STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365922	A. BUILDING _____ B. WING _____	03/05/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SIENNA HILLS NURSING & REHABILITATION	73841 PLEASANT GROVE ROAD ADENA, OH 43901

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 0584 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.** Based on observation and interview the facility failed to ensure the facility was maintained in a clean, sanitary and homelike environment. This affected four residents (Resident #4, #12, #20, #29) of 37 residents residing in the facility. The census was 37. Findings include: 1. On 03/03/20 at 7:43 A.M. Resident #4's wheelchair armrests were observed to be cracked and torn on both arms. An additional observation on 03/04/20 at 4:00 P.M. revealed the arm rests remained cracked and torn with the left armrest missing approximately two inches of padding and the cracks remaining on both arm rests. 2. On 03/02/20 at 11:01 A.M. observation of Resident #29's room revealed brown splatter on the wall above the head board of her bed, and the privacy curtain hanging between her bed and her roommate's had multiple brown spots on the curtain. 3. On 03/02/20 at 2:30 P.M. observation of the sofas in the sitting room on 100 hall revealed the vinyl sofa facing the television to have approximately a twelve inch by six inch group of small cracks on the left sofa cushion, and the arms of the sofa were cracked. Resident #20 was seated on the right side of the sofa and stated the sofa was in poor condition and needed replaced. 4. On 03/02/20 at 4:24 P.M. observation of Resident #12's room revealed the wall behind the resident's head board had gouges in the drywall. The wall to the left of the resident's bed had a golf ball sized hole in it, and the tile floor at the entry of the room was chipped and had missing pieces of tile where the floor met the transition strip. On 03/05/20 at 12:35 P.M. interview with Maintenance #5 verified the above findings and stated the sofas had been removed from use, and the arm rests on Resident #4's wheel chair had been replaced.
F 0585 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, missing item log, policy review and interview, the facility failed to ensure staff were actively looking for missing items and that missing items were documented when reported. This affected one (Resident #2) of two residents reviewed for missing property. Findings include: Medical record review revealed Resident #2 was admitted on [DATE] with [DIAGNOSES REDACTED].#2 had any missing personal property. On 03/02/20 at 2:08 P.M., interview with Resident #2 stated he was missing one country compact disc (CD) and one gospel CD since the first part of February 2020. Resident #2 stated he had told Social Service (SS) #7, and the facility did not look for the items or replace them. On 03/04/20 at 9:19 A.M., interview with SS #7 verified Resident #2 had told her the CD's were missing and stated the CD's were not on his inventory list so she didn't know if he ever really had the CD's or not. SS #7 verified she had not entered the items onto the Concern/Missing Items list because she normally does not document missing items unless it had been a while and the items did not show up. SS #7 stated she just found out on 03/01/20 of the missing items but still did not log or inform the interdisciplinary team (IDT) of the missing items because the Ohio Department of Health was in the building. On 03/04/20 between 10:07 A.M. and 10:18 A.M., interview with the Administrator stated any resident or family who reported an item missing was to be logged on the missing item log and a search conducted. If the item was not found within a day or two, the entire team should conduct a search and inform the resident of the outcome in order to come to a resolution. The investigation was to start immediately and there had been no missing items reported to her since taking over as Administrator in mid February 2020. Review of the undated policy titled Missing Item, revealed all missing items were to be reported to social services and/or the Administrator. Social services was responsible for tracking and communicating the item description to the interdisciplinary team and completing a missing item form. A thorough investigation was to be conducted and the results of the investigation was to be reviewed with the resident and/or representative.
