

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/11/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175159	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/04/2019
NAME OF PROVIDER OR SUPPLIER PROVIDENCE PLACE LTCU			STREET ADDRESS, CITY, STATE, ZIP CODE 8909 PARALLEL PKY KANSAS CITY, KS 66112		
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F 000	INITIAL COMMENTS	F 000			
F 692 SS=D	The following citations represent the findings of a Health Resurvey. Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: The facility identified a census of 44 residents. The sample included 22 residents, with 1 resident sampled for nutrition. Based on observation, record review, and interview, the facility failed to implement timely interventions to avoid weight loss for 1 resident reviewed for weight loss. Resident # 17 had a weight loss of 7.95 % in 1 month.	F 692			

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 692	Continued From page 1 Finding included: - The electronic medical record (EMR) physician's order sheet (POS) documented a diagnosis of unspecified dementia without behavior disturbance (progressive mental disorder characterized by failing memory, confusion). The Admission Minimum Data Set (MDS) dated 3/4/19, revealed a Brief interview for Mental Status score of 9, which indicated moderate cognitive impairment. He/she was independent with eating, consumed a regular diet and did not have chewing or swallowing difficulty. Resident #17 did not have dental abnormalities and wore dentures. The resident was 61 inches tall and weighed 132 pounds. The Nutrition Care Area Assessment (CAA), dated 3/4/19, noted the resident was to continue the regular, thin liquid diet, staff should honor food preferences and provide snacks as requested. Resident had a BIMS of 9 which indicated moderate cognitive impairment. The care plan dated 2/27/2019 instructed staff that resident #17 had upper and lower dentures and was independent with eating. The care plan directed staff that the resident was on a NAS (no added salt), regular diet with thin liquids, weigh weekly. Provide resource 2.0 (nutritional supplement) 60ml, three times a day with medication pass. The EMR documented diet order on 2/27/19 of regular diet, thin consistency. The clinical record revealed the following weights:	F 692			

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F 692	Continued From page 2 2/25/2019 132 pounds (lbs). 3/5/2019 131.7 lbs. 3/25/2019 121.5 lbs. 4/2/2019 122.4 lbs. Review of the weights revealed a significant weight loss of 7.95% from 2.25.19 to 3/25/19 and 7.06% from 3/5/19 to 4/2/19. The dietary note on 3/29/19 at 2:48 PM, documented consultant dietitian B, recommended to start resource 2.0 60 ml, three times a day at medication pass for weight stabilization. The dietary note on 4/3/19 at 3:21 PM, documented dietitian BB, recommended resident #17 to continue with NAS, regular, thin liquid diet as ordered. Honor food preferences and provide snacks as requested. Continue with Resource 2.0 60 ml TID for weight stabilization. Review of the MAR (medication administration record) and TAR (treatment administration record) failed to show the Resource 2.0 was being administered three times a day. Observation on 4/3/2019 at 11:54 PM, resident resting in wheelchair in his/her room. The resident denied being hungry. Observation on 4/4/2019 at 12:04 PM, he/she consumed all his/her bread, 75% of sausage biscuit without chewing difficulty. He /she consumed 240 ml of his/her coffee. Interview on 4/3/2019 at 4:21 PM, direct care staff N, stated that resident #17 was independent with eating and he/she was unaware that the resident had experienced weight loss. Direct care staff, N,	F 692			

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F 692	Continued From page 3 stated that certified nursing assistant weighed the resident and they report it to the nurse. Interview on 4/4/2019 at 11:45 AM direct care staff M, stated, resident #17 was weighed and the weight was reported to the nurse. Staff M was unaware of the resident's weight loss. Interview on 4/4/2019 at 1:30 PM, Dietician BB, stated, residents weights were tracked on a log sheet. Staff BB revealed that the resident had a 5% weight loss and he/she recommended the facility staff to start Resource 2.0 60 ml, three times a day. Dietary staff B verified the order was not transcribed into the hard chart or the EMR. Interview on 4/4/19 at 2:30 PM, Administrative Nursing Staff D, stated the expectation was that dietary staff BB would document the order in the hard chart and the physician order sheet in order for the nursing staff to transcribe it to the Electronic Health record to be administered. The facility's policy Weight Loss Protocol revised 4/16/2015 recorded that the Registered dietician would start supplements if appropriate. The facility failed to implement interventions for a cognitively impaired resident (#17), who was identified with a significant weight loss.	F 692			
F 756 SS=E	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.	F 756			

