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F 000	INITIAL COMMENTS The following citations represent the findings of a Health Resurvey.	F 000		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to	F 690		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 11/25/2019

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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restore as much normal bowel function as possible.
This REQUIREMENT is not met as evidenced by:
The facility reported a census of 100 residents. The 20 sampled residents included two for indwelling catheters. Based on observation, interview, and record review the facility failed to provide safe, sanitary, and hygienic catheter care when staff allowed Resident (R)33's indwelling catheter drainage bag to touch the floor during cleaning, and the staff did not replace the bag.

Findings included:

- Review of R33's "Physician's Order Progress Note" dated 10/27/19 documented the following diagnoses: age-related cognitive decline, retention of urine (lack of ability to urinate and empty the bladder), lack of coordination, and neuromuscular dysfunction bladder (dysfunction of the urinary bladder caused by a lesion of the nervous system).

Review of the quarterly "Minimum Data Set" (MDS) dated 04/29/19 revealed a Brief Interview for Mental Status (BIMS) of 12, indicating moderately impaired cognition (8-12). The resident required extensive assistance of two staff for toileting and limited assistance of one staff for personal hygiene, and had an indwelling catheter.

Review of the annual MDS dated 08/02/19 revealed a BIMS of 12, which indicated moderately impaired cognition. The resident required extensive assistance of two staff for toileting and personal hygiene, and an indwelling catheter noted.

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Review of the Urinary Incontinence and Indwelling Catheter "Care Area Assessment" (CAA) dated 08/02/19 revealed the resident required assistance of two staff and had an indwelling catheter.

Review of "Care Plan" revised 08/21/19 revealed the resident had impaired physical mobility related to weakness and required staff assistance for activities of daily living (ADL). The resident had an indwelling catheter in use with potential for infection. The staff were to observe for signs and symptoms of urinary tract infections such as odorous urine, frequency in elimination, and change in color/clarity of urine. The Certified Nurse Aides (CNA) would perform catheter care each shift, assist the resident with toileting needs, provide peri-care, manage incontinence, and clothing management.

Observation of care for R33 on 11/13/19 at 07:48 AM revealed CNA G sat peri-care wipes directly on the resident's bed with no barrier and CNA F took the drainage bag to the restroom, CNA F noted the output, uncapped, and emptied the bag. The resident's drainage bag touched the floor as CNA F held the tubing. CNA G and CNA F reported they placed vinegar and water in the resident's bag, and soaked it for five to ten minutes. The CNA swished the mixture around and emptied it in less than one minute and put it into the holder in the bathroom with all of the tubing closed.

Interview on 11/13/19 at 08:00 AM with CNA G confirmed the peri-wipes should be sat on a barrier.

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Interview on 11/13/19 at 08:01 AM with CNA F revealed CNA's let the water/vinegar mixture soak for about 10-20 minutes, empty it, clamp everything, and put it in the holder bag in the bathroom.

Interview on 11/13/19 at 08:05 AM with Licensed Nurse (LN) P revealed the CNA's placed the wipes on a barrier such as a paper towel or a towel. Staff washed out the indwelling catheter drainage bag with half water/half vinegar and cleaned the tips and ends with an alcohol pad. The vinegar/water mixture would stay in the drainage bag for 30 seconds to a minute and staff should leave the clamps open so that the bag could air dry. LN P stated the resident's drainage bag should never touch the floor and she expected staff to get a new bag if that happened.

Interview on 11/13/19 at 08:31 AM with LN B revealed CNAs completed catheter care and logged the task in POC (Point of Care electronic charting). LN B confirmed she expected the CNAs to lay the peri-care wipes on a barrier. If an indwelling catheter drainage bag touched the floor staff needed to obtain a new bag. The vinegar/water mixture would be swished around, drained out, and the clamps should be shut.

Review of the facility's Catheter Care policy revised 03/19 instructed staff to document catheter care in POC. Staff would keep the drainage bag and tubing off the floor. The policy lacked instruction or indication for the use of vinegar and water mixture

The facility failed provide safe, sanitary, and hygienic catheter care for R33.