F 0641 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure each resident receives an accurate assessment.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review and interview, the facility failed to ensure comprehensive assessments were accurate. This affected two (Residents #2 and #12) of four residents reviewed for preadmission screening and resident review. The census was 37. Findings include: 1. Medical record review revealed Resident #2 was admitted on [DATE] with [DIAGNOSES REDACTED]. On 01/04/19, Resident #2 was diagnosed with [REDACTED]. Review of the discharge return anticipated Minimum Data Set 3.0 (MDS) assessment dated [DATE] revealed the cognition section of the comprehensive assessment was documented as 'not assessed'. On 03/04/20 at 10:50 A.M., interview with Assistant Director of Nursing (ADON) #4 verified the cognition section of Resident #2's above MDS assessment should have been completed. ADON #4 stated Social Service (SS) #7 did not complete the section due to the resident was not at the facility, and SS #7 did not realize there was a second part of the cognition assessment that should have been completed if the resident was unavailable or unwilling to participate in the assessment. 2. Review of the Preadmission Screen (PAS) dated 01/31/12 revealed PAS Determination included to consult with the local county department of human services for facility payment, and the resident was transferring to the facility on [DATE]. Review of the record revealed Resident #12 was admitted on [DATE] with [DIAGNOSES REDACTED]. Review of the the history and physical examination [REDACTED]. Review of the annual MDS assessment dated [DATE] revealed Resident #12 did not have a serious mental illness and/or intellectual disability. On 03/04/20 at 9:07 A.M., observation revealed Resident #12 was sitting in a specialty wheelchair with a communication board to the right of the resident. On 03/04/20 at 7:05 P.M., interview with SS #7 verified Resident #12's annual MDS assessment was inaccurate for intellectual disability.
F 0644 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview the facility failed to ensure Residents #1, #12 and #20, who had indicators of serious mental illness and/or developmental disability, had a pre-admission screening and resident review (PASARR) completed to determine whether the resident qualified for Level II services. This affected three residents reviewed for PASARR. Findings include: 1. Review of Resident #1's medical record revealed an admission date of [DATE] with [DIAGNOSES REDACTED]. Further review of the [DIAGNOSES REDACTED].#99. Review of the five day/significant change Minimum Data Set (MDS) assessment dated [DATE] revealed the resident was cognitively intact and was not currently considered by the state level 2 PASARR process to have a serious mental illness and/or intellectual disability or related condition. Review of the PASARR results dated 10/19/10 revealed the resident may be admitted to a nursing facility and would benefit from mental health counseling. No

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

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F 0644 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) assessment was noted after the [DIAGNOSES REDACTED]. Review of the psychoactive medication required due to alteration in mood and behavior related to anxiety and restlessness, sadness, loss of interest, difficulty falling asleep initiated 01/19/19 revealed interventions including acknowledge resident's moods in 1:1 interactions. encourage resident to attend group activities, encourage resident to take active social role within the facility, encourage verbalization, monitor for adverse psychoactive medication effects. Review of the physical orders revealed [MEDICATION NAME] (antianxiety medication) five milligrams 1/2 tab four times a day for adjustment disorder with mixed anxiety, depression and paranoid [MEDICAL CONDITION] written 09/24/19. On 03/02/20 at 5:40 P.M. interview with Social Services Designee (SSD) #7 verified a new assessment should have been completed when the [DIAGNOSES REDACTED]. Review of Resident #20's medical record revealed an admission date of [DATE] with [DIAGNOSES REDACTED]. Review of the annual MDS dated [DATE] revealed the resident had moderate cognitive impairment and had serious mental illness and intellectual disability but no services. Review of the 2011 PASARR revealed to link the resident to developmental disability services. On 03/04/20 at 3:00 P.M. interview with SSD #7 verified the resident was not linked to the developmental disability services. Further interview revealed she called the county board for developmental disabilities and he was not in the system. SSD #7 verified the resident should have been linked to the services for screening to see if his was eligible through the county board for developmental disabilities. 3. Review of the Preadmission Screen (PAS) dated 01/31/12 revealed PAS Determination included to consult with the local county department of human services for facility payment and the resident was transferring to the facility on [DATE]. Review of the record revealed Resident #12 was admitted on [DATE] with [DIAGNOSES REDACTED]. Review of the the history and physical examination [REDACTED]. Review of the record revealed no evidence an admission PASARR was completed, and the resident had a qualifying intellectual disability diagnoses. Review of the annual MDS assessment dated [DATE] revealed Resident #12 did not have a serious mental illness and/or intellectual disability. On 03/04/20 at 9:07 A.M., observation revealed Resident #12 was sitting in a specialty wheelchair with a communication board to the right of the resident. On 03/04/20 at 7:05 P.M., interview with SSD #7 verified there was no evidence a PASARR for Resident #12 had been completed, the annual MDS assessment was inaccurate, and Resident #12 had qualifying [DIAGNOSES REDACTED]. On 03/05/20 at 8:31 A.M., interview with SSD #7 stated there was no admission or subsequent PASARR completed or submitted for Resident #12 and the resident had not been receiving any county services since admission.