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F 756	Continued From page 4 §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 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 identified a census of 44 residents. The sample included 22 residents. Based on observation, record review and interview the facility failed ensure the consultant pharmacist identified drug irregularities and the facility acted	F 756			

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F 756	Continued From page 5 upon the pharmacist recommendations related to behavior monitoring for antidepressants (class of medications used to treat mood disorders and relieve symptoms of depression[abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness and emptiness]) for 2 of 5 residents (#11 and #33) and antipsychotics (class of medications used to treat psychosis[any major mental disorder characterized by a gross impairment in reality testing] and other mental emotional conditions) for 3 of 5 residents (#11, #2, and #33). The facility further failed to ensure the consultant pharmacist identified inappropriate indication of use for antipsychotic medication for 2 of 5 residents (#11 and #2), and the facility failed to act upon the pharmacy recommendations in a timely manner for 2 of 5 residents (#33 and #5), one that required a stop date for an as needed antianxiety (class of medications that calm and relax people with excessive anxiety (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear), nervousness, or tension) medication (#33). Findings included: - Resident #11's April 2019's electronic medical record (EMR) documented diagnoses which included: hypertension (elevated blood pressure), major depressive disorder (major mood disorder), Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure), and Parkinson's disease (slowly progressing neurologic disorder characterized by resting tremor, rolling of the fingers, masklike faces, shuffling gait, muscle rigidity and weakness).	F 756			

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F 756	Continued From page 6 The Annual Minimum Data Set (MDS) assessment dated 6/7/18 documented a Brief Interview for Mental Status (BIMS) score of 13 which indicated intact cognition. The assessment recorded that the resident received antipsychotic medications, antidepressant medications, and diuretic (medication to promote the formation and excretion of urine) medications for 7 days during the look back period. It documented that a gradual dose reduction (GDR) was clinically contraindicated on 10/18/17. The resident did not trigger for mood and no behaviors noted. The Quarterly MDS assessment dated 2/12/19 documented a BIMS score of 12 which indicated moderately impaired cognition. The assessment revealed the same medication use, mood, and behavior documentation as the Annual MDS dated 6/7/18. The assessment documented a GDR was clinically contraindicated on 1/11/19. The Care Area Assessment for psychotropic medication use, dated 6/7/18, documented that the resident was at risk for adverse side effects for use of antidepressants for depression and antipsychotic medication for dementia with behaviors. The AIMS (abnormal involuntary movement scale) assessment dated 2/12/19 documented no concerns for resident #11. The care plan reviewed 2/20/19 documented the pharmacy consultant reviewed medications every month and made recommendations as indicated. The care plan further instructed staff to monitor for increased signs and symptoms of depression and adverse reactions to medications.	F 756			

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F 756	Continued From page 7 The electronic medical record (EMR) documented an order dated 2/2/17 for behavior monitoring secondary to being prescribed Risperdal (antipsychotic) every shift and for behavior monitoring secondary to being prescribed Celexa every shift. Celexa give 29 milligrams (mg) by mouth daily for major depressive disorder ordered 2/1/17 and then discontinued 12/7/18 and reordered on 12/8/18. Risperdal give 0.25 mg by mouth daily for dementia with behavioral disturbances. Review of the EMR physician order for Risperdal lacked the appropriate indication of use. The orders were discontinued when the resident discharged on December 4, 2018, and the facility failed to restart the behavior monitoring for both Risperdal and Celexa when the resident returned 12/8/18. Review of the treatment administration record from September 1, 2018 to December 4, 2018 noted missed opportunities of documented behavior monitoring for Celexa 52 times and Risperdal 52 times. The EMR lacked any behavior monitoring documentation upon readmitting to the facility from December 7, 2018 to present. Review of the Medication Regimen Review from September 2018 to February 2019 lacked recommendations regarding the missed opportunities of behavioral monitoring or recommendations for Risperdal indication for use. On 4/4/19 at 8:38 AM, resident #11 was in the dining room seated in his/her wheelchair,	F 756			

