



IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
RUSSELL S. BARRON – Director

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BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
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December 26, 2018

Lowell Smith, Administrator
Coeur D'Alene Of Cascadia
2514 North Seventh Street
Coeur D'Alene, ID 83814-3720

Provider #: 135052

Dear Mr. Smith:

On **December 14, 2018**, we conducted an on-site revisit to verify that your facility had achieved and maintained compliance. We presumed, based on your allegation of compliance, that your facility was in substantial compliance as of **October 30, 2018**. However, based on our on-site revisit we found that your facility is not in substantial compliance with the following participation requirements:

- F0000 -- S/S: -- -- Initial Comments**
- F0580 -- S/S: G -- 483.10(g)(14)(i)-(iv)(15) -- Notify Of Changes (injury/decline/room, Etc.)**
- F0610 -- S/S: D -- 483.12(c)(2)-(4) -- Investigate/prevent/correct Alleged Violation**
- F0684 -- S/S: G -- 483.25 -- Quality Of Care**
- F0689 -- S/S: G -- 483.25(d)(1)(2) -- Free Of Accident Hazards/supervision/devices**
- F0758 -- S/S: D -- 483.45(c)(3)(e)(1)-(5) -- Free From Unnec Psychotropic Meds/prn Use**

Enclosed is a Statement of Deficiencies and Plan of Correction, Form CMS-2567 listing Medicare and/or Medicaid deficiencies. If applicable, a similar State Form will be provided listing licensure health deficiencies. In the spaces provided on the right side of each sheet, answer each deficiency and state the date when each will be completed. **NOTE:** The alleged compliance date must be after the "Date Survey Completed" (located in field X3.) **Please**

provide ONLY ONE completion date for each federal and state tag (if applicable) in column (X5) Completion Date to signify when you allege that each tag will be back in compliance. Waiver renewals may be requested on the Plan of Correction.

After each deficiency has been answered and dated, the administrator should sign the Form CMS-2567 and State Form (if applicable), Statement of Deficiencies and Plan of Correction in the spaces provided and return the original(s) to this office.

Your Plan of Correction (PoC) for the deficiencies must be submitted by **January 5, 2019**.

The components of a Plan of Correction, as required by CMS must:

- Address what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;
- Address how you will identify other residents who have the potential to be affected by the same deficient practice and what corrective action(s) will be taken;
- Address what measures will be put in place and what systemic changes will be made to ensure that the deficient practice does not recur;
- Indicate how the facility plans to monitor performance to ensure the corrective action(s) are effective and compliance is sustained.
- Include dates when corrective action will be completed in column (X5).

If the facility has not been given an opportunity to correct, the facility must determine the date compliance will be achieved. If CMS has issued a letter giving notice of intent to implement a denial of payment for new Medicare/Medicaid admissions, consider the effective date of the remedy when determining your target date for achieving compliance.

- The administrator must sign and date the first page of the federal survey report, Form CMS-2567 and the state licensure survey report, State Form (if applicable).

All references to federal regulatory requirements contained in this letter are found in *Title 42, Code of Federal Regulations*.

As noted in the Bureau of Facility Standards' letter of **October 4, 2018**, following the survey of **September 14, 2018**, we have already made the recommendation to the Centers for Medicare and Medicaid Services (CMS) for a civil money penalty, Denial of Payment for New Admissions effective **December 14, 2018** and termination of the provider agreement on **March**

14, 2019, if substantial compliance is not achieved by that time. The findings of non-compliance on **December 14, 2018**, has resulted in a continuance of the remedy(ies) previously mentioned to you by the CMS. On **December 4, 2018**, CMS notified the facility of the intent to impose the following remedies:

- DPNA made on or after **December 18, 2018**
- **Termination of the provider agreement March 14, 2019**

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

If you believe the deficiencies have been corrected, you may contact please contact Debby Ransom, RN, RHIT, Bureau Chief, Bureau of Facility Standards, 3232 Elder Street, Post Office Box 83720, Boise, Idaho, 83720-0009; phone number: (208) 334-6626, option 5; fax number: (208) 364-1888, with your written credible allegation of compliance. If you choose and so indicate, the PoC may constitute your allegation of compliance.