F 0645 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**PASARR screening for Mental disorders or Intellectual Disabilities** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, medical record review, preadmission screening and resident review (PASARR) and interview, the facility failed to complete PASARR's as required. This affected two (Resident #12 and #26) of four residents reviewed for PASARR. The census was 37. Findings include: 1. Review of the Preadmission Screen (PAS) dated 01/31/12 revealed PAS Determination included to consult with the local county department of human services for facility payment. The resident was transferring to the facility on [DATE]. Review of the record revealed Resident #12 was admitted on [DATE] with [DIAGNOSES REDACTED]. Review of the the history and physical examination [REDACTED]. Review of the record revealed no evidence an admission PASARR was completed, and the resident had a qualifying intellectual disability diagnoses. On 03/04/20 at 9:07 A.M., observation revealed Resident #12 was sitting in a specialty wheelchair with a communication board to the right of the resident. On 03/04/20 at 7:05 P.M., interview with Social Service (SS) #7 verified there was no evidence a PASARR for Resident #12 had been completed, and Resident #12 had qualifying [DIAGNOSES REDACTED]. On 03/05/20 at 8:31 A.M., interview with SS #7 stated there was no PASARR completed or submitted for Resident #12, and the resident had not been receiving any county services since admission. 2. Review of Resident #26's medical record revealed an admission date of [DATE] with [DIAGNOSES REDACTED]. Review of the PASARR dated 07/18/14 revealed the resident had no indication of mental illness nor a developmental disability; however, an in-person assessment was required and may be performed after admission to the nursing facility. No other PASARR was located on the medical record. Review of the Significant Change MDS dated [DATE] revealed the resident was cognitively intact and required extensive assistance of two staff members with bed mobility, transfers, dressing and toilet use. The resident also required extensive assistance of one staff member. The resident was not currently considered by the state level II PASARR process to have pervious mental illness and/or developmental disability. On 03/04/20 at 3:03 P.M. interview with SS #7 verified the resident had a developmental disability, and the facility should have identified the PASARR was not accurate. The resident should have had an in-person review after admission to the facility to determine if he required a level II screen
F 0657 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**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, policy review, resident and staff interview, the facility failed to ensure a resident was afforded the opportunity to participate in her own care plan conference. This affected one (Resident #8) of one resident reviewed for care plan conferences. Findings include: A review of Resident #8's medical record revealed the resident was admitted to the facility on [DATE]. Her [DIAGNOSES REDACTED]. A review of Resident #8's profile in her electronic health record revealed she had a court appointed guardian. The guardianship went into effect on 11/01/13, and the resident was deemed to be incompetent. A review of Resident #8's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed she had adequate hearing and clear speech. She was able to make herself understood and was able to understand others. She was cognitively intact and was not known to have any behaviors nor was she known to reject care. She required an extensive assist of one for transfers. A review of a multidisciplinary care conference assessment dated [DATE] revealed that was the last care conference held for the resident. The assessment identified those in attendance, which included a Registered Nurse (RN), dietician, social worker, activity director and nursing administration. There was no indication of the resident attending the meeting nor her court appointed guardian. The notification of the plan of care meeting was indicated to have been done by written notification but did not specify who was notified/ invited. A review of Resident #8's nurses' progress notes revealed a care plan conference invitation was sent to the resident's guardian on 12/06/19. There was no indication of the resident being invited to attend her care plan conference. On 03/02/20 10:37 A.M., an interview with Resident #8 revealed she had not been invited to attend any of her care plan conferences. She stated she did not know what that even was. On 03/03/20 at 12:00 P.M., an interview with Social Service Designee (SSD) #7 revealed the facility held plan of care meetings upon admission, quarterly, when there was a significant change in the resident's status or if something was going on that needed to be communicated to the resident's family or guardian. She reported they invited the residents' power of attorneys or any family member the resident wanted to attend. Residents were invited by receiving the same postcard the families received that included the date and time of the meeting. She said she hand delivered them but did not document doing so. If a resident had a guardian, she stated they left it up to the guardian to decide whether or not the resident would be invited to attend the care plan conference. If they did not hear back from the guardian, they hold the meeting without the guardian or the resident present. She acknowledged care conferences were to review a resident's plan of care, discuss their goals and plans for discharge, and anything else that was going on with the resident. She agreed the residents should be a part of that meeting, if they were cognitively intact, without needing the guardian's permission for the resident to attend. A review of the facility's policy on plan of care meetings undated revealed plan of care meetings would be held on each resident upon admission, quarterly, and as needed. Participants would be the following : resident and/ or the resident's representative, nursing, dietary, social services, activities and therapy as needed. The meeting minutes would be recorded in the electronic health record (EHR) during or after the plan of care meeting.