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F 756	Continued From page 8 appeared in good spirits with no behaviors noted. On 4/3/19 at 4:10 PM, licensed nursing staff I stated that the behavior monitoring should be filled out every shift. On 4/4/19 10:30 AM, direct care staff M stated that when resident #11 wanted something, he/she wanted it right now and it to be done the way he/she wanted it done. On 4/4/19 at 2:00 PM, administrative nursing staff D confirmed behavior monitoring should be done every shift and was not sure why this was not done. Administrative nursing staff D stated that he/she believed that the antipsychotic medications should have a diagnosis of psychosis or schizophrenia, but it was not the appropriate diagnosis. On 4/11/19 at 9:51 AM, consultant GG stated that he/she does not normally let the facility know if there are blanks in the behavior monitoring, and that he/she tried every month to review the medications to make sure that the appropriate diagnosis was there. The facility policy "Psychotropic Medications" dated 2013 directed nursing staff to monitor for the presence of target behaviors. The facility's policy 'Pharmacy Recommendations and Physician Approvals of Medication Changes' dated 8/15/17 stated the Pharmacy will review resident medical records monthly that will include monthly communication to facility regarding medication review information such as recommendations. The DON or designee will not each recommendation and put in physician's mailbox for review. Once returned, the DON or	F 756			

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F 756	Continued From page 9 designee will distribute pharmacy recommendations to the nursing staff to process and update the eMAR (electronic medication administration record). The nurse will sign and date the original pharmacy recommendation after processing, then place it in the medical records mailbox to be filed in the chart. If medical records received pharmacy recommendation with no signature it would be returned to the DON. The facility failed to ensure the consultant pharmacist adequately reviewed, and addressed missed documentation for behavior monitoring for Celexa (antidepressant) and Risperdal (antipsychotic) and that the pharmacist identified inappropriate indication of use for the antipsychotic medication ordered for resident for resident #11. - Resident #2's April 2019 electronic medical record (EMR) documented diagnoses which included: dementia (progressive mental disorder characterized by failing memory, confusion), hypertension (elevated blood pressure), Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure), and anxiety (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear). The Quarterly Minimum Data Set (MDS) assessment dated 9/27/18 documented staff interview for the Brief Interview for Mental Status (BIMS) indicating short and long-term memory problem with severely impaired cognition. The assessment recorded that the resident received antipsychotic medication, antidepressant medication for 6 days during the look back period and diuretic medication for 2 days during the look	F 756			

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F 756	Continued From page 10 back period. The resident did not trigger for mood and no behaviors noted. The Significant Change MDS assessment dated 3/14/19 revealed the same BIMS score, medication use, mood, and behavior documentation as the Quarterly MDS dated 9/27/18. The Care Area Assessment (CAA) for cognitive loss, dated 3/14/19, documented resident #2 refused to take medications and to minimize disruptions and changes in routine. The CAA for psychotropic medication use, dated 3/14/19, documented nursing will continue to monitor resident #2 for behaviors. The AIMS (abnormal involuntary movement scale) assessment dated 3/21/19 documented minimal movement noted. The care plan dated 5/7/18 directed nursing staff to monitor and document observed behaviors and attempted interventions. The EMR documented an order dated 9/25/18 for behavior monitoring secondary to being prescribed Seroquel (antipsychotic) for dementia with behaviors every shift. Seroquel give 12.5 milligrams (mg) by mouth at bedtime for dementia with behaviors was ordered 9/20/18. Review of the EMR physician order for Seroquel lacked the appropriate indication of use. Review of the treatment administration record from October 1, 2018 to March 1, 2019 noted missed opportunities of documented behavior for	F 756			

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F 756	Continued From page 11 Seroquel 91 times. Review of the Medication Regimen Review from August 2018 to February 2019 lacked recommendations regarding the missed opportunities of behavioral monitoring or recommendations for Seroquel indication for use. On 4/4/19 at 1:58 PM resident #2 sat at a table near the nurse station in his/her wheelchair with a book in front of him/her. Resident #2 appeared content with the book and no behaviors noted at that time. On 4/3/19 at 4:10 PM, licensed nursing staff I stated that the behavior monitoring should be filled out every shift. On 4/4/19 at 10:45 AM, licensed nursing staff H stated that resident #2 can be resistive to care at times. On 4/4/19 at 2:00 PM, administrative nursing staff D confirmed behavior monitoring should be done every shift and was not sure why this was not done. Administrative nursing staff D stated that he/she believed that the antipsychotic medications should have a diagnosis of psychosis or schizophrenia, but it was not the appropriate diagnosis. On 4/11/19 at 9:51 AM, consultant GG stated that he/she does not normally let the facility know if there are blanks in the behavior monitoring, and that he/she tried every month to review the medications to make sure that the appropriate diagnosis is there. The facility's policy 'Pharmacy Recommendations	F 756			