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F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take	F 756		

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when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by:

The facility census totaled 100 residents with five residents reviewed for unnecessary medications. Based on observation, interview, and record review the facility failed to ensure the pharmacist identified and reported missing pain assessments and follow-up for effectiveness for as needed (PRN) pain medications for Resident (R)75 and missing vital sign documentation for R82.

Findings included:

- Review of resident R75's "Hospital Discharge Orders" dated 10/18/19 revealed the resident had a diagnosis of pain.

Review of the quarterly "Minimum Data Set" (MDS) dated 06/12/19 revealed a "Brief Interview for Mental Status" (BIMS) score of 15, indicating intact cognition.

Review of the significant change MDS dated 09/13/19 revealed a BIMS score of 14, indicating intact cognition.

Review of the resident's "Physician Orders" revealed R75 had and order for Tylenol 325 milligrams (mg), one to two tablets every four hours, as needed (PRN) for pain or temperature greater than 101 degrees Fahrenheit (F). The resident also had an order for Tramadol (pain medication) 50 mg, one tablet, by mouth, every six hours as needed for pain, discontinued on 10/18/19.

Review of the September 2019 "Electronic

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Medication Administration Record" (EMAR) revealed the resident received PRN Tramadol on 09/01, 09/14, 09/18, 09/20, 09/21, 09/22, 09/26, and 09/29. The staff did not document pain levels and/or did not follow-up for the effectiveness of the medication.

Review of the October 2019 EMAR revealed staff administered as needed Tylenol to R75 on 10/22, 10/28, and 10/29. The staff did not document pain levels and/or did not follow-up for effectiveness of the medication.

Review of the pharmacist's monthly medication reviews from 09/18/19 through 10/19/19 revealed the consultant pharmacist failed to identify the facility did not assess pain and follow-up for effectiveness of PRN pain medications.

During an interview on 11/07/19 at 12:51 PM Certified Medication Aide (CMA) S stated if a resident received a pain medication the nursing staff were supposed to follow-up for effectiveness.

During an interview on 11/07/19 at 01:12 PM Licensed Nurse (LN) U stated nursing staff were to assess pain level, check for effectiveness of the medication, and document on the EMAR in a note.

During an interview on 11/13/19 at 04:13 PM, Administrative Nurse B stated it was her expectation the consultant pharmacist review the charts each month and make staff aware of the lack of pain medication follow-up for effectiveness.

Onn 11/13/19 and 11/14/19 attempts were made

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to contact the consultant pharmacist but were unable to reach the pharmacist for an interview.

Review of the "Medication Review" policy revised 6/8/18 revealed, "Monitoring is the ongoing collection and analysis of information (such as observations and diagnostic test results) and comparison to baseline data in order to: Ascertain the individual's response to treatment and care, including progress or lack of progress toward a therapeutic goal."

The facility failed to ensure the consultant pharmacist identified and reported missing pain assessments and/or reassessment for pain levels when administering PRN pain medications to R75.

- Review of R82's "Care Plan" (CP) dated 07/02/19 revealed the resident had diagnoses of hypertension (elevated blood pressure) and atrial fibrillation (rapid, irregular heart beat).

Review of the annual "Minimum Data Set" (MDS) dated 06/12/19 documented a Brief Interview for Mental Status (BIMS) score of 11, which indicated moderately impaired cognition.

Review of the "Care Area Assessment" (CAA) dated 06/12/19 for Cognitive Loss/Dementia revealed R82 had a diagnosis of dementia. The CAA documented R82's long-term memory was intact and short-term memory was highly impaired.

Review of the CP dated 07/02/19 documented R82 had cardiovascular disease and had a risk for decreased cardiac output, which included interventions to observe for elevated blood

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pressure, shortness of breath, edema, low heart rate, and low blood pressure.

Review of the "Physician Orders" dated 09/06/19 and 09/07/19 revealed R82 received Norco (narcotic medication to treat moderate to severe pain), Eliquis (medication to prevent the formation of blood clots), furosemide (medication to promote the formation and excretion of urine), and metoprolol (medication to lower blood pressure and causes the heart to beat more slowly).

Review of "Physician Orders" dated 12/27/17 revealed R82 received amiodarone (medication to treat irregular heartbeat) and lisinopril (medication to treat high blood pressure).

Record review of R82's vital signs revealed the most recent full set of vital signs (blood pressure, pulse, respirations, oxygen saturation level, temperature) documented on 10/20/18, which was the only full set of vital signs documented in R82's vital sign record.

