MEDICATION NAME]. This interview with NP #2 continued. She stated that her expectation was for the pharmacy consultant to provide the facility with the recommendations on the date he completed the MRR and for the facility staff to put the recommendations in her folder as soon as they were provided with them. She further stated if the PMHNP was reviewing a recommendation for [MEDICAL CONDITION] medication, then the reviewed recommendation should be placed in her folder as soon as the PMHNP ' s review was completed. NP #2 stated that there was no reason why it should take over a month for her to be given the pharmacy recommendations. During an interview with the Administrat
F 0758 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews, staff interviews and physician and nurse practitioner interviews, the facility failed to monitor labs for [MEDICAL CONDITION] medications as ordered (Residents #76 and #24) and orders written for as needed use of [MEDICAL CONDITION] medications were time limited (Residents #14 and #71) for 4 of 6 sampled residents reviewed for unnecessary medications. Findings included: 1) Resident #76 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Resident #76 had a physician's orders [REDACTED]. Resident #76's February 2020 Medication Administration Record [REDACTED]. The MAR indicated [REDACTED]. The resident's MAR for February 8th 2020 was blank, indicating the labs were not drawn. The resident's most recent quarterly Minimum Data Set ((MDS) dated [DATE] indicated the resident was coded as receiving antipsychotics, antidepressants, and antianxiety medications 7 out of 7 days during the assessment period. During a record review, laboratory results could not be found for hemoglobin A1C level during the month of February 2020. The most recent hemoglobin A1C level for Resident #76 was drawn 11/8/2019. On 03/04/2020 at 10:27am an interview was conducted with the Director of Nursing (DON) regarding results of the hemoglobin A1C that was ordered to be drawn in February 2020. She stated she could not find any results that would indicate the lab was drawn and was not sure why it was not drawn. An interview was conducted with the unit manager on 03/05/2020 at 10:27am. She stated the nurse who worked on the first shift on 3/5/2020 should have seen the order for the hemoglobin A1C on the resident's MAR for 02/08/, filled out a requisition form, and had it ready for the lab technician when she/he came to the facility to draw the labs. If the lab technician did not come during first shift, then the first shift nurse should have passed on the information and the requisition form to the oncoming nurse. She stated the nurse working February 8th works weekends only and may not have known the process for completing labs. Attempts to contact the nurse, who worked on the first shift of 02/08/20, during the survey were not successful. On 03/05/2020 at 9:59am during an interview with the facility's Nurse Practitioner, (NP) she stated Quetiapine [MEDICATION NAME] or [MEDICATION NAME] is known to cause [MEDICAL CONDITION] in patients, both those with diabetes and those without diabetes so recommendations suggest checking hemoglobin A1C levels to monitor for this. She did not feel that missing the labs had endangered the resident as he had no signs or symptoms of [MEDICAL CONDITION] reported while in the facility. She further stated she had given the nurses an order to draw the missed lab that day. On 03/05/2020 at 12:25pm an interview was conducted with the facility's administrator and the DON in which they stated they expected physician ordered labs to be drawn per physician's orders [REDACTED].#24 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. The resident's most recent quarterly Minimum Data Set (MDS), dated [DATE] revealed the resident was coded as having had antipsychotic, antianxiety, and antidepressant medications 7 out of 7 days during the assessment period. Resident #24 was also coded as having received [MED] 6 out of 7 days during the assessment period. Record review revealed a physician's orders [REDACTED]. The resident's January 2020 Medication Administration Record [REDACTED]. The MAR indicated [REDACTED]. The January 2020 MAR indicated [REDACTED]. Laboratory results for Resident #24 did not reveal results for a hemoglobin A1C in January 2020. On 03/04/2020 at 10:27am an interview was conducted with the Director of Nursing (DON) regarding results of the hemoglobin A1C that should have been drawn in January 2020. She stated she could not find any results that would indicate the lab was drawn and she was uncertain why Nurse #7 would have signed off the MAR indicated [REDACTED]. If the lab technician did not come during first shift, then the first shift nurse should have passed on the information and the requisition form to the oncoming nurse. She stated the nurse working February 8th works weekends only and may not have known the process for completing labs. Attempts to contact Nurse #7 during the survey were unsuccessful. 03/05/20 12:35 PM a phone interview was conducted with Physician #2. He stated the resident had diabetes type 2 and was on [MEDICATION NAME]. The recommendations are to monitor hemoglobin A1C in these patients due to the side effect of [MEDICAL CONDITION]. He further stated he did not feel the resident suffered any harm from not having the lab completed as ordered. On 03/05/2020 at 12:25pm an interview was conducted with the facility's administrator and the DON in which they stated they expected physician ordered labs to be drawn per physician's orders [REDACTED].