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F 756	Continued From page 12 and Physician Approvals of Medication Changes' dated 8/15/17 stated the Pharmacy will review resident medical records monthly that will include monthly communication to facility regarding medication review information such as recommendations. The DON or designee will not each recommendation and put in physician's mailbox for review. Once returned, the DON or designee will distribute pharmacy recommendations to the nursing staff to process and update the eMAR (electronic medication administration record). The nurse will sign and date the original pharmacy recommendation after processing, then place it in the medical records mailbox to be filed in the chart. If medical records received pharmacy recommendation with no signature it would be returned to the DON. The facility failed to ensure the consultant pharmacist adequately reviewed, and addressed missed documentation for behavior monitoring for Seroquel (antipsychotic) and that the pharmacist identified inappropriate indication of use for the antipsychotic medication ordered for resident for resident #2. - Resident #33's April 2019's Electronic medical record (EMR) documented diagnoses which included: dementia (progressive mental disorder characterized by failing memory, confusion), atrial fibrillation (rapid, irregular heart beat), major depressive disorder (major mood disorder), and anxiety (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear). The Admission Minimum Data Set (MDS) assessment dated 10/4/18 documented a Brief Interview for Mental Status (BIMS) score of 12	F 756			

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F 756	Continued From page 13 which indicated moderately impaired cognition. The assessment recorded that the resident received antidepressant medication, anticoagulant (blood thinner) medication, and diuretic medication for 7 days during the look back period and opioid medication for 2 days during the look back period. The resident had no behaviors and noted minimal depression. The Quarterly MDS assessment dated 3/17/19 documented a BIMS score of 13 which indicated intact cognition. The assessment recorded that the resident received anticoagulant (blood thinner) medication, and diuretic medication for 7 days, antidepressant medication for 6 days and opioid medication for 2 days during the look back period. The resident had no behaviors or mood concerns noted. The Care Area Assessment for cognitive loss, dated 10/4/18, triggered, but lacked analysis of findings or further investigation. The care plan dated 10/4/18 directed staff to monitor for increased signs and symptoms of depression, and on 10/11/18 to give medications as ordered and monitor and document side effects and effectiveness. The EMR documented an order dated 10/4/18 for behavior monitoring secondary to being prescribed sertraline for depression and an order dated 10/19/18 for behavior monitoring secondary to being prescribed Xanax for anxiety. Sertraline HCl give 50 milligrams (mg) by mouth daily for major depressive disorder was ordered 10/4/18. Xanax give 0.25 mg by mouth every 6 hours as needed for anxiety was ordered on 10/18/18.	F 756			

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F 756	Continued From page 14 Review of the physician order lacked a stop date for the as needed Xanax order. Review of the treatment administration record from October 1, 2018 to March 31, 2019 noted missed opportunities of documented behaviors monitoring for sertraline 120 times and Xanax 97 times. Review of the Medication Regimen Review from October 2018 to February 2019 lacked recommendations regarding the missed opportunities of behavioral monitoring for Xanax. Review of the Medication Regimen Review for November 2018 noted a recommendation to limit psychotropic medication to 14 days unless the physician reviews, evaluates and documents rational for extension for Xanax which lacked follow up from the physician. On 4/4/19 at 8:39 AM, resident #33 self-propelled in his/her wheelchair down the hallway. Resident #33 was content with no behaviors noted. On 4/3/19 at 4:10 PM, licensed nursing staff I stated that the behavior monitoring should be filled out every shift. On 4/4/19 at 2:00 PM, administrative nursing staff D confirmed behavior monitoring should be done every shift and was not sure why this was not done. On 4/11/19 at 9:51 AM, consultant GG stated that he/she does not normally let the facility know if there are blanks in the behavior monitoring. He/she revealed that the physicians are expected to do a follow up on medications as ordered and	F 756			

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F 756	Continued From page 15 as long as that follow up occurs a stop date was not expected on the order. The facility's policy 'Pharmacy Recommendations and Physician Approvals of Medication Changes' dated 8/15/17 stated the Pharmacy will review resident medical records monthly that will include monthly communication to facility regarding medication review information such as recommendations. The DON or designee will not each recommendation and put in physician's mailbox for review. Once returned, the DON or designee will distribute pharmacy recommendations to the nursing staff to process and update the eMAR (electronic medication administration record). The nurse will sign and date the original pharmacy recommendation after processing, then place it in the medical records mailbox to be filed in the chart. If medical records received pharmacy recommendation with no signature it would be returned to the DON. The facility failed to ensure the consultant pharmacist adequately reviewed, and addressed missed documentation for behavior monitoring for sertraline (antidepressant) and Xanax (anxiety) and the facility failed to act upon the pharmacist recommendation on the as needed Xanax order that lacked a stop date for resident #33. -The EMR (electronic medical record) for resident #5 documented diagnoses that included GERD (acid reflux disorder), asthma, allergic rhinitis (inflammation inside of the nose), and COPD (a progressive lung disease). The admission minimum data set (MDS) dated 01/03/19 lacked a BIMS score due to short- and	F 756			