Review of the pharmacy recommendations from August 2018 to October 2019 lacked recommendations regarding R82's vital signs.

An observation on 11/06/19 at 05:03 PM revealed R82 interacted with tablemates at the dining table. Her hands appeared shaky as she positioned items in front of her and prepared to eat her yogurt.

An interview on 11/07/19 at 12:17 PM with Certified Medication Aide (CMA) H revealed she obtained vital signs and charted the results in the electronic health record or gave to the assigned

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nurse for that shift to chart.

An interview on 11/07/19 at 12:05 PM with Licensed Nurse (LN) Q stated she reviewed resident records to ensure vital signs were obtained and documented weekly. LN Q reviewed assured she reviewed all alternative locations for evidence of vital sign documentation and confirmed the last set of vital signs for R82 were documented was on 10/20/18.

An interview on 11/07/19 at 12:17 PM with LN L stated the Certified Nurse Aides (CNA) obtained and documented vital sign results. LN L stated she followed up to ensure the vital signs were done, "Only if I have time."

An interview on 11/07/19 at 12:19 PM with Administrative Nurse R stated charge nurses ensured vital signs were obtained and documented weekly for all residents.

An interview on 11/07/19 at 12:26 PM with Administrative Nurse K reviewed R82's chart, medication record, treatment record, nursing notes, and physician orders, and confirmed the last set of vital signs for R82 documented on 10/20/18.

An interview on 11/07/19 at 12:40 PM with Administrative Nurse B stated vital signs were usually obtained weekly for residents who received blood pressure medications. Administrative Nurse B reviewed R82's record and confirmed the most recent set of vital signs for R82 documented on 10/20/18 and confirmed an active physician order dated 12/27/17 which directed staff to obtain vital signs weekly. Administrative Nurse B stated the facility did not

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monitor R82's vital signs and that it was not acceptable for any resident to go a full a year without a full set of vital signs documented.

An interview on 11/07/19 at 01:05 PM with Physician T stated he expected weekly vital signs and monthly weights for residents, daily blood pressure monitoring for residents who received blood pressure medications, and any vital signs obtained by facility staff were documented in the resident's chart. Physician T reviewed R82's chart and confirmed that aside from a request for vital signs during a visit there was no evidence the facility obtained, documented, and monitored R82's vital signs, and verbalized it was unacceptable.

An attempt was made to contact the consultant pharmacist on 11/13/19 and 11/14/19 but was unable to reach the pharmacist for an interview.

The facility's policy titled, "Medication Review," revised 06/08/18, documented "Monitoring is the ongoing collection and analysis of information (such as observations and diagnostic test results) and comparison to baseline data in order to ascertain the individual's response to treatment and care. . . Detect any complications or adverse consequences of the condition or of the treatments. . . Support decisions about modifying, discontinuing, or continuing any interventions." The policy documented the pharmacist reviews included, but were not limited to, medical records, medication administration records, and responses to recommendations from previous reports.

The pharmacy failed to review the documentation and monitoring of vital signs and provide

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F 756	Continued From page 11 recommendations for R82.	F 756		
F 757 SS=D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: The facility census totaled 100 residents with five residents reviewed for unnecessary medications. Based on interview, observation, and record review the facility failed to ensure two of five residents did not receive unnecessary medications due to the failure to assess and reassess for effectiveness of as needed pain medications for Resident (R)75 and failed to document vital signs for R82.	F 757		

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Findings included:

- Review of resident R75's "Hospital Discharge Orders" dated 10/18/19 revealed a diagnosis of pain.

Review of the quarterly "Minimum Data Set" (MDS) dated 06/12/19 revealed a "Brief Interview for Mental Status" (BIMS) score of 15, indicating intact cognition.

Review of the significant change MDS dated 09/13/19 revealed a BIMS score of 14, indicating intact cognition.

Review of the resident's "Physician Orders" revealed an order for Tylenol 325 mg (milligrams), one to two tablets every four hours, as needed (PRN) for pain or temperature greater than 101 degrees Fahrenheit (F). The resident also had an order for Tramadol (pain medication) 50 mg, one tablet, by mouth, every six hours as needed for pain, discontinued on 10/18/19.