In accordance with 42 CFR §488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You may also contest scope and severity assessments for deficiencies, which resulted in a finding of SQC or immediate jeopardy. To be given such an opportunity, you are required to send your written request and all required information as directed in Informational Letter #2001-10. Informational Letter #2001-10 can also be found on the Internet at:

<http://healthandwelfare.idaho.gov/Providers/ProvidersFacilities/StateFederalPrograms/NursingFacilities/tabid/434/Default.aspx>

go to the middle of the page to **Information Letters** section and click on **State** and select the following:

- BFS Letters (06/30/11)

2001-10 Long Term Care Informal Dispute Resolution Process
2001-10 IDR Request Form

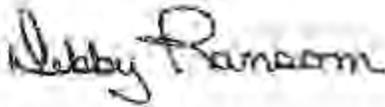
This request must be received by **January 5, 2019**. If your request for informal dispute resolution is received after **January 5, 2019**, the request will not be granted. An incomplete

Lowell Smith, Administrator
December 26, 2018
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informal dispute resolution process will not delay the effective date of any enforcement action.

Thank you for the courtesies extended to us during the survey. If you have any questions, comments or concerns, please contact Debby Ransom, RN, RHIT, Bureau Chief at (208) 334-6626, option 5.

Sincerely,

A handwritten signature in black ink that reads "Debby Ransom". The signature is written in a cursive style with a large initial "D".

Debby Ransom, RN, RHIT, Chief
Bureau of Facility Standards

dr/
Enclosures

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

PRINTED: 03/11/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135052	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 12/14/2018
NAME OF PROVIDER OR SUPPLIER COEUR D'ALENE OF CASCADIA			STREET ADDRESS, CITY, STATE, ZIP CODE 2514 NORTH SEVENTH STREET COEUR D'ALENE, ID 83814		
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{F 000}	INITIAL COMMENTS The following deficiencies were cited during the on-site follow-up survey conducted at the facility on December 13, 2018 and December 14, 2018. The surveyors conducting the survey were: Brad Perry, LSW, Team Coordinator Teresa Kobza, RD Ann Monhollen, RN Survey Abbreviations: BG = Blood Glucose BIMS = Brief Interview for Mental Status BP = Blood Pressure CNA = Certified Nursing Assistant DNS = Director of Nursing Services I&A= Incident and Accident HS = At Bedtime LPN = Licensed Practical Nurse MAR = Medication Administration Record MDS = Minimum Data Set assessment mg= milligram mg/dl = milligram per deciliter MRR = Medication Regime Review PRN = as needed RN = Registered Nurse ROM = Range of motion WNL = Within normal limits	{F 000}			
F 580 SS=G	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which	F 580		1/22/19	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

01/05/2019

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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F 580	<p>Continued From page 1</p> <p>results in injury and has the potential for requiring physician intervention;</p> <p>(B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications);</p> <p>(C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or</p> <p>(D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii).</p> <p>(ii) When making notification under paragraph (g) (14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician.</p> <p>(iii) The facility must also promptly notify the resident and the resident representative, if any, when there is-</p> <p>(A) A change in room or roommate assignment as specified in §483.10(e)(6); or</p> <p>(B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section.</p> <p>(iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s).</p> <p>§483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct</p>	F 580			