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F 756	Continued From page 16 long-term memory problems, and revealed resident requires the assistance of one staff member for ADL's (activities of daily living) and required the use of a wheelchair or walker. Review of the CAA (care area assessment) dated 01/03/19 documented that resident #5 had short-term and long-term memory loss related to dementia. Review of the care plan revised on 04/01/19 documented resident had COPD, required short frequent meals, close monitoring for side effects of breathing treatments and respiratory complications, and received omeprazole before breakfast and to monitor for side effects of medications. Review of the medication orders revealed the following medications dated 12/27/18: Fluticasone Furoate "Breo Ellipta" inhaler, Vilanterol Aerosol Powder Breath activated 100-25 mcg/inhalation - 1 puff inhale orally one time a day for inflammation inside of the nose. Omeprazole tablet delayed release - give 2 tablets by mouth daily for acid reflux disorder. The Medication Record Review for December 2018 and January 2019 revealed the pharmacist recommended that the omeprazole order to include a dosage strength, and for the Breo Ellipta to include the instructions "rinse mouth after use." Review of resident #5's medical record lacked evidence that the pharmacy recommendations were addressed by the facility. An observation of resident #5 on 04/04/19 at	F 756			

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F 756	Continued From page 17 02:43 PM revealed the resident in the dining room watching a movie with other residents. He/she was well-groomed, alert and appeared to be enjoying the activity. An interview with licensed nursing staff H on 04/04/19 at 12:54 PM confirmed the omeprazole order did not include a dose and the Breo Ellipta order did not include instructions to rinse mouth after use. An interview with administrative staff D on 04/04/19 at 01:47 PM confirmed that the order for omeprazole did not include a dose and that the order for Breo Ellipta inhaler did not include instructions to rinse mouth after use. The facility's policy for pharmacy recommendations and physician approvals of medication changes (last reviewed 08/15/17) provided instructions as follows: Pharmacy will review resident medical records monthly that will include monthly communication to facility regarding medication review information such as recommendations. The DON or designee will not each recommendation and put in physician's mailbox for review. Once returned, the DON or designee will distribute pharmacy recommendations to the nursing staff to process and update the eMAR (electronic medication administration record). The nurse will sign and date the original pharmacy recommendation after processing, then place it in the medical records mailbox to be filed in the chart. If medical records receive pharmacy recommendation with no signature it would be returned to the DON. The facility failed to ensure the physician followed up on pharmacy recommendations.	F 756			

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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 identified a census of 44 residents. The sample included 22 residents. Based on observation, record review and interview the facility failed clarify medication orders for 1 of 5 residents (#5). Findings included: - The EMR (electronic medical record) for resident #5 documented diagnoses that included GERD (acid reflux disorder), asthma, allergic rhinitis (inflammation inside of the nose), and COPD (a progressive lung disease).	F 757			

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F 757	Continued From page 19 The admission minimum data set (MDS) dated 01/03/19 lacked a BIMS score due to short- and long-term memory problems, and revealed resident requires the assistance of one staff member for ADL's (activities of daily living) and required the use of a wheelchair or walker. Review of the CAA (care area assessment) dated 01/03/19 documented that resident #5 had short-term and long-term memory loss related to dementia. Review of the care plan revised on 04/01/19 documented resident had COPD, required short frequent meals, close monitoring for side effects of breathing treatments and respiratory complications, and received omeprazole before breakfast and to monitor for side effects of medications. Review of the medication orders revealed the following medications dated 12/27/18: Fluticasone Furoate "Breo Ellipta" inhaler, Vilanterol Aerosol Powder Breath activated 100-25 mcg/inhalation - 1 puff inhale orally one time a day for inflammation inside of the nose. Omeprazole tablet delayed release - give 2 tablets by mouth daily for acid reflux disorder. The Medication Record Review for December 2018 and January 2019 revealed the pharmacist recommended that the omeprazole order to include a dosage strength, and for the Breo Ellipta to include the instructions "rinse mouth after use." Review of resident #5's medical record lacked evidence that the pharmacy recommendations	F 757			