Review of the September 2019 "Electronic Medication Administration Record" (EMAR) revealed the resident received PRN Tramadol on 09/01, 09/14, 09/18, 09/20, 09/21, 09/22, 09/26, and 09/29. Staff did not document pain levels and/or did not follow-up for effectiveness of the medication.

Review of October 2019 EMAR revealed staff gave the resident as needed Tylenol on 10/22, 10/28, and 10/29. Staff did not document pain levels and/or did not follow-up for effectiveness of the medication.

During an interview on 11/07/19 at 12:51 PM

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Certified Medication Aide (CMA) S stated if a resident received a pain medication, the nursing staff were supposed to follow-up for effectiveness.

During an interview on 11/07/19 at 01:12 PM, Licensed Nurse (LN) U stated nursing staff were to assess pain level, check for effectiveness of the medication, and document on the EMAR in a note.

During an interview on 11/13/19 at 08:59 AM, Administrative Nurse B stated if a resident needed or asked for a PRN pain medication the nurse should assess for pain and location of pain prior to giving the medication and then reassess for effectiveness of the pain medication given approximately 30 minutes after giving the medication. Administrative Nurse B stated the pain reassessment should be documented on the EMAR. Administrative Nurse B stated residents who were cognitively intact should be assessed using a numerical pain scale and reevaluated using the same numerical pain scale. Administrative Nurse B verified there were times when follow-up for effectiveness was not completed on the EMAR for R75.

Review of the "Pain Management Protocol" revised: 12/18 revealed: "Licensed Nurse may use one of the following Pain Scales to determine pain intensity ...Numerical Scale of 0/10 ...Use the pain scales above to further evaluate residents with pain ...document assessments."

The facility failed to assess and/or reassess for pain level when administering PRN pain medications to R75.

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- Review of diagnoses listed in R82's "Care Plan" (CP) dated 07/02/19 revealed diagnoses of hypertension (elevated blood pressure) and atrial fibrillation (rapid, irregular heart beat).

Review of the "Physician Orders" dated 09/06/19 and 09/07/19 revealed R82 received Norco (narcotic medication to treat moderate to severe pain), Eliquis (medication to prevent the formation of blood clots), furosemide (medication to promote the formation and excretion of urine), and metoprolol (medication to lower blood pressure and causes the heart to beat more slowly).

Review of "Physician Orders" dated 12/27/17 revealed R82 received amiodarone (medication to treat irregular heartbeat) and lisinopril (medication to treat high blood pressure).

Review of the annual "Minimum Data Set" (MDS) dated 06/12/19 documented a Brief Interview for Mental Status (BIMS) score of 11, which indicated moderately impaired cognition.

Review of the "Care Area Assessment" (CAA) dated 06/12/19 for Cognitive Loss/Dementia revealed R82 had a diagnosis of dementia. The CAA documented R82's long-term memory was intact and short-term memory was highly impaired.

Review of the CP dated 07/02/19 documented R82 had cardiovascular disease and was at risk for decreased cardiac output, which included interventions to observe for elevated blood pressure, shortness of breath, edema, low heart rate, and low blood pressure.

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Record review of R82's vital signs revealed the most recent full set of vital signs (blood pressure, pulse, respirations, oxygen saturation level, temperature) documented on 10/20/18, which was the only full set of vital signs documented in R82's vital sign record.

Review of physician visit documentation for 2019 revealed R82's vital signs recorded during the visit on 08/02/19.

An observation on 11/06/19 at 05:03 PM revealed R82 interacted with tablemates at the dining table. Her hands appeared shaky as she positioned items in front of her and prepared to eat her yogurt.

An interview on 11/07/19 at 12:17 PM with Certified Medication Aide (CMA) H revealed she obtained vital signs and charted the results in the EMR or gave to the assigned nurse for that shift to chart.

An interview on 11/07/19 at 12:05 PM with Licensed Nurse (LN) Q stated she reviewed resident records to ensure vital signs were obtained and documented weekly. LN Q reviewed assured she reviewed all alternative locations for evidence of vital sign documentation and confirmed the last set of vital signs for R82 were documented was on 10/20/18.