#14 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Resident #14's May 2019 Medication Administration Record [REDACTED]. The monthly medication review by the pharmacist completed on 5/30/2019 recommended discontinuing the order for as needed [MEDICATION NAME] or adding a stop date that did not exceed 14 days. The monthly medication review completed by the consult pharmacist on 6/30/2019 also recommended discontinuing the order for as needed [MEDICATION NAME] and [MEDICATION NAME] or adding a stop date that did not exceed 14 days. The September 2019 medication review dated 9/25/2019 for Resident #14 completed by the consultant pharmacist read, repeated recommendation to discontinue as needed orders for [MEDICATION NAME] and [MEDICATION NAME] or place a stop date that did not exceed 14 days. This order was acknowledged/signed by the NP on 9/25/2019. Resident #14's monthly MARs from (NAME)2019 through September 25, 2019 indicated the as needed orders for both the [MEDICATION NAME] and [MEDICATION NAME] without stop dates remained on the resident's medication administration record. The MARs indicted the resident was not administered any of the as needed orders of the [MEDICATION NAME] or [MEDICATION NAME]. On 3/4/2020 at 12:23pm an interview was conducted with Nurse Practitioner (NP) #2 who signed the and acknowledged the September 25th pharmacy recommendation. She stated she acted on the recommendation as soon as she was made aware. She stated she did not receive the 5/30/2019 or the 6/30/2019 pharmacy

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F 0758 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 8) recommendations to stop the as needed orders for [MEDICATION NAME] and [MEDICATION NAME] until 9/25/2019. She explained that the recommendation were being put into a folder in the physician's box and were not getting to her or the physician. She stated she was made aware of the issue in September and it had been corrected. She further stated she was aware when [MEDICATION NAME] or [MEDICATION NAME] were written as needed, they would require a stop date of no more than 14 days. A phone interview with Physician #2 was conducted on 03/05/20 12:35pm in which he stated the facility has been told to fax pharmacy recommendations to him if the NP is not in the building to address them on the day the recommendation was received by the facility. He stated he was not aware of the delay in acknowledging and acting on the pharmacy recommendations from May and (NAME)and is not sure why that would have occurred. 4-a). Resident #71 was admitted to the facility on [DATE]. Her cumulative [DIAGNOSES REDACTED]. The resident ' s medical record included a physician's order [REDACTED]. There was no documentation in the medical record to indicate an end date was specified for the PRN medication; and, there was no documentation for the rationale of using [MEDICATION NAME] PRN for an extended duration of time. Resident #71's Medication Administration Records (MARs) revealed the resident did not receive PRN [MEDICATION NAME] in either July or (NAME)of 2019. She did receive PRN [MEDICATION NAME] 14 times in September 2019. A Pharmacist Consultation Report dated 9/25/19 indicated Resident #71 had a PRN order for a sedative/hypnotic (7.5 mg [MEDICATION NAME]) which had been in place for greater than 14 days without a stop date. The provider responded to the recommendation on 10/3/19 and discontinued this medication. Based on the resident ' s MAR, she received PRN [MEDICATION NAME] 2 times between 10/1/19 and 10/3/19. On 10/8/19, 7.5 mg [MEDICATION NAME] was ordered by the provider to be given as one capsule by mouth every 24 hours as needed for [MEDICAL CONDITION] for a period of 14 days. Resident #71 ' s MAR indicated [REDACTED]. On 10/24/19, PRN [MEDICATION NAME] was re-ordered for Resident #71 with instructions to give as one capsule (7.5 mg) by mouth every 24 hours as needed for [MEDICAL CONDITION]. There was no documentation in the medical record to indicate an end date was specified for the PRN medication; and, there was no documentation for the rationale of using [MEDICATION NAME] PRN for an extended duration of time. The resident ' s MAR indicated [REDACTED]. Resident #71 ' s medical record included a quarterly Minimum Data Set (MDS) assessment dated [DATE]. This assessment revealed the resident had intact cognitive skills for daily decision making. No rejection of care nor behaviors were reported. The MDS indicated Resident #71 received a hypnotic medication on 3 out of 7 days during the look back period. Resident #71 ' s MARs revealed she received PRN [MEDICATION NAME] 19 times in November 2019, 19 times in December 2019, and 12 times in January 2020. The PRN order for [MEDICATION NAME] initiated on 10/24/19 continued until 1/14/20. At that time, [MEDICATION NAME] was ordered to be given on a scheduled (versus as needed) basis in response to a Pharmacy Consultation Report dated 10/26/19. The consultation report recommended PRN [MEDICATION NAME] be discontinued. A telephone interview was conducted on 3/4/20 at 2:31 PM with the facility's