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F 580	<p>Continued From page 2</p> <p>part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by:</p> <p>Based on staff interview and record review, it was determined the facility failed to ensure the physician was notified timely of a residents' low BG levels and of falls that resulted in head injury. This was true for 1 of 8 residents (Resident #10) whose records were reviewed. Resident #10 was harmed when she experienced a cognitive decline after experiencing multiple unwitnessed falls and multiple low BG levels and the physician was not notified and/or not notified timely. This failed practice harmed Resident #10 when the resident experienced a decline in condition and the physician was not notified in order for the physician to make treatment/care decisions. Findings include:</p> <p>The facility's Resident Change of Condition policy and procedure, dated 11/28/17, documented when the staff recognize a significant change in status the nurse should communicate with the physician to meet the residents' needs. The policy documented the facility was to immediately inform the resident, confer with the physician, and notify the resident's representative when there was "a significant change in the resident's physical, mental, or psychosocial status." The policy defined a change of condition to include deteriorating mobility, falls, and behavior changes.</p> <p>Resident #10 was readmitted to the facility on 1/8/18, with diagnoses which included repeat falls, Parkinson's Disease, muscle weakness,</p>	F 580	<p>This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Coeur d'Alene Health of Cascadia does not admit that the deficiencies listed on the CMS Form 2567L exist, nor does the Facility admit to any statements, findings, facts or conclusions that form the basis for the alleged deficiencies. The Facility reserves the right to challenge in legal proceedings, all deficiencies, statements, findings, facts and conclusions that form the basis for the deficiency.</p> <p>F 580 - Notify of Changes</p> <p>Resident Specific The clinical management team and attending physician reviewed resident falls, current medications, BG levels, change in cognition, and overall health status for resident #10. Physician directives have been updated as indicated.</p> <p>Other Residents The clinical management team reviewed residents with falls/repeat falls since December 1st, hypoglycemia episodes/negative blood glucose trending, and those with a recent change in cognition. The physician was notified and directives followed as indicated.</p>		

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F 580	<p>Continued From page 3</p> <p>schizophrenia, diabetes, and major depression single episode.</p> <p>A Mental Health Progress Note, dated 10/2/18, documented Resident #10's thought process was intact, and her associations were logical. The note documented she had normal thought content and no hallucinations. The note documented she was oriented to situation, place, and person and her memory was intact.</p> <p>A quarterly MDS assessment, dated 10/18/18, documented Resident #10 was cognitively intact and required supervision while walking in her room or the corridor. The MDS assessment documented Resident #10 required extensive assistance of one staff member with bed mobility, transfers, toileting, and locomotion on and off the unit. The MDS documented Resident #10 experienced one fall without injury since the prior assessment.</p> <p>Resident #10's December 2018 recapitulated Physician's Orders included the following:</p> <ul style="list-style-type: none"> - Monitor BGs twice daily and notify the physician if BG was less than 60 or greater than 500 mg/dl, ordered 6/14/18. - Novolog (Insulin Aspart) 12 units subcutaneously at lunch and dinner for diabetes, ordered 6/14/18. - Tresiba (Insulin Degludec) 50 units subcutaneously in the morning for diabetes, ordered 7/25/18 and discontinued 12/4/18. - Tresiba (Insulin Degludec) 45 units subcutaneously at bedtime for diabetes, ordered 7/25/18, and discontinued 12/4/18. - Tresiba (Insulin Degludec) 45 units 	F 580	<p>Facility Systems</p> <p>Nursing staff and IDT have been educated to notify physician with changes. Re-education was provided by Director of Clinical Operations, Director of Nursing (DNS), and/or designee to include but not limited to timely notification of falls/fall trending, hypoglycemia/BG outliers, resident change of condition, and negative changes in cognition.</p> <p>The system is amended to include oversight by the DNS in clinical meeting with review of previous days <input type="checkbox"/> change of conditions, blood sugars results and interventions, potential medical concerns that may impact falls, use of SBAR communication with physician response, and follow-up to Stop-n-Watch for potential identification of subtle resident changes.</p> <p>Monitor</p> <p>The Director of Nursing and/or designee will audit five residents weekly for proper notification of physician(s) to include but not limited to notification of falls, out of range blood sugars and follow-up by physician until no deficiency is identified. The Resource RN will provide oversight for quality clinical review of medical causes that impact falls during twice monthly reviews until quality review is consistent.</p> <p>Starting the week of January 6, 2018, the</p>		