An interview on 11/07/19 at 12:17 PM with LN L stated the Certified Nurse Aides (CNA) obtained and documented vital sign results. LN L stated she followed up to ensure the vital signs were done, "Only if I have time."

An interview on 11/07/19 at 12:19 PM with

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Administrative Nurse R stated charge nurses ensured vital signs were obtained and documented weekly for all residents.

An interview on 11/07/19 at 12:26 PM with Administrative Nurse K reviewed R82's chart, medication record, treatment record, nursing notes, and physician orders, and confirmed the last set of vital signs for R82 documented on 10/20/18.

An interview on 11/07/19 at 12:40 PM with Administrative Nurse B stated vital signs were usually obtained weekly for residents who received blood pressure medications. Administrative Nurse B reviewed R82's record and confirmed the most recent set of vital signs for R82 documented on 10/20/18 and confirmed an active physician order dated 12/27/17 which directed staff to obtain vital signs weekly. Administrative Nurse B stated the facility did not monitor R82's vital signs and that it was not acceptable for any resident to go a full a year without a full set of vital signs documented.

An interview on 11/07/19 at 01:05 PM with Physician T stated he expected weekly vital signs and monthly weights for residents, daily blood pressure monitoring for residents who received blood pressure medications, and any vital signs obtained by facility staff were documented in the resident's chart. Physician T reviewed R82's chart and confirmed that aside from a request for vital signs during a visit there was no evidence the facility obtained, documented, and monitored R82's vital signs, and verbalized it was unacceptable.

The facility did not provide a policy for the

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F 757	Continued From page 17 frequency of obtaining vital signs. The facility failed to ensure adequate monitoring when they did not obtain and document R82's vital signs.	F 757		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented	F 758		

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in the clinical record; and

§483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order.

§483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication.
This REQUIREMENT is not met as evidenced by:
The facility census totaled 100 residents with five residents reviewed for unnecessary medications. Based on observation, interview and record review the facility failed to ensure one of five residents did not receive unnecessary medications due to administering Seroquel (an antipsychotic medication) without having an appropriate diagnosis for Resident (R)25.

Findings included:

- Review of an electronically signed progress note dated 09/06/19 revealed R25 had a diagnosis of dementia with behavioral disturbance (progressive mental disorder characterized by failing memory, confusion.)

Review of the Annual "Minimum Data Set" (MDS) dated 01/26/19 revealed a brief interview for mental status (BIMS) score of 99 indicating a BIMS could not be completed. R25 had both

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short-term and long-term memory loss. The resident had inattention, continuously present, which did not fluctuate. R25 had a Total Mood Severity Score of 02 indicating minimal depression, exhibited physical and verbal behavior directed toward others four to six days during the lookback period, had rejection of cares behaviors, and received an antipsychotic medication daily.

Review of the Quarterly MDS dated 07/29/19 revealed a BIMS score of 99 indicating a BIMS could not be completed. R25 had both short-term and long-term memory loss, behavior for inattention was continuously present and did not fluctuate, had a Total Severity Score of 00 indicating no depression, exhibited wandering behaviors one to three days during the lookback period, and received an antipsychotic medication daily.

Review of the "Behavior Care Area Assessment" (CAA) dated 01/29/19 revealed the resident hit and became combative with staff on two evenings during the lookback period. The resident had a diagnosis of Alzheimer's dementia (progressive mental deterioration characterized by confusion and memory failure) with escalated behaviors in the evening.

Review of the "Behaviors" care plan dated 08/20/19 revealed R25 hit staff during cares, yelled and cussed at staff with an intervention to administer Seroquel as ordered.

Review of the "Physician Orders" revealed R25 had an order dated 04/25/19 for Seroquel 25 mg (milligrams), 0.5 tabs by mouth in the morning. The order lacked a diagnosis for the use of

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Seroquel. R25 also had an order dated 12/07/18 for Seroquel 25 mg, by mouth, at bedtime. The order lacked a diagnosis for the use of Seroquel.

Review of a "Progress Note" dated 09/06/19 revealed R25 received Seroquel for a diagnosis of dementia with behavioral disturbance.

Review of the "Monthly Consultant Pharmacy Review Notes" revealed a recommendation on 06/10/19 to consider increasing Zoloft (an antidepressant medication) to appropriate anxiety/agitation dosages in an attempt to discontinue Seroquel due to BPSD (Behavioral and Psychological Symptoms of Dementia) diagnosis. This same recommendation was made again on 08/01/19.