F 0660 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Plan the resident's discharge to meet the resident's goals and needs.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, preadmission screening and resident review (PASARR) and interview, the facility failed to ensure discharge planning was on-going to meet the needs of the resident. This affected one (Resident #2) of four residents reviewed for PASARR. The census was 37. Findings include: Medical record review revealed Resident #2 was admitted on [DATE] with [DIAGNOSES REDACTED]. Review of the care plan: Discharge planning, dated 04/13/18, revealed the resident's placement at the facility was long term, and the goal was to continue to adjust and accept facility placement. On 11/25/19, an

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F 0660 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 2) assessment was completed by the Area of Aging for an Assisted Living Waiver for Resident #2. Review of the Multidisciplinary Care Conferences dated 11/27/19 revealed the resident was to be discharged to the community. Passport had completed their assessment and recommendations were to be sent to the facility and Home Choice had appointed a transition coordinator. Further review of the medical record revealed no documented evidence of discharge planning after 11/27/19. Review of the discharge return anticipated Minimum Data Set 3.0 assessment dated [DATE] revealed a discharge plan was already occurring for the resident to return to the community and a referral had been made to the local agency. Review of the PASARR Summary of Findings dated 02/05/20 revealed care in a nursing facility did not appear to be the best setting for Resident #2, and the resident's needs were determined to be able to be met in a community setting. The medical necessity determination for nursing home placement was denied. On 03/04/20 at 3:55 P.M., interview with the Director of Nursing verified the advanced care planning for discharge was not accurate and the resident has been working towards an apartment outside the facility. On 03/04/20 at 5:35 P.M., interview with Social Service (SS) #7 stated at the time of the Multidisciplinary Care Conference on 11/27/19 there was no rush to proceed with discharge planning because there was no where for him to go. SS #7 stated he then [MEDICAL CONDITION], had an admission to the hospital and the facility had been appealing the PASARR decision. On 03/05/20 at 10:10 A.M., interview with SS #7 verified there was no evidence of on-going discharge planning or assistance to proceed with community discharge for Resident #2, and she had not been working towards a discharge plan prior to 2020 because they were appealing the PASARR decision. SS #7 verified payment for long term care has been denied and now she was unsure how this would affect him financially.