consultant pharmacist. During the interview, the pharmacist reported he did not have access to the residents ' medical records or his notes at that time. The pharmacist reported if he made a recommendation about a PRN [MEDICAL CONDITION] medication, he would generally regenerate the recommendation or ask the facility about it if he had not received a response back from the provider by his next monthly visit. Multiple unsuccessful attempts were made to contact the facility ' s Medical Director by telephone for an interview. An interview was conducted on 3/5/20 at 11:15 AM with the facility ' s Director of Nursing (DON). During the interview, the DON reported nursing staff tried to watch for PRN [MEDICAL CONDITION] used beyond 14 days. Although this was an issue previously identified by the facility, the DON reported a plan of correction had not been developed to ensure orders for PRN [MEDICAL CONDITION] included an acceptable end date. 4-b) Resident #71 was admitted to the facility on [DATE]. Her cumulative [DIAGNOSES REDACTED]. Resident #71 ' s medical record included a quarterly Minimum Data Set (MDS) assessment dated [DATE]. This assessment revealed the resident had intact cognitive skills for daily decision making. No rejection of care nor behaviors were reported. The resident ' s medical record included a physician's order [REDACTED]. There was no documentation in the medical to indicate an end date for the medication; and, there was no documentation for the rationale of using [MEDICATION NAME] for an extended duration of time. Resident #71's Medication Administration Records (MARs) revealed the resident received PRN [MEDICATION NAME] 3 times in December 2019 and 1 time in January 2020. The PRN order for [MEDICATION NAME] initiated on 12/12/19 was continued until the resident was discharged to a hospital on [DATE]. A telephone interview was conducted on 3/4/20 at 2:31 PM with the facility's consultant pharmacist. During the interview, the pharmacist reported he did not have access to the residents ' medical records or his notes at that time. The pharmacist was unable to recall details of his medication regimen reviews for Resident #71. However, he reported if a recommendation was made about a PRN [MEDICAL CONDITION] medication, he would generally regenerate the recommendation or ask the facility about it if he had not received a response back from the provider by his next monthly visit. Multiple unsuccessful attempts were made to contact the facility ' s Medical Director by telephone for an interview. An interview was conducted on 3/5/20 at 11:15 AM with the facility ' s Director of Nursing (DON). During the interview, the DON reported nursing staff tried to watch for PRN [MEDICAL CONDITION] used beyond 14 days. Although this was an issue previously identified by the facility, the DON reported a plan of correction had not been developed to ensure orders for PRN [MEDICAL CONDITION] included an acceptable end date.

F 0760 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Ensure that residents are free from significant medication errors.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on facility, hospital, and consulting Infectious Disease (ID) record reviews, and staff, nurse practitioner and ID clinical supervisor interviews, the facility failed to continue voriconazole (an antifungal medication) as recommended by the consulting ID physician, resulting in an unintended 30-day lapse of treatment for 1 of 2 residents reviewed for respiratory infections (Resident #71). The findings included: Resident #71 was admitted to the facility on [DATE]. Her cumulative [DIAGNOSES REDACTED]. Necrotizing pneumonia is a rare complication of pneumonia in which tissue death (necrosis) begins to occur in the lung. The resident ' s admission Minimum Data Set ((MDS) dated [DATE] revealed she had intact cognitive skills for daily decision making and was independent with her Activities of Daily Living. Section N of the MDS indicated Resident #71 received an antibiotic on 7 out of 7 days during the look back period. She was reported to receive oxygen therapy while a resident at the facility. Resident #71 ' s care plan included the following areas of focus, in part: --Resident exhibits or is at risk for respiratory complications related to [MEDICAL CONDITION], other cavitary lesion (Date Initiated: 4/1/19); --Resident exhibits or is at risk for complications of infection related to [MEDICAL CONDITION], cavitary lesion in lung, and necrotizing pneumonia (Date Initiated: 4/1/19; Revised on: 4/2/19). Resident #71 ' s medical record revealed she was discharged to the hospital on [DATE] with a [DIAGNOSES REDACTED]. Her hospital discharge summary reported the resident underwent [REDACTED]. She was started on antibiotics and 200 milligrams (mg) voriconazole (an oral antifungal medication) to be given twice daily for 3 months. Discharge plans included follow-up with a pulmonologist within 1-2 weeks. The resident was discharged from the hospital back to the facility on [DATE]. A review of the re-admission orders [REDACTED]. On 5/17/19, the consulting pulmonologist recommended changing voriconazole to itraconazole 200 mg daily (another antifungal medication) due to its availability and lower cost. He also indicated an infectious disease consultation would need to be arranged for Resident #71. The resident ' s Medication Administration Records (MARs) for May, June, July, and (NAME)2019 documented itraconazole was initiated on 5/18/19 as one-100 mg capsule provided twice daily. The medication was continued through 8/20/19. Resident #71 was seen for a consultation with her infectious disease (ID) physician on 8/15/19. He noted the resident had [MEDICATION NAME] [DIAGNOSES REDACTED] (an infection, usually of the lungs, caused by the fungus Aspergillus) and recommended to stop the itraconazole and initiate the use of voriconazole to provide better activity for Aspergillus. A review of the Resident #71 ' s paper chart at the facility revealed it included a hard copy of the prescription written by the ID physician on 8/15/19 for 200 mg voriconazole to be given as one tablet (200 mg dose) by mouth two times daily. The prescription was written for 60 tablets (providing 30 days of treatment) with two additional refills. A notation on the prescription indicated the start date was 8/15/19 and the end date was 11/13/19. Resident #71 ' s physician orders [REDACTED]. The first order entered into the facility ' s electronic medical record on 8/16/19 initiated 200 mg voriconazole for the resident to be given twice daily; no end date was specified for on this order entry. However, the order was revised on 8/16/19 to indicate voriconazole would be provided for 60 days (versus 3 months as the ID physician recommended). Resident #71 ' s (NAME)2019 MAR documented the administration of voriconazole was initiated for Resident #71 on 8/16/19. The resident was seen for follow-up by the ID physician on 9/12/19. He recommended continuation of the voriconazole as previously prescribed. Based on documentation from the resident ' s September and October 2019 MARs, the resident received voriconazole through the month of September. However, the medication was discontinued after the morning dose on 10/15/19 (60 days after it had been initiated). She did not receive voriconazole during the remainder of October. On 11/11/19, the resident was started on an antibiotic for a [DIAGNOSES REDACTED].#71 ' s

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F 0760 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 9) November 2019 MAR indicated she had not received the voriconazole during this month to date. Resident #71 ' s paper chart at the facility included call documentation dated 11/12/19 at 10:51 AM from the ID physician ' s office records. A notation made by the ID physician ' s office read, in part: I talked to the unit manager at (name of facility) and the VFend (brand name for voriconazole) had dropped off their orders and her last dose was 10/16 .She said if we faxed orders over for the VFend they can restart .Patient is stable and labs are stable per (name of Unit Manager at the facility) The ID physician requested an order be sent to the facility to resume voriconazole as 200 mg twice daily. An Interdisciplinary Team (IDT) Progress note dated 11/12/19 at 11:11 AM documented a nurse spoke with the ID physician ' s office to report a new antibiotic had been initiated for Resident #71. The ID office was also informed the resident ' s antifungal medication had been discontinued and a new prescription was needing to be faxed to the facility. The note indicated a request was made for all paperwork from the ID office (including orders, labs, and visit notes) be faxed to the facility because a family member typically transported the resident to their office for her appointments and rarely turned in a paperwork to staff after the resident ' s appointments. On 11/13/19, 200 mg voriconazole was ordered to be re-initiated by the nurse practitioner (NP) who cared for the resident at the facility. The new order indicated the start date for voriconazole was 11/14/19; the end date was noted to be indefinite. Documentation on Resident #71 ' s October and November 2019 MARs indicated she did not receive voriconazole from 10/15/19 up until 11/14/19 (a treatment lapse of 30 days). Resident #71 was seen for a follow-up visit on 12/12/19 with the ID physician. A progress note from this visit documented the ID physician had been unaware the resident ' s voriconazole was discontinued at the facility until he received a phone call note on 11/11/19. At the time of this visit, the ID physician planned to continue the voriconazole treatment for [REDACTED]. On 1/28/20, Resident #71 was transferred to a hospital with acutely progressive confusion and fever. She was diagnosed with [REDACTED]. On 2/3/20, the resident was seen by her ID physician in the hospital. A note authored by the physician read, in part: .I started voriconazole mid (NAME)2019, however for some reason the facility she is at discontinued therapy just a few weeks after, and this was then restarted 11/13 . Resident #71 was discharged from the hospital and re-entered the facility on 2/5/20. An interview was conducted on 3/3/20 at 12:40 PM with NP #1. During the interview, the NP reported Resident #71 ' s medications were managed by the consulting pulmonologist and ID physicians. When asked, the NP recalled the facility was in communication with the resident ' s ID physician when some of her lab work was elevated towards the end of January 2020. He recommended the voriconazole be held (which it was) for a couple of days just prior to the