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F 580	<p>Continued From page 4</p> <p>subcutaneously in the morning for diabetes, ordered 12/4/18.</p> <p>- Tresiba (Insulin Degludec) 40 units subcutaneously at bedtime for diabetes, ordered 12/4/18.</p> <p>a. Resident #10's 11/1/18 through 12/13/18 MAR, documented she had 4 BG levels less than 60 mg/dl.</p> <p>A physician order request, dated 11/6/18 at 9:00 PM, documented her BG level was 44 mg/dl and she was "very diaphoretic" (sweating). The notification documented she was provided glucose gel and her BG level raised to 81 mg/dl. The notification documented she had a low oral intake at dinner and her pre-dinner BG level was 129 mg/dl. Resident #10 was provided her evening doses of Novolog and Tresiba when her BG was 44 mg/dl. The notification documented Resident #10's morning BG levels were normally below 100 mg/dl with an HS snack provided.</p> <p>The request asked the physician review her BG levels and consider reducing her Novolog and Tresiba. The request was documented as faxed to the physician on 11/7/18, time not noted. The physician did not respond to the request. The physician reviewed the low BG level and her insulin was adjusted on 12/4/18 (28 days) after the request.</p> <p>b. Resident #10's clinical record documented she experienced six falls between 11/11/18 and 12/4/18, and the physician was not notified of falls and/ or not notified timely when she had a change in cognition. Examples include:</p>	F 580	<p>review will be documented on the audit tool. Any concerns will be addressed immediately and discussed with the IDT. The QAPI committee may adjust the frequency of the monitoring after 12 weeks, as it deems appropriate.</p>		

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F 580	<p>Continued From page 5</p> <p>i. Resident #10's clinical record included a Post Fall Investigation report, dated 11/29/18. It documented she experienced a fall on 11/11/18. Resident #10's clinical record did not contain documentation the physician was notified of the fall on 11/11/18.</p> <p>ii. An I&A Report, dated 11/12/18 at 7:40 PM, documented Resident #10 experienced an unwitnessed fall in her room tripping over the legs of her front wheeled walker. The I&A documented she hit her head on the floor.</p> <p>A physician order request, dated 11/12/18 at 11:35 PM, documented Resident #10 had an unwitnessed fall in her room and she stated she fell on her back and hit her head. The notification documented she had no hematoma noted and neurological assessments were started. The request was faxed on 11/12/18, untimed. The physician responded and signed the request on 11/27/18, 15 days later.</p> <p>iii. An I&A Report, dated 11/13/18 at 11:50 PM, documented Resident #10 experienced an unwitnessed fall from bed. She was found kneeling next to her bed and denied hitting her head. The I&A documented she had a 5 cm by 3 cm bruise on the pad of her left hand near her thumb. The I&A documented she was able to remember her full name and date of birth but was unable to remember her location. The I&A documented she was attempting to go to the bathroom and she got dizzy and fell to the floor.</p> <p>A physician order request, dated 11/13/18 at 11:50 PM, documented Resident #10 was found on the floor kneeling by her bed, by an aide . The</p>	F 580			

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F 580	<p>Continued From page 6</p> <p>notification documented Resident #10 denied hitting her head and she had injured her hand. The notification documented neurological assessments were started per protocol. The request was faxed on 11/14/18 at 9:05 AM. The physician responded to the request on 11/27/18, 14 days later. The physician responded with an order for staff to monitor Resident #10 for "latent injury" for 72 hours after the fall on 11/13/18</p> <p>iv. Resident #10's clinical record documented she experienced a fall on 11/14/18 in a Progress Note, dated 11/16/18 at 2:55 AM and on a Post Fall Investigation report, dated 11/19/18. Resident #10's clinical record did not contain documentation the physician was notified of the fall on 11/14/18.</p> <p>v. An I&A Report, dated 11/19/18 at 10:20 AM, documented Resident #10 experienced an unwitnessed fall from her chair in her room. She was found lying on her stomach with her head on her arms. The I&A documented Resident #10 was trying to "find her apartment" and fell out of her chair.</p> <p>A physician order request, dated 11/19/18 at 1:41 PM, documented Resident #10 experienced an unwitnessed fall and was found on the floor lying face down. The request documented Resident #10 had increased confusion, and lethargy, and she was not requesting assistance. The request documented the nursing staff asked the provider see Resident #10 due to her recent falls on 11/13, 11/14, and 11/19. The request did not include a date of when the notification was faxed to the provider. The physician did not respond to the request.</p>	F 580			