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F 757	Continued From page 20 were addressed by the facility. Review of resident #5's medical record lacked evidence that the facility was providing medication interventions to prevent adverse reactions as pharmacy recommended. Review of the progress notes lacked documentation that the mouth was rinsed after the use of the Breo Ellipta inhaler. Review of the care plan lacked documentation to rinse the mouth after the use of the Breo Ellipta inhaler. Review of the MAR (medication administration record) lacked instruction to rinse the mouth after administration of the Breo Ellipta inhaler and lacked a drug strength for the omeprazole. Review of the physician's orders lacked instruction to rinse mouth after administration of the Breo Ellipta inhaler and lacked a drug strength for the omeprazole. Review of assessments lacked documentation of oral cavity assessments and lacked documentation that resident's mouth was rinsed after administration of the Breo Ellipta inhaler. An observation of resident #5 on 04/04/19 at 02:43 PM revealed the resident in the dining room watching a movie with other residents. He/she was well-groomed, alert and appeared to be enjoying the activity. An interview with licensed nursing staff H on 04/04/19 at 12:54 PM confirmed the omeprazole order did not include a dose and the Breo Ellipta	F 757			

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F 757	Continued From page 21 order did not include instructions to rinse mouth after use. An interview with administrative staff D on 04/04/19 at 01:47 PM confirmed that the order for omeprazole did not include a dose and that the order for Breo Ellipta inhaler did not include instructions to rinse mouth after use. The facility's policy for pharmacy recommendations and physician approvals of medication changes (last reviewed 08/15/17) provided instructions as follows: Pharmacy will review resident medical records monthly that will include monthly communication to facility regarding medication review information such as recommendations. The DON or designee will not each recommendation and put in physician's mailbox for review. Once returned, the DON or designee will distribute pharmacy recommendations to the nursing staff to process and update the eMAR (electronic medication administration record). The nurse will sign and date the original pharmacy recommendation after processing, then place it in the medical records mailbox to be filed in the chart. If medical records receive pharmacy recommendation with no signature it would be returned to the DON. The facility failed to clarify two medication orders with the physician for resident #5.	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	F 758			

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F 758	Continued From page 22 processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be 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.	F 758			

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F 758	Continued From page 23 §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 identified a census of 44 residents. The sample included 22 residents. Based on observation, record review and interview the facility failed to review and address the missed documentation for antidepressants (class of medications used to treat mood disorders and relieve symptoms of depression[abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness and emptiness]) for 2 of 5 residents (#11 and #33) and antipsychotics (class of medications used to treat psychosis[any major mental disorder characterized by a gross impairment in reality testing] and other mental emotional conditions) for 3 of 5 residents (#11, #2, and #33). The facility further failed to assure antipsychotic medication ordered was supported by the proper diagnosis for 2 of 5 residents (#11 and #2) and one that required a stop date for an as needed antianxiety (class of medications that calm and relax people with excessive anxiety (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear), nervousness, or tension) medication (#33). Findings included: - Resident #11's April 2019's electronic medical record (EMR) documented diagnoses which included: hypertension (elevated blood pressure), major depressive disorder (major mood disorder), Alzheimer's disease (progressive mental	F 758			

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F 758	Continued From page 24 deterioration characterized by confusion and memory failure), and Parkinson's disease (slowly progressing neurologic disorder characterized by resting tremor, rolling of the fingers, masklike faces, shuffling gait, muscle rigidity and weakness). The Annual Minimum Data Set (MDS) assessment dated 6/7/18 documented a Brief Interview for Mental Status (BIMS) score of 13 which indicated intact cognition. The assessment recorded that the resident received antipsychotic medications, antidepressant medications, and diuretic (medication to promote the formation and excretion of urine) medications for 7 days during the look back period. It documented that a gradual dose reduction (GDR) was clinically contraindicated on 10/18/17. The resident did not trigger for mood and no behaviors noted. The Quarterly MDS assessment dated 2/12/19 documented a BIMS score of 12 which indicated moderately impaired cognition. The assessment revealed the same medication use, mood, and behavior documentation as the Annual MDS dated 6/7/18. The assessment documented a GDR was clinically contraindicated on 1/11/19. The Care Area Assessment for psychotropic medication use, dated 6/7/18, documented that the resident was at risk for adverse side effects for use of antidepressants for depression and antipsychotic medication for dementia with behaviors. The AIMS (abnormal involuntary movement scale) assessment dated 2/12/19 documented no concerns for resident #11.	F 758			