resident ' s hospitalization on [DATE]. Upon further inquiry, the NP did not recall any other lapse in voriconazole therapy for this resident. An interview was conducted on 3/4/20 at 10:15 AM with Unit Manager #2. During the interview, Resident #71 ' s consultation visits with the ID physician and implementation of his recommendations were discussed. Unit Manager #2 reported a family member typically accompanied the resident to her appointments with the ID physician. The unit manager recalled when the resident returned from her consult appointment in August, she had a prescription for the voriconazole and thought the prescription had a 60-day stop date on it. Unit Manager #2 reported when a family member took a resident to an outside physician ' s office, the facility would typically send a copy of her MAR and labs with the resident. However, she also stated it had been difficult to obtain consultation notes and recommendations back from Resident #71 ' s ID physician ' s office so the facility would be informed of them. When asked how it was recognized the voriconazole was discontinued on 10/15/19 after 60 days of administration, Unit Manager #2 thought one of the nurses had alerted her to it. However, she did not recall at that time who the nurse was. A follow-up interview was conducted on 3/4/20 at 3:05 PM with Unit Manager #2. During the interview, the Unit Manager reported she contacted the ID physician ' s office earlier on this date (3/4/20). The ID office stated medical records at the facility needed to request the ID consultation reports so they would be sent to the facility. A second follow-up interview was conducted with Unit Manager #2 on 3/5/20 at 8:23 AM. Upon inquiry, the Unit Manager reported a physician progress notes [REDACTED]. During the interview, the Unit Manager was asked why there was a discrepancy between the two orders for voriconazole input on 8/16/19, (one with no stop date and the other with a stop date of 60 days). The unit manager reported she was not sure. She stated there was some confusion at first as to who was going to handle the management of Resident #71 ' s medication orders and whether it would be the primary provider at the facility, the ID physician, or the [MEDICAL CONDITION] consultant. It was uncertain as to where the 60-day end date for the voriconazole had originated from. Multiple attempts were made to contact the ID physician during the 4-day on-site survey. Several messages were left requesting a return phone call from the physician. However, the ID physician did not return the call. The Clinical Supervisor from the ID physician ' s office returned a phone call on 3/5/20 at 10:30 AM and a telephone interview was conducted with her. Upon inquiry, the supervisor confirmed Resident #71 was seen at the ID office on 8/15/19, 9/12/19, 12/12/19, and while she was in the hospital during her most recent admission. When asked how recommendations from the ID physician consultations were be relayed to the facility, the supervisor reported the physician typically wrote orders on an order sheet to send back to the facility. Multiple unsuccessful attempts were made to contact the facility ' s Medical Director by telephone for an interview. An interview was conducted on 3/5/20 at 11:15 AM with the facility ' s Director of Nursing (DON). During the interview, concern was shared regarding the lapse of voriconazole administered to Resident #71 for approximately 1 month from mid-October to mid-November. Upon reviewing the voriconazole prescription sent back with the resident from the ID consult on 8/15/19, the DON stated this should have at least raised questions about the 60-day end date put into the computer orders for the voriconazole. The prescription explicitly indicated the medication had a start date of 8/15/19 and an end date of 11/13/19. The DON was then asked who was responsible to obtain the ID physician ' s recommendations made for Resident #71 and to implement any recommendations approved by the resident ' s physician or NP at the facility. The DON responded by stating she recognized it was the facility's responsibility. The DON also stated she would expect the patient to come back with recommendations from the outside consult and for the facility to follow-up on obtaining the reports and/or recommendations if these were not returned to the facility with the resident.
F 0761 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, and staff interviews, the facility: 1) Failed to discard expired medications stored on 2 of 2 medication carts observed (300 Hall med cart and 400 Hall med cart); and, 2) Failed to store medications as specified by the manufacturer on 2 of 2 medication carts observed (300 Hall med cart and 400 Hall med cart). The findings included: 1-a) Accompanied by Nurse #9, an observation of the 300 Hall medication cart was conducted on 3/3/20 at 3:12 PM. The observation revealed a bubble pack card containing 50 milligram (mg) [MEDICATION NAME] (an opioid medication) with 23 tablets remaining for Resident #38 was stored on the cart. The bubble pack card was labeled by the pharmacy with an expiration date of 12/31/19. An interview was conducted on 3/3/20 at 3:20 PM with Nurse #9. During the interview, the nurse confirmed the identified medication was expired. When asked what the facility ' s process was for identifying