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F 580	Continued From page 7 A Progress Note, dated 11/20/18 at 5:20 AM, documented Resident #10 was confused and was yelling out 'help me.' The progress note documented she had weakness and needed verbal reminders to use her walker, and her gait was unsteady at this time. The note documented she complained of pain to the back left-side of her head from when she fell. The note documented Resident #10 verbalized she was having "trouble saying," what she wanted to "say," and she had slow thought processes. Resident #10 complained of head pain on 11/20/18 and neurological assessments were not completed for another 28 hours after she complained of the head pain. The Progress Notes, dated 11/21/18 at 3:00 AM, 10:40 AM, and 9:52 PM, documented Resident #10 was alert to herself with confusion and she was having increased confusion over the past week, and difficulty expressing her words. One of the notes documented she was afraid of her call light and was asking where the "small boy" was. A Progress Note, dated 11/22/18, documented Resident #10 was alert to herself with confusion. A Progress Note, dated 11/23/18, documented Resident #10 was alert to herself with confusion. The note documented she called out several times and when staff asked her what she needed, she had a "hard" time "saying" what she needed. A Progress Note, dated 11/27/18 at 6:59 AM, documented Resident #10 frequently calling out. The note documented she was more confused	F 580			

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F 580	<p>Continued From page 8</p> <p>over the past few weeks resulting in falls. The note documented her mental health provider noticed an overall decline in Resident #10's cognition. The note documented Resident #10 required more time to complete sentences and experienced an increased difficulty completing sentences.</p> <p>A Progress Note, dated 12/3/18, documented Resident #10 was confused and stated she did not want a snack because she was "late" for her "airplane."</p> <p>vi. A Progress Note, dated 12/4/18 at 11:35 PM, documented during Residents #10's HS medication pass she was assisted to the bathroom and had to be lowered to the floor. The note documented she had lower leg weakness and she was assessed following the assisted fall. The note documented Resident #10's vital signs were WNL except for her BG which was 53 mg/dl.</p> <p>A physician order request to the physician, dated 12/4/18 at 9:00 PM, documented Resident #10 experienced an assisted fall when she was in the bathroom. The notification documented her legs were weak and they gave out on her. The request documented the nursing staff assessed her BG level and it was 53 mg/dl. The provider did not respond to the request.</p> <p>A Progress Note, dated 12/5/18, documented Resident #10 was making inconsistent statements to staff and had a cognitive decline over the past two weeks. The note documented Resident #10 was "not herself," and experienced periods of restlessness where staff was unable to</p>	F 580			

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F 580	Continued From page 9 redirect her and/or she was sleeping more. On 12/14/18 at 10:55 AM, the DNS with the Administrator present, stated when a resident fell the staff was to complete an incident report and initiate neurological assessments if the fall was unwitnessed, and if the resident hit their head or suspected a head injury. The DNS stated when Resident #10 complained of head pain on 11/20/18, and had slow thought processes, the staff should have notified the physician. Resident #10 experienced a decline in her cognitive and physical ability between 10/2/18 and 12/14/18. The facility failed to notify the physician in a manner and time in which he could respond to the change in the resident's condition.	F 580			
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.	F 610		1/22/19	