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F 758	Continued From page 25 The care plan reviewed 2/20/19 documented the pharmacy consultant reviewed medications every month and made recommendations as indicated. The care plan further instructed staff to monitor for increased signs and symptoms of depression and adverse reactions to medications. The electronic medical record (EMR) documented an order dated 2/2/17 for behavior monitoring secondary to being prescribed Risperdal (antipsychotic) every shift and for behavior monitoring secondary to being prescribed Celexa every shift. Celexa give 29 milligrams (mg) by mouth daily for major depressive disorder ordered 2/1/17 and then discontinued 12/7/18 and reordered on 12/8/18. Risperdal give 0.25 mg by mouth daily for dementia with behavioral disturbances. Review of the EMR physician order for Risperdal lacked the appropriate indication of use. The orders were discontinued when the resident discharged on December 4, 2018, and the facility failed to restart the behavior monitoring for both Risperdal and Celexa when the resident returned 12/8/18. Review of the treatment administration record from September 1, 2018 to December 4, 2018 noted missed opportunities of documented behavior monitoring for Celexa 52 times and Risperdal 52 times. The EMR lacked any behavior monitoring documentation upon readmitting to the facility from December 7, 2018 to present. On 4/4/19 at 8:38 AM, resident #11 was in the	F 758			

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F 758	Continued From page 26 dining room seated in his/her wheelchair, appeared in good spirits with no behaviors noted. On 4/3/19 at 4:10 PM, licensed nursing staff I stated that the behavior monitoring should be filled out every shift. On 4/4/19 10:30 AM, direct care staff M stated that when resident #11 wanted something, he/she wanted it right now and it to be done the way he/she wanted it done. On 4/4/19 at 2:00 PM, administrative nursing staff D confirmed behavior monitoring should be done every shift and was not sure why this was not done. Administrative nursing staff D stated that he/she believed that the antipsychotic medications should have a diagnosis of psychosis or schizophrenia, but it was not the appropriate diagnosis. The facility policy "Psychotropic Medications" dated 2013 directed nursing staff to monitor for the presence of target behaviors. The facility failed to adequately review, and address missed documentation for behavior monitoring for Celexa (antidepressant) monitoring and Risperdal (antipsychotic) monitoring and assure the indication was appropriate for the antipsychotic medication ordered for resident #11. - Resident #2's April 2019 electronic medical record (EMR) documented diagnoses which included: dementia (progressive mental disorder characterized by failing memory, confusion), hypertension (elevated blood pressure), Alzheimer's disease (progressive mental deterioration characterized by confusion and	F 758			

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F 758	Continued From page 27 memory failure), and anxiety (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear). The Quarterly Minimum Data Set (MDS) assessment dated 9/27/18 documented staff interview for the Brief Interview for Mental Status (BIMS) indicating short and long-term memory problem with severely impaired cognition. The assessment recorded that the resident received antipsychotic medication, antidepressant medication for 6 days during the look back period and diuretic medication for 2 days during the look back period. The resident did not trigger for mood and no behaviors noted. The Significant Change MDS assessment dated 3/14/19 revealed the same BIMS score, medication use, mood, and behavior documentation as the Quarterly MDS dated 9/27/18. The Care Area Assessment (CAA) for cognitive loss, dated 3/14/19, documented resident #2 refused to take medications and to minimize disruptions and changes in routine. The CAA for psychotropic medication use, dated 3/14/19, documented nursing will continue to monitor resident #2 for behaviors. The AIMS (abnormal involuntary movement scale) assessment dated 3/21/19 documented minimal movement noted. The care plan dated 5/7/18 directed nursing staff to monitor and document observed behaviors and attempted interventions.	F 758			

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F 758	Continued From page 28 The EMR documented an order dated 9/25/18 for behavior monitoring secondary to being prescribed Seroquel (antipsychotic) for dementia with behaviors every shift. Seroquel give 12.5 milligrams (mg) by mouth at bedtime for dementia with behaviors was ordered 9/20/18. Review of the EMR physician order for Seroquel lacked the appropriate indication of use. Review of the treatment administration record from October 1, 2018 to March 1, 2019 noted missed opportunities of documented behavior for Seroquel 91 times. On 4/4/19 at 1:58 PM resident #2 sat at a table near the nurses station in his/her wheelchair with a book in front of him/her. Resident #2 appeared content with the book and no behaviors noted at that time. On 4/3/19 at 4:10 PM, licensed nursing staff I stated that the behavior monitoring should be filled out every shift. On 4/4/19 at 10:45 AM, licensed nursing staff H stated that resident #2 can be resistive to care at times. On 4/4/19 at 2:00 PM, administrative nursing staff D confirmed behavior monitoring should be done every shift and was not sure why this was not done. Administrative nursing staff D stated that he/she believed that the antipsychotic medications should have a diagnosis of psychosis or schizophrenia, but it was not the appropriate diagnosis. The facility policy "Psychotropic Medications"	F 758			