and removing an expired controlled substance medication from the med cart, Nurse #9 reported the medication would be removed from the med cart while witnessed by another licensed nurse. The medication would be put in a plastic bag and locked up until it could be returned to the pharmacy. An interview was conducted on 3/4/20 at 8:35 AM with the facility ' s Director of Nursing (DON) and Administrator. During the interview, the DON reported she had been made aware some medications on the medication carts were identified on 3/3/20 as being expired. A follow-up interview was conducted on 3/4/20 at 9:58 AM with the DON. Upon request, the DON described the facility ' s process to ensure expired medications were removed from the med carts. She reported the 2nd shift supervisor was responsible for checking the meds on the med carts and in the med store rooms once a month. When an expired controlled substance medication was identified, it would be pulled from the med out and signed out on the controlled substance inventory book (along with a second signature). The medication would then be put in bag, sealed, scanned (to let the pharmacy know the expired med was needing to be returned), and then the medication would be locked in the med cart until it was picked up by pharmacy. 1-b) Accompanied by Nurse #8, an observation of the 400 Hall medication cart was conducted on 3/3/20 at 2:45 PM. The observation revealed a bubble pack card containing 0.5 milligrams (mg) [MEDICATION NAME] (an antianxiety medication) containing 21 tablets for Resident #71 was stored on the cart. The bubble pack card was labeled by the pharmacy with an expiration date of 12/31/19. An interview was conducted on 3/3/20 at 3:09 PM with Nurse #8. During the interview, the nurse confirmed the identified medication was expired. When asked what the facility ' s process was for identifying and removing an expired controlled substance medication from the med cart, the

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	345277	A. BUILDING _____ B. WING _____	03/05/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
WOODLAND HILL CENTER	400 VISION DRIVE ASHEBORO, NC 27203

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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F 0761 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 10) nurse reported she was unsure but could ask her unit manager for guidance. An interview was conducted on 3/4/20 at 8:35 AM with the facility ' s Director of Nursing (DON) and Administrator. During the interview, the DON reported she had been made aware some medications on the medication carts were identified on 3/3/20 as being expired. A follow-up interview was conducted on 3/4/20 at 9:58 AM with the DON. Upon request, the DON described the facility ' s process to ensure expired medications were removed from the med carts. She reported the 2nd shift supervisor was responsible for checking the meds on the med carts and in the med store rooms once a month. When an expired controlled substance medication was identified, it would be pulled from the med out and signed out on the controlled substance inventory book (along with a second signature). The medication would then be put in bag, sealed, scanned (to let the pharmacy know the expired med was needing to be returned), and then the medication would be locked in the med cart until it was picked up by pharmacy. 1-c) Accompanied by Nurse #8, an observation of the 400 Hall medication cart was conducted on 3/3/20 at 2:45 PM. The observation revealed a bubble pack card containing 5/325 milligrams (mg) [MEDICATION NAME]/[MEDICATION NAME] (a combination opioid medication) containing 13 tablets for Resident #49 was stored on the cart. The bubble pack card was labeled by the pharmacy with an expiration date of 2/29/20. An interview was conducted on 3/3/20 at 3:09 PM with Nurse #8. During the interview, the nurse confirmed the identified medication was expired. When asked what the facility ' s process was for identifying and removing an expired controlled substance medication from the med cart, the nurse reported she was unsure but could ask her unit manager for guidance. An interview was conducted on 3/4/20 at 8:35 AM with the facility ' s Director of Nursing (DON) and Administrator. During the interview, the DON reported she had been made aware some medications on the medication carts were identified on 3/3/20 as being expired. A follow-up interview was conducted on 3/4/20 at 9:58 AM with the DON. Upon request, the DON described the facility ' s process to ensure expired medications were removed from the med carts. She reported the 2nd shift supervisor was responsible for checking the meds on the med carts and in the med store rooms once a month. When an expired controlled substance medication was identified, it would be pulled from the med out and signed out on the controlled substance inventory book (along with a second signature). The medication would then be put in bag, sealed, scanned (to let the pharmacy know the expired med was needing to be returned), and then the medication would be locked in the med cart until it was picked up by pharmacy. 