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F 610	<p>Continued From page 10</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure a resident's fall was thoroughly investigated. This was true for 1 of 3 residents (Resident #10) who were reviewed for falls. This failure created the potential for harm due to a lack of an investigation to rule out abuse or neglect. Findings include:</p> <p>The facility's Accidents and Supervision to Prevent Accidents policy, dated 11/28/17, documented a fall was defined as unintentionally coming to rest on the ground and/or floor.</p> <p>The facility's Fall Response and Management policy, dated 11/28/17, documented staff were to investigate the cause of the fall after the resident was stable. The policy directed staff to document the fall in the resident's medical record and implement immediate interventions to prevent a repeat fall. The policy further stated if there was an unwitnessed fall or resident injury, staff were to obtain an x-ray if a fracture was suspected and monitor neurological assessments. Staff were also to complete a post-fall investigation, event report, revise the care plan as appropriate, and document the incident or injury in the resident's medical record. This policy was not followed.</p> <p>Resident #10 was readmitted to the facility on 1/8/18, with diagnoses which included repeat falls, Parkinson's Disease, muscle weakness, schizophrenia, diabetes, and major depression single episode.</p> <p>A quarterly MDS assessment, dated 10/18/18,</p>	F 610	<p>F610 - Investigate / Prevent / Correct Alleged Violation</p> <p>Resident Specific The IDT reviewed progress notes, the medical record, and I&A reports for resident #10 to validate falls and dates of fall for 11/11/18, 11/14/18, and 12/04/18 incidents. I & A reports have been initiated as indicated. Falls have been thoroughly investigated, medical causes have been identified, a plan to prevent recurrence has been adjusted as indicated.</p> <p>Other Residents IDT has cross-reviewed the I&As and progress notes for other residents who have fallen in the past 30 days to validate a thorough investigation of the falls have been completed to include potential medical causes, implementation of a plan to prevent further occurrences, and following the facility's policy and procedure for each incident.</p> <p>Facility Systems Administrator and DNS have been educated by clinical resource RN on thorough/timely investigation process for I&As and fall management policy and procedure. Nursing staff and IDT have been educated on the investigation process for managing I & As. Re-education was provided by DNS to include but not limited to proper</p>		

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F 610	<p>Continued From page 11</p> <p>documented Resident #10 was cognitively intact and required supervision while walking in her room or the corridor. The MDS assessment documented Resident #10 required extensive assistance of one staff member with bed mobility, transfers, toileting, and locomotion on and off the unit. The MDS documented Resident #10 experienced one fall without injury since the prior assessment.</p> <p>Resident #10's Fall Risk Assessments, dated 11/16/18 and 12/3/18, documented she was at high risk for falls.</p> <p>Resident #10's clinical record documented she experienced seven falls between 11/11/18 and 12/4/18.</p> <p>Resident #10's clinical record documented she experienced a fall on 11/11/18 on a Post Fall Investigation report, dated 11/29/18. There was no I&A report related to this fall.</p> <p>Resident #10's clinical record documented she experienced a fall on 11/14/18 in a Progress Note, dated 11/16/18 at 2:55 AM and on a Post Fall Investigation report, dated 11/19/18. There was no I&A report related to this fall.</p> <p>A Progress Note, dated 12/4/18 at 11:35 PM, documented during Residents #10's HS medication pass she was assisted to the bathroom and had to be lowered to the floor. The Progress Note documented she had lower leg weakness and she was assessed following the assisted fall. Resident #10's vitals where WNL except for her BG which was 53. Resident #10's clinical record did not contain an I&A regarding</p>	F 610	<p>assessment and investigation into falls, appropriate and timely interventions, facility's policy and procedure on fall management and accurate documentation.</p> <p>The system is amended to include oversight by the DNS in clinical meeting with review of progress notes for documented falls and verification that an incident and accident report was initiated, along with a thorough/timely investigation.</p> <p>Monitor Executive Director and/or designee will audit residents progress notes twice weekly to validate a thorough incident and accident report was completed until no deficiency is identified.</p> <p>Starting the week of January 6, 2018, the review will be documented on the audit tool. Any concerns will be addressed immediately and discussed with the IDT. The QAPI committee may adjust the frequency of the monitoring after 12 weeks, as it deems appropriate.</p>		