An observation on 11/07/19 at 12:12 PM revealed R25 sat at a dining room table and ate lunch with other residents. R25 was quiet, calm and allowed staff to assist her with meals and did not exhibit any negative behaviors.

During an interview on 11/13/19 at 01:12 PM Licensed Nurse (LN) O stated R25 received Seroquel, but she could not find a diagnosis for it.

During an interview on 11/13/19 at 01:55 PM Administrative Nurse B stated if the diagnosis of dementia w/behaviors was on the progress note then that would be the diagnosis for Seroquel. Administrative Nurse B stated the policy for Psychotropic Medications did not mention anything about using antipsychotics with dementia.

During an interview on 11/13/19 at 04:16 PM Administrative Nurse B verified there was not any

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F 758	Continued From page 21 discussion concerning the diagnosis for Seroquel and dementia with behaviors concerning R25. Review of the "Psychotropic Drugs" policy revised 09/18 revealed, "Residents who have not used psychotropic drugs will not be given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record." The facility failed to ensure R25 did not receive unnecessary medications by teh failure of staff to ensure an appropriate diagnosis for the use of Seroquel for the resident.	F 758		
F 800 SS=E	Provided Diet Meets Needs of Each Resident CFR(s): 483.60 §483.60 Food and nutrition services. The facility must provide each resident with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs, taking into consideration the preferences of each resident. This REQUIREMENT is not met as evidenced by: The facility identified a census of 100 residents with one main kitchen where staff prepared meals and four dining rooms. Based on observation, interview, and record review the facility failed to maintain proper food temperatures when the dietary staff did not ensure the cold foods were held at or below 41 degrees Fahrenheit (F) prior to serving the cold food items to residents. Findings included: - Record review of food temperature logs lacked documentation for any temping of cold food.	F 800		

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An observation on 11/05/19 at 12:03 PM of Dietary Staff (DS) DD checked temperatures of chicken and potato salad, in which both items resulted above 41 degrees F. Observation revealed no ice or cooling methods used under or around these cold food items.

During an interview on 11/05/19 at 12:03 PM DS DD stated she did not check the temperature of the potato salad or chicken salad prior to serving. When asked to temp the items, the potato salad resulted 55 degrees F and the chicken salad resulted 59 degrees F. DS DD reported she did not consider placing the items on ice or in a cooler to ensure they remained at or below 41 degrees F.

During an interview on 11/05/2019 at 04:32 PM Certified Dietary Manager (CDM) V stated dietary staff were advised to use ice to maintain temperatures of cold items prior to serving. CDM V could not confirm the staff checked temperatures of cool/cold food items prior to serving due to the lack of documentation on the food temperature logs.

The facility's policy "Maintaining Food Temperatures" dated 2009 documented foods served to residents were served at a temperature to maintain food safety and safety of residents. The policy documented cold food remained in the refrigerate at 41 degrees F or below until time to serve or no more than 10 minutes prior to serving, and the dietary manager and/or designee completed and documented routine food temperature checks.

The facility failed to maintain proper food

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F 800	Continued From page 23 temperatures when the dietary staff did not ensure the cold foods were held at or below 41 degrees Fahrenheit (F) prior to serving the food items to residents.	F 800		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: The facility identified a census of 100 residents with one main kitchen which included a high temperature dishwasher and a three compartment sink for manual dishwashing that required the use of sanitizing solution. The facility also contained two resident houses (Wheaton and Graber) that each included one kitchen and a low temperature dishwasher which required the use of sanitizing solution. Based on observation, interview, and record review the facility failed to	F 812		

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maintain sanitizer solution concentration levels for two low temperature dishwashers when dietary staff did not report ineffective test results or maintain logs, and failed to maintain the sanitizer solution for manual dishwashing in the main kitchen when dietary staff did not document test results or maintain logs of the sanitizer concentration results. This failure had the ability to affect all residents in the facility.

Findings included:

- Review of the records located in the main kitchen lacked evidence of a log for the Quat sanitizing solution (a surfactant cleaning chemical that is typically used in hospitals and food processing plants).