F 0675 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Honor each resident's preferences, choices, values and beliefs.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, personal fund review, social security administration payee request review and interview, the facility failed to consistently pursue the whereabouts of a resident's social security payee status. This affected one (Resident #6) of three residents reviewed for personal funds. Findings include: Medical record review revealed Resident #6 was admitted on [DATE] with [DIAGNOSES REDACTED]. Review of the admission Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #6 entered the facility from the community and had impaired cognition for daily decision-making. Review of the Social Security Administration: Payee Request dated 09/05/19 revealed the facility requested payee for resident social security, and the resident owed the facility the patient's monthly liability. There was no confirmation the request dated 09/05/19 was sent or received by Social Security Administration. There was also no evidence of subsequent attempts to receive the resident's monthly liability. Review of the Resident Fund Management Service dated 09/05/19 revealed the resident fund account was a transferring account with no monthly allowance amount documented. There were no transactions completed between 09/05/19 and 12/31/19. Review of the Resident Statement Landscape dated 02/12/20 revealed $110.00 was deposited into the resident's account. Review of the record revealed no documented evidence the resident was aware money had been deposited into her fund account. On 03/02/20 at 2:30 P.M., interview with Resident #6 stated she had no knowledge if she had any money, but if she did would like some personal care items like better shampoo, lotion, etc. On 03/04/20 at 12:38 P.M., interview with the Administrator stated Resident #6 did not have any funds in her account between 09/05/19 and 02/12/20. The Administrator stated the resident's family had deposited $110.00 into her account; however, there was no evidence the resident was notified. The Administrator further stated Resident #6 had not been receiving her Social Security monthly allowance because no one knew where her social security check had been going, she had contacted the Social Security Administration twice without any response but did not have any proof or documentation of this. The resident has a guardian appointed by the court, and she did not know where the resident's Social Security money was either. The Administrator stated the facility was paid by Medicaid for the resident's care and the social security was only the resident's monthly spending allowance of $30.00 but had not received it since admission. Review of the provided Fax sheet and Social Security Administration revealed no evidence of proof submitted or when. Review of the medical record revealed no evidence the facility was actively pursuing where the resident's social security monthly allowance was. On 03/04/20 at 1:27 P.M., interview with the Administrator stated she was able to contact Social Security Administration since the surveyor's inquiry of the resident's monthly allowance and was told the resident needed a re-determination. A claims representative would be contacting the facility for the re-determination.
F 0684 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide appropriate treatment and care according to orders, resident's preferences and goals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, medical record review and interview, the facility failed to ensure specialized equipment met the positioning needs of a resident. This affected one (Resident #12) of two residents reviewed for positioning. The census was 37. Findings include: Medical record review revealed Resident #12 was admitted on [DATE] with [DIAGNOSES REDACTED]. Review of the care plan: Potential for Self-care Deficit, revised 07/13/17, revealed therapy was to treat and evaluate as needed and staff was to notify therapy of any decline in condition. Review of the monthly Order Summary Report dated 03/05/20 revealed Resident #12 was ordered a tilt and space (specialty) wheelchair with Dycem (non-slip material) and pressure reduction cushion as tolerated. On 03/04/20 at 9:07 A.M., Resident #12 was observed in the dining room in a specialized wheelchair leaning to right with no bolsters, positioning devices or supports to maintain an upright position. A communication board was observed on the table to the right of the resident. Resident #12 was observed eating mechanical soft meat at the time of the observation. On 03/04/20 at 2:00 P.M., Resident #12 was observed in her specialty wheelchair leaning to the right with no support to keep the resident upright. Resident #12 was observed drinking from a lidded cup at the time of the observation. On 03/05/20 at 10:15 A.M., Resident #12 was observed in her specialty wheelchair going into the dining room for an activity, and the resident was leaning to the right with a bed pillow behind her right shoulder and head. At the time of the observation, interview with Licensed Practical Nurse (LPN) #27 verified the above observation and stated the resident had not had the wheelchair for longer than a year, the resident consistently leaned to the right and was difficult to properly positioned her wheelchair. On 03/05/20 at 11:27 A.M., interview with LPN #15 verified Resident #12 was unable to be properly positioned in the specialty wheelchair and consistently leaned to the right even with attempts to use a pillow behind her.