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F 610	Continued From page 12 the details about the fall to include the location of the fall, and if she hit her head while assisted to the floor. On 12/14/18 at 10:55 AM, the DNS with the Administrator present, stated when a resident fell the staff was to complete an incident report. The DNS defined a fall as any unplanned change in elevation. The DNS stated she would look into if there were I&As completed for the two possible falls on 11/11/18 and 11/14/18 and the staff assisted fall on 12/4/18. The facility failed to complete a thorough investigation of the falls; including potential medical causes, implement a plan to prevent further occurrences, and following the facility's policy and procedure for each event.	F 610			
{F 684} SS=G	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, record review, and policy review, it was determined the facility failed to ensure professional standards of practice were followed for 2 of 3 residents (#10 and #143) who were reviewed for standards of practice. Resident #10 was harmed when she	{F 684}	F684 <input type="checkbox"/> Quality of Care Resident Specific The IDT reviewed resident #10 current medications, medical condition, and blood sugars for proper BG monitoring and	1/22/19	

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{F 684}	<p>Continued From page 13</p> <p>experienced a cognitive decline following multiple unwitnessed falls with incomplete neurological assessments, and multiple low BG levels where the BG management protocol was not followed. Resident #10 also had the potential for harm when the facility failed to monitor orthostatic blood pressures as ordered. Resident #143 had the potential for harm when neurological assessments were incomplete following unwitnessed falls. These failed practices had the potential to adversely affect or harm other residents whose care and services were not delivered according to accepted standards of clinical practices. Findings include:</p> <p>1. Resident #10 was readmitted to the facility on 1/8/18, with diagnoses which included repeat falls, Parkinson's disease, muscle weakness, schizophrenia, diabetes, and major depression single episode.</p> <p>A quarterly MDS assessment, dated 10/18/18, documented Resident #10 was cognitively intact and required supervision while walking in her room or the corridor. The MDS assessment documented Resident #10 required extensive assistance of one staff member with bed mobility, transfers, toileting, and locomotion on and off the unit. The MDS documented Resident #10 experienced one fall without injury since the prior assessment.</p> <p>a. Resident #10's cognition decreased following multiple unwitnessed falls with inconsistently completed or incomplete neurological assessments and episodes of hypoglycemia. Examples include:</p>	{F 684}	<p>management per the facility's protocol, adjustments have been made as indicated. Neurological assessment has been completed with no adverse concerns identified. Orthostatic blood pressures orders have been clarified with the attending physician, adjustments have been made per MD order.</p> <p>The IDT reviewed resident #143 Neurological assessment with no adverse concerns identified.</p> <p>Other Residents Clinical management team reviewed diabetic residents for proper BG monitoring and management per the facility's protocol, physician notification and adjustments have been made as indicated.</p> <p>Residents with a fall since January 1st have been reviewed for thorough neurological assessment. The physician(s) has been updated as indicated. No adverse resident outcomes were identified.</p> <p>Facility Systems The nursing staff have been educated on professional standards post fall, diabetic management, post fall investigation, facility's fall management protocol and order clarifications. Re-education was provided by Director of Clinical Operations, DNS and/or designee to include but not limited to, blood sugar monitoring, hypoglycemia management</p>		

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{F 684}	<p>Continued From page 14</p> <p>A Mental Health Progress Note, dated 10/2/18, documented Resident #10's thought process was intact, and her associations were logical. The note documented she had normal thought content and no hallucinations. The note documented she was oriented to situation, place, and person and her memory was intact.</p> <p>Resident #10's Fall Risk Assessments, dated 11/16/18 and 12/3/18, documented she was at high risk for falls.</p> <p>The facility's Neurological Evaluation policy and procedure, dated 11/28/17, documented neurological assessments were routine measurements when a resident was suspected of or hit their head. The policy documented the physician's order dictated the frequency of the neurological assessments. The policy documented the staff verified with the physician for the frequency of the assessments and if the physician did not specify a time frame, the staff should assess residents every 15 minutes for an hour, every 30 minutes for an hour, every hour for two hours, and every 4 hours for 72 hours, unless the physician specified otherwise. The policy documented staff should wake a resident up to their fullest and highest functioning level and assess their BP, temperature, pulse, respiration, pupil response, their level of consciousness, eye movement, and motor function response.</p> <p>The care plan area addressing Resident #10's risk for falls, revised 8/28/18, documented she had a cognitive impairment, a history of falls, impaired balance, Parkinson's disease, and the use of psychotropic medications.</p>	{F 684}	<p>and documentation, review and monitoring of other medical causes post fall, physician notification per facility protocol, fall investigation packet completion, and updated facility neurological assessment policy, and process for post fall neuro assessment completion.</p> <p>The system is amended to include IDT review in clinical meeting for completion and documentation of neurological assessment, fall investigation packet with review of medical causes, physician notification and timely engagement as indicated, and completion of BG monitoring and management.</p> <p>Monitor The Director of Nursing and/or designee will audit diabetic residents post fall for medical cause review/assessment to include but not limited to BG monitoring and management for diabetic residents, neurological assessment completion, and orthostatic blood pressures until no deficiency is identified.</p> <p>Starting the week of January 6, 2018, the review will be documented on the audit tool. Any concerns will be addressed and discussed with the IDT Team. The QAPI committee may adjust the frequency of the monitoring after 12 weeks, as it deems appropriate</p>		