1-d) Accompanied by Nurse #8, an observation of the 400 Hall medication cart was conducted on 3/3/20 at 2:45 PM. The observation revealed a bubble pack card containing 50 milligram (mg) [MEDICATION NAME] (an opioid medication) containing 22 tablets labeled for Resident #12 was stored on the cart. The bubble pack card was labeled by the pharmacy with an expiration date of 2/29/20. An interview was conducted on 3/3/20 at 3:09 PM with Nurse #8. During the interview, the nurse confirmed the identified medication was expired. When asked what the facility ' s process was for identifying and removing an expired controlled substance medication from the med cart, the nurse reported she was unsure but could ask her unit manager for guidance. An interview was conducted on 3/4/20 at 8:35 AM with the facility ' s Director of Nursing (DON) and Administrator. During the interview, the DON reported she had been made aware some medications on the medication carts were identified on 3/3/20 as being expired. A follow-up interview was conducted on 3/4/20 at 9:58 AM with the DON. Upon request, the DON described the facility ' s process to ensure expired medications were removed from the med carts. She reported the 2nd shift supervisor was responsible for checking the meds on the med carts and in the med store rooms once a month. When an expired controlled substance medication was identified, it would be pulled from the med out and signed out on the controlled substance inventory book (along with a second signature). The medication would then be put in bag, sealed, scanned (to let the pharmacy know the expired med was needing to be returned), and then the medication would be locked in the med cart until it was picked up by pharmacy. 1-e) Accompanied by Nurse #8, an observation of the 400 Hall medication cart was conducted on 3/3/20 at 2:45 PM. The observation revealed a bubble pack card containing 50 milligram (mg) [MEDICATION NAME] (an opioid medication) containing 5 tablets labeled for Resident #17 was stored on the cart. The bubble pack card was labeled by the pharmacy with an expiration date of 2/29/20. An interview was conducted on 3/3/20 at 3:09 PM with Nurse #8. During the interview, the nurse confirmed the identified medication was expired. When asked what the facility ' s process was for identifying and removing an expired controlled substance medication from the med cart, the nurse reported she was unsure but could ask her unit manager for guidance. An interview was conducted on 3/4/20 at 8:35 AM with the facility ' s Director of Nursing (DON) and Administrator. During the interview, the DON reported she had been made aware some medications on the medication carts were identified on 3/3/20 as being expired. A follow-up interview was conducted on 3/4/20 at 9:58 AM with the DON. Upon request, the DON described the facility ' s process to ensure expired medications were removed from the med carts. She reported the 2nd shift supervisor was responsible for checking the meds on the med carts and in the med store rooms once a month. When an expired controlled substance medication was identified, it would be pulled from the med out and signed out on the controlled substance inventory book (along with a second signature). The medication would then be put in bag, sealed, scanned (to let the pharmacy know the expired med was needing to be returned), and then the medication would be locked in the med cart until it was picked up by pharmacy. 2-a) Accompanied by Nurse #8, an observation of the 400 Hall medication cart was conducted on 3/3/20 at 2:45 PM. The observation revealed a 30 milliliter (ml) bottle of 2 milligram (mg) / ml [MEDICATION NAME] oral concentrate (an antianxiety medication) dispensed from the pharmacy on 1/30/20 for Resident #72 was stored on the cart. The bottle was labeled by the pharmacy with an auxiliary sticker which read, Refrigerate. A second sticker placed on the medication read, Refrigerate/Do Not Freeze. An interview was conducted on 3/3/20 at 3:09 PM with Nurse #8. During the interview, the nurse reported the [MEDICATION NAME] should have been kept in the refrigerator when it was delivered to the facility. An interview was conducted on 3/4/20 at 8:35 AM with the facility ' s Director of Nursing (DON) and Administrator. During a discussion of the med storage observations, the DON reported she would have expected the [MEDICATION NAME] oral concentrate to have been stored in the med room refrigerator. 2-b) Accompanied by Nurse #9, an observation of the 300 Hall medication cart was conducted on 3/3/20 at 3:12 PM. The observation revealed an opened dropper bottle of 1% [MEDICATION NAME] ophthalmic suspension (a steroid eye drop medication) dispensed from the pharmacy on 2/14/20 for Resident #84 was stored lying down on its side in the top drawer of the medication cart. The manufacturer ' s storage instructions printed on the label of the eye drops read, Store Upright. An interview was conducted on 3/3/20 at 3:20 PM with Nurse #9. During the interview, the nurse was shown the labeling with storage instructions on the eye drop medication. Nurse #9 reported the suspension eye drop bottle would need to be stored in another drawer of the med cart so it could be stored upright. An interview was conducted on 3/4/20 at 8:35 AM with the facility ' s Director of Nursing (DON) and Administrator. During a discussion of the med storage observations, the DON reported she would expect medications to be stored in accordance with the manufacturer ' s instructions.