Review of the dishwasher logs for Wheaton House revealed low dishwasher sanitizing solution concentration results of 25 parts per million (ppm) every day from 10/01/19 to 11/04/19, except for 10/11/19, 10/17/19, and 10/30/19 when no results were recorded on the log. There were no logs available prior to 10/01/19.

Review of the dishwasher logs for Graber House revealed consistent results of 50 ppm; however, lacked dishwasher sanitizing solution logs prior to 11/01/19.

An observation on 11/13/19 at 03:59 PM revealed Certified Nurse Aide (CNA) X tested the dishwasher sanitizer solution, which resulted 25 ppm. CNA X got different test strips from another location and tested again, which resulted 50 ppm.

An observation on 11/13/19 at 04:20 PM revealed

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CNA AA and Licensed Nurse (LN) Z tested the dishwasher sanitizing solution at Graber House, which resulted 50 ppm.

An interview on 11/04/19 at 01:48 PM with Dietary Staff (DS) V stated she did not maintain a log for the Quat sanitizing solution used to manually wash the dishes and reported that dietary staff used either a premixed sanitizer per manufacturer's instructions or the Quat solution to clean kitchen and/or dining surfaces. DS V stated she did not monitor the dishwasher sanitizer logs in the Graber and Wheaton houses and referred to Maintenance Staff (MS) W.

An interview on 11/13/19 at 03:59 PM with CNA X stated effective dishwasher sanitizing solution tested at 50-100 ppm. CNA X reported she used the wrong test strips and received low test results. CNA X could not confirm the length of time the results were below 50ppm or how long she had used the wrong test strips, and stated she did not ask for proper test strips and did not report the concern prior to the survey.

An interview on 11/13/19 at 04:09 PM with LN Y stated she first called maintenance to order dishwasher sanitizer solution test strips last week after a state surveyor visited Wheaton House.

An interview on 11/13/19 at 04:37 PM with Administrative Nurse B stated she received the dishwasher sanitizing solution test result logs from Graber and Wheaton, then turned the logs in to Administrative Staff BB for filing. Administrative staff BB reported she did not keep the logs.

An interview on 11/13/19 at 04:37 PM with MS W

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stated staff reported concerns regarding dishwashers at Graber House and Wheaton House and he communicated with vendors regarding equipment concerns. MS W stated he did not keep copies of the dishwasher logs and was first notified the morning of 11/13/19 that he needed to order dishwasher sanitizing solution test strips for Wheaton House. MS W reviewed the work order history and reported he did not receive any work orders related to dishwasher sanitizer issues.

An interview on 11/13/19 at 05:08 PM with Administrative Staff A stated she expected staff to report dishwasher sanitizer concerns to maintenance and obtain proper test strips when needed. Administrative Staff A stated she expected Quat and dishwasher sanitizer result logs to be maintained in every kitchen and that there were enough test strips available to maintain the sanitizing solutions. AS A reported she expected sanitizing solution logs to be kept from survey to survey and any concerns about the function of the dishwashers and/or any sanitizing solution concentrations were addressed right away.

The facility's policy titled, "Dish Washing," revised September of 2018 lacked information or instruction for the low temperature dishwashers that required the use of sanitizing solution.

The facility's policy titled, "Dishwashing - Manually," revised 08/31/18, instructed to "Test the sanitizer frequently" and "Change water frequently." The policy lacked further information or instruction regarding frequency of testing the sanitizing solution, effective concentration levels, maintaining logs, and frequency of changing the

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F 812	Continued From page 27 water or replacing the sanitizing solution. The facility did not provide a policy for low temperature dishwashers that required the use of sanitizing solution, did not provide a policy regarding the use and/or maintenance of Quat sanitizing solutions, and did not provide a policy for the use of approved or specified sanitizing solutions, effective concentration levels for sanitizing solutions, or information and/or instruction for maintaining sanitizing solutions. The facility failed to maintain sanitizer solution concentration levels for two low temperature dishwashers when they did not report ineffective test results or maintain logs, and failed to maintain the sanitizer solution for manual dishwashing in the main kitchen when they did not document test results or maintain logs of the sanitizer concentration results.	F 812		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying,	F 880		

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reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.
(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and
(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.