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F 758	Continued From page 29 dated 2013 directed nursing staff to monitor for the presence of target behaviors. The facility failed to adequately review, and address missed documentation for behavior monitoring for Seroquel and assure the indication was appropriate for the antipsychotic medication ordered for resident for resident #2. - Resident #33's April 2019's Electronic medical record (EMR) documented diagnoses which included: dementia (progressive mental disorder characterized by failing memory, confusion), atrial fibrillation (rapid, irregular heart beat), major depressive disorder (major mood disorder), and anxiety (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear). The Admission Minimum Data Set (MDS) assessment dated 10/4/18 documented a Brief Interview for Mental Status (BIMS) score of 12 which indicated moderately impaired cognition. The assessment recorded that the resident received antidepressant medication, anticoagulant (blood thinner) medication, and diuretic medication for 7 days during the look back period and opioid medication for 2 days during the look back period. The resident had no behaviors and noted minimal depression. The Quarterly MDS assessment dated 3/17/19 documented a BIMS score of 13 which indicated intact cognition. The assessment recorded that the resident received anticoagulant (blood thinner) medication, and diuretic medication for 7 days, antidepressant medication for 6 days and opioid medication for 2 days during the look back period. The resident had no behaviors or mood	F 758			

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F 758	Continued From page 30 concerns noted. The Care Area Assessment for cognitive loss, dated 10/4/18, triggered, but lacked analysis of findings or further investigation. The care plan dated 10/4/18 directed staff to monitor for increased signs and symptoms of depression, and on 10/11/18 to give medications as ordered and monitor and document side effects and effectiveness. The EMR documented an order dated 10/4/18 for behavior monitoring secondary to being prescribed sertraline for depression and an order dated 10/19/18 for behavior monitoring secondary to being prescribed Xanax for anxiety. Sertraline HCl give 50 milligrams (mg) by mouth daily for major depressive disorder was ordered 10/4/18. Xanax give 0.25 mg by mouth every 6 hours as needed for anxiety was ordered on 10/18/18. Review of the treatment administration record from October 1, 2018 to March 31, 2019 noted missed opportunities of documented behaviors monitoring for sertraline 120 times and Xanax 97 times. On 4/4/19 at 8:39 AM, resident #33 self-propelled in his/her wheelchair down the hallway. Resident #33 was content with no behaviors noted. On 4/3/19 at 4:10 PM, licensed nursing staff I stated that the behavior monitoring should be filled out every shift. On 4/4/19 at 2:00 PM, administrative nursing staff D confirmed behavior monitoring should be done every shift and was not sure why this was not	F 758			

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F 758	Continued From page 31 done.	F 758			
F 761 SS=D	The facility policy "Psychotropic Medications" dated 2013 directed nursing staff to monitor for the presence of target behaviors. The facility failed to adequately review, and address missed documentation for behavior monitoring for sertraline and Xanax, and the facility failed to address the as needed Xanax order that lacked a stop date for resident #33. Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can	F 761			

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F 761	Continued From page 32 be readily detected. This REQUIREMENT is not met as evidenced by: The facility identified a census of 44 residents and 3 medication rooms. Based on observation, record review, and interview, the facility failed to provide a separately locked, permanently affixed compartments for storage of controlled drugs for the emergency medication box of controlled drugs for 1 medication room (#1). Findings included: - On 4/2/19 at 10:03 AM, the #1 medication room contained an unlocked controlled drug emergency medication box on an open shelf with no second lock noted for the controlled drug box. According to Centers for Medicare and Medicaid Services (CMS) schedule 2 controlled medications are to be maintained within a separately locked permanently affixed compartment. On 4/2/19 at 4:35 PM administrative nursing staff D confirmed the controlled drug emergency medication box was not permanently affixed or locked in the medication room. The facility failed to provide a policy for medication storage. The facility failed to provide a separately locked, permanently affixed compartments for storage of controlled drugs for the emergency medication box of controlled drugs in one medication room.	F 761			