F 0867 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews, observations, staff interviews and physician interview, the facility's Quality Assessment and Assurance (QAA) Committee failed to maintain implemented procedures and monitor interventions the committee had put into place following the annual recertification survey dated 1/25/2019. This was for four recited deficiencies in the areas of Care Plan Timing and Revision, Drug Regimen Review, Free from Unnecessary [MEDICAL CONDITION] Medications, and Labeling and Storage of Drugs that were previously cited on 1/25/2019. The continued failure of the facility during two federal surveys of record shows a pattern of the facility's inability to sustain an effective QAA program. The findings included: This citation is cross referenced to: F657-Based on record review and staff interview, the facility failed to incorporate Nursing Assistants into the care planning process for 2 of 2 residents (Residents #33 and #70) reviewed for the care plan process. During the facility's annual recertification survey on 1/25/2019 the facility was cited for failing to incorporate a Nursing Assistant in the care planning process (Resident #2 and #23) for 2 of 2 residents reviewed for participation in care planning. F756- Based on record reviews, and staff, consultant pharmacist, Nurse Practitioner, Psychiatric Mental Health Nurse Practitioner, and physician interviews, the consultant pharmacist failed to identify and report medication irregularities (Residents #71, #76, #24 and #389), failed to complete a monthly medication regimen review (Resident #71), the facility failed to act upon pharmacy recommendations in a timely manner (Residents #71, #14, and #70), and also failed to retain pharmacy consultation reports (Resident #71). This was for 6 of 6 residents reviewed for unnecessary medications. During the facility's recertification survey on 1/25/2019 the facility was cited for failing to act on irregularities in a resident's medication orders which included possible drug interactions and side effects, the use of 3 antidepressants and antidepressants prescribed for Dementia without behaviors for 1 (Resident #52) of 6 residents

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F 0867 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 11) reviewed for unnecessary medications. F758-Based on record reviews, staff interviews and physician and nurse practitioner interviews, the facility failed to monitor labs for [MEDICAL CONDITION] medications as ordered (Residents #76 and #24) and orders written for as needed use of [MEDICAL CONDITION] medications were time limited (Residents #14 and #71) for 4 of 6 sampled residents reviewed for unnecessary medications. During the facility's recertification survey on 1/25/2019 the facility was cited for failing to act on irregularities in a resident's medication orders regarding possible drug interactions and side effects, the use of 3 antidepressants and an antidepressant prescribed for Dementia without behaviors for 1 (Resident #52) of 6 residents reviewed for unnecessary medications. F761-Based on observations, record review, and staff interviews, the facility: 1) Failed to discard expired medications stored on 2 of 2 medication carts observed (300 Hall med cart and 400 Hall med cart); and, 2) Failed to store medications as specified by the manufacturer on 2 of 2 medication carts observed (300 Hall med cart and 400 Hall med cart). During the facility's recertification survey on 1/25/2019 the facility was cited for failing to discard an opened expired [MED] (Resident #34) and failing to store unopened [MED] in the refrigerator until opened (Resident #29) for 2 of 2 medication carts reviewed for medication storage. On 03/05/2020 at 2:25 PM an interview was conducted with the facility administrator and the DON regarding repeat deficiencies at F657, 756, F758, and F761. The DON stated unit managers were responsible for making sure staff members were assigned to go to care plan meetings. The absence of a Nursing Assistant during care plan meetings was likely an oversight. In regards to F756 and F758 the DON and Administrator acknowledge they have been actively working with the Physicians, Nurse Practitioners, and the consult Pharmacist to resolve the issues. The DON further stated medication carts were being checked at the end of each month and expiration dates were being highlighted on the labels. She thought human error might have been a contributing factor along with some labels being difficult to read.
F 0947 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention.** Based on observation, record review and staff interviews, the facility failed to ensure Nursing Assistants (NAs) completed annual dementia training for 2 of 8 Nursing Assistants reviewed for required in-service training (NA#4 and NA#5). The findings included: a. NA #4 had a hire date of 1/22/2019. Dementia training was assigned to NA #4 on 2/11/2019 via online platform with a due date of 5/12/2019. Facility records indicated the training was not completed. The facility could not provide evidence NA#4 had ever completed dementia training since her hire on 1/22/2019. In an interview with NA#4 on 3/3/2020 at 10:30am she stated the facility did provide dementia training but she did not recall the date of the training. NA#4 was observed providing incontinence care to a resident with dementia on 3/3/2020 at 9:16am. There were no concerns with the NA's interaction with the resident. During an interview with the Director of Nursing (DON) on 3/3/2020 at 4:13pm. She stated the individual responsible for staff development was on vacation and could not be reached. She further stated she did not know why the employees had not completed the required training and she was not certain how training was being tracked. On 3/5/2020 at 12:25pm, an interview was conducted with the DON and the Facility Administrator in which both indicated it was their expectation for all NAs to receive annual dementia training. b. NA #5 had a hire date of 8/21/2018. Dementia training was assigned to NA#5 on 2/11/2019 via online platform, with a due date of 5/12/2019. Facility records indicated the training was not completed. The facility could not provide evidence NA#5 had ever completed dementia training since her hire date on 8/21/2018. In an interview with NA#5 on 3/3/2020 at 10:35am she stated the facility did provide dementia training but she did not recall when the training occurred. NA#5 was observed providing meal tray set up to a resident with dementia on 3/3/2020 at 12:10pm. There were no concerns with the NA's interaction with the resident. During an interview with the Director of Nursing (DON) on 3/3/2020 at 4:13pm. She stated the individual responsible for staff development was on vacation and could not be reached. She further stated she did not know why the employees had not completed the required training and she was not certain how training was being tracked. On 3/5/2020 at 12:25pm, an interview was conducted with the DON and the Facility Administrator in which both indicated it was their expectation for all NAs to receive annual dementia training.