§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the

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corrective actions taken by the facility.

§483.80(e) Linens.
Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.

§483.80(f) Annual review.
The facility will conduct an annual review of its IPCP and update their program, as necessary.
This REQUIREMENT is not met as evidenced by:
The facility reported a census of 100 residents with 20 residents included in the sample and 2 reviewed for indwelling catheters. Based on observation, interview, and record review the facility failed to follow infection prevention/control measures when staff failed to provide safe, sanitary, and hygienic catheter care by allowing Resident (R)33's indwelling catheter drainage bag to touch the floor without replacing it and failed to place a barrier underneath the peri-wipes staff used on R33.

Findings included:

- Review of R33's "Physician's Order Progress Note" dated 10/27/19 documented the following diagnoses: age-related cognitive decline, retention of urine (lack of ability to urinate and empty the bladder), lack of coordination, and neuromuscular dysfunction bladder (dysfunction of the urinary bladder caused by a lesion of the nervous system).

Review of the Quarterly "Minimum Data Set" (MDS) dated 04/29/19 revealed a Brief Interview for Mental Status (BIMS) of 12, indicating moderate cognitive impairment. The resident

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required extensive assistance of two staff for toileting, limited assistance of one staff for personal hygiene, and had an indwelling catheter.

Review of the Annual MDS dated 08/02/19 revealed a BIMS of 12, which indicated moderate cognitive impairment. The resident required extensive assistance of two staff for toileting and personal hygiene, and used an indwelling catheter.

Review of the "Urinary Incontinence and Indwelling Catheter Care Area Assessment" (CAA) dated 08/02/19 revealed the resident required assistance of two staff and had an indwelling catheter.

Review of "Care Plan" revised 08/21/19 revealed the resident had impaired physical mobility related to weakness and required staff assistance for activities of daily living (ADL). The resident had an indwelling catheter in use with potential for infection. The staff were to observe for signs and symptoms of urinary tract infections such as odorous urine, frequency in elimination, and change in color/clarity of urine. The Certified Nurse Aides (CNA) would perform catheter care each shift, assist the resident with toileting needs, provide peri-care, manage incontinence, and clothing management.

Observation of care for R33 on 11/13/19 at 07:48 AM revealed CNA G sat peri-care wipes directly on the resident's bed with no barrier and CNA F took the drainage bag to the restroom, CNA F noted the output, uncapped, and emptied the bag. The resident's drainage bag touched the floor as CNA F held the tubing. CNA G and CNA F reported they placed vinegar and water in the

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resident's bag and soaked it for five to ten minutes. The CNA swished the mixture around and emptied it in less than one minute and put it into the holder in the bathroom with all of the tubing closed.

Interview on 11/13/19 at 08:00 AM with CNA G confirmed the peri-wipes should be sat on a barrier.

Interview on 11/13/19 at 08:01 AM with CNA F revealed CNA's let the water/vinegar mixture soak for about 10-20 minutes, empty it, clamp everything, and put it in the holder bag in the bathroom.

Interview on 11/13/19 at 08:05 AM with Licensed Nurse (LN) P revealed the CNA's placed the wipes on a barrier such as a paper towel or a towel. Staff washed out the indwelling catheter drainage bag with half water/half vinegar and cleaned the tips and ends with an alcohol pad. The vinegar/water mixture would stay in the drainage bag for 30 seconds to a minute and staff should leave the clamps open so that the bag could air dry. LN P stated the resident's drainage bag should never touch the floor and she expected staff to get a new bag if that happened.

Interview on 11/13/19 at 08:31 AM with LN B revealed CNAs completed catheter care and logged the task in POC (Point of Care - electronic charting). LN B confirmed she expected the CNAs to lay the peri-care wipes on a barrier. If an indwelling catheter drainage bag touched the floor staff needed to obtain a new bag. The vinegar/water mixture would be swished around, drained out, and the clamps should be shut.

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F 880	Continued From page 32 Review of the facility's Catheter Care policy revised 03/19 instructed staff to document catheter care in POC. Staff would keep the drainage bag and tubing off the floor. The policy lacked instruction or indication for the use of vinegar and water mixture The facility failed to follow infection prevention/control measures when staff failed to provide safe, sanitary, and hygienic catheter care for R33.	F 880		