F 0758 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**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 review, review of the facility's nursing drug handbook and staff interview, the facility failed to ensure hypnotic (medications that induce sleep) medications were not used longer than their intended use, without a gradual dose reduction attempt, and without adequate monitoring of the resident's target behavior. This affected one (Resident #28) of five residents reviewed for unnecessary medications. Findings include: A review of Resident #28's medical record revealed she was admitted to the facility from another nursing facility on 01/30/20. She was [AGE] years old and had the [DIAGNOSES REDACTED]. A review of Resident #28's active physician's orders [REDACTED]. The order had been in place since her admission on 01/30/20 but originated on 07/03/19, while she was residing in the other nursing facility. A review of Resident #28's Medication Administration Record [REDACTED]. A review of Resident #28's behavior monitoring sheets revealed the resident was being monitored for signs of feeling down, depressed or hopeless. She was also being monitored for the generic behaviors of frequent crying, repetitive movements, yelling/ screaming, kicking/ hitting, pushing, grabbing, pinching/ scratching/ spitting, biting, wandering, abusive language, threatening behavior, sexually inappropriate behavior, rejection of care or none of the above. The generic behaviors were the same for each resident who was being monitored for behaviors and were not resident specific. She was not being monitored for [MEDICAL CONDITION] as a target behavior for which she was receiving the [MEDICATION NAME] for. There was no evidence in Resident #8's medical record that a gradual dose reduction attempt (GDR) was attempted for the use of [MEDICATION NAME]. She had been on the same dose since she was

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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 0758 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 3) admitted to the facility on [DATE] and had been on that same dose since 07/03/19 when she resided in the prior nursing facility. A review of the Nursing Drug Handbook from PharMerica (used by the facility as a drug reference book) revealed [MEDICATION NAME] was a high risk medication for geriatric clients. [MEDICATION NAME] was identified in the Beers Criteria as a potentially inappropriate medication to be avoided in clients [AGE] years and older due to an increased risk of impaired cognition, [MEDICAL CONDITION], falls, fractures with Benzodiazepine use. The drug reference book indicated it was intended for the short term use for [MEDICAL CONDITION]. On 03/04/20 at 1:45 P.M., an interview with Licensed Practical Nurse (LPN) #27 revealed she was not aware of Resident #28 displaying any behaviors. She stated she had worked the night shift and had not known the resident to have any problems with [MEDICAL CONDITION]. She was not familiar with the psychoactive medications Resident #28 was receiving nor did she know what target behaviors they should be monitoring for. She acknowledged the behaviors they were monitoring Resident #28 for were the same behaviors being monitored for with all residents. She denied [MEDICAL CONDITION] was one of the target behaviors they were monitoring her for. She indicated any behaviors that occurred would be documented in the nurses' progress notes or in the Point of Care (POC) Response History in the electronic health record (EHR). She indicated the resident came from another nursing facility on the [MEDICATION NAME]. She was not sure how long the drug hand book recommended [MEDICATION NAME] to be used for and did not know it was intended for short term use. She agreed, since the resident was receiving [MEDICATION NAME] for [MEDICAL CONDITION], they should be monitoring for that as one of her target behaviors. On 03/04/20 at 2:20 P.M., an interview with the Director of Nursing revealed there was no evidence a GDR was attempted for the use of [MEDICATION NAME] since Resident #28 had been in the facility. She also acknowledged the behavior monitoring sheets being used to document the resident's behaviors did not include [MEDICAL CONDITION] as one of the target behaviors.
F 0812 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and policy review, the facility failed to ensure the kitchen was maintained in a clean, safe and sanitary condition. This had the potential to affect 36 of 37 residents. The facility identified one resident, Resident #26, as receiving nothing by mouth. Findings include: 1. On 03/02/20 at 10:50 A.M. the dishwasher repair man was observed in the dish room working on the dish washer and was not wearing a hair net. The stove/oven were located to the repairmen's right side and he had to walk past the food preparation areas/steam table to provide his service. This was verified with Dietary Director #13 at the time of the observation. Review of the facility Hair Net Policy, dated 05/19 revealed hair restraints shall be worn by all dietary employees while on duty to cover ALL hair and by anyone in the food preparation area. 2. On 03/02/20 at 10:55 A.M. observation of the reach in cooler revealed the following: Two vanilla Dannon Creamy Yogurt and two strawberry Dannon Creamy Yogurt all dated 12/13/19; Five vanilla Dannon Creamy Yogurt and four strawberry Dannon Creamy Yogurt all dated 01/24/20; and 24 vanilla and 23 strawberry Dannon Creamy Yogurt dated 02/21/20 On 03/02/20 at 11:00 A.M. interview with Dietary Director #13 revealed the date on the yogurt was the expiration date and the yogurts should not be provided to residents after the date stamped on the container. Further interview revealed Resident #36 had an order for [REDACTED].#13 verified the yogurts should have been disposed of and not given to the residents after the date stamped on the container had past. Review of the Date Marking Policy, dated 09/16, revealed commercially processed foods with high acidity (example: yogurt, sour cream, hard cheese, cured meat) may be held until their manufacturer's use by date and all foods shall be discarded after their manufacturer's use by date.