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{F 684}	Continued From page 15 Resident #10's clinical record documented she experienced six falls, between 11/11/18 and 11/29/18. For those falls, the neurological assessments were not completed and/or were not consistently completed per the facility's policy. Examples include: i. Resident #10's clinical record documented she experienced an unwitnessed fall on 11/11/18 on a Post Fall Investigation report, dated 11/29/18. The neurological assessments were not completed for the 11/11/18 unwitnessed fall. ii. An I&A Report, dated 11/12/18 at 7:40 PM, documented Resident #10 experienced an unwitnessed fall in her room tripping over her front wheeled walker legs. The report documented Resident #10 stood up and she was unsteady on her feet and fell down, Resident #10 stated she felt "stupid" for falling. The I&A documented neurological assessments were initiated, but not completed per facility policy. The 11/12/18, neurological assessments included 13 entries which followed a timeline of every 15 minutes for one hour, every hour for four hours, and every four hours for 19 hours during the assessment period. This was not consistent with the facility's policy to assess residents every 15 minutes for an hour, every 30 minutes for an hour, every hour for two hours, and every 4 hours for 72 hours. iii. An I&A Report, dated 11/13/18 at 11:50 PM, documented Resident #10 experienced an unwitnessed fall from bed. She was found kneeling next to her bed and denied hitting her	{F 684}			

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{F 684}	<p>Continued From page 16</p> <p>head. The I&A documented she was able to remember her full name and date of birth but was unable to remember her location. The I&A documented she was attempting to go to the bathroom and she got dizzy and fell to the floor. The I&A documented neurological assessments were initiated but were not completed per facility policy.</p> <p>The 11/13/18, neurological assessments included 13 entries which followed a timeline of every 15 minutes for one hour, every hour for four hours, and every four hours for 19 hours during the assessment period. This was not consistent with the facility's policy to assess residents every 15 minutes for an hour, every 30 minutes for an hour, every hour for two hours, and every 4 hours for 72 hours.</p> <p>iv. Resident #10's clinical record documented she experienced a fall on 11/14/18 in a Progress Note, dated 11/16/18 at 2:55 AM and on a Post Fall Investigation report, dated 11/19/18. Resident #10's clinical record did not contain a progress note or I&A containing details about the fall on 11/14/18, to include the location of the fall, if she hit her head, or if it was unwitnessed. Neurological assessments were not initiated or performed.</p> <p>v. An I&A Report, dated 11/19/18 at 10:20 AM, documented Resident #10 experienced an unwitnessed fall from her chair in her room. She was found lying on her stomach with her head on her arms. The I&A documented Resident #10 was trying to "find her apartment" and fell out of her chair. The I&A documented neurological assessments were initiated, but were not</p>	{F 684}			

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{F 684}	<p>Continued From page 17 completed per facility policy.</p> <p>The 11/19/18 neurological assessment included 27 entries which were not completed. The neurological assessments were initiated on 11/19/18 at 10:20 AM. They were then assessed at 10:35 AM, 11:00 AM (25 minutes between), 11:15 AM, 11:45 AM, 12:15 PM, 12:45 PM, 4:45 PM, 8:45 PM. On 11/20/18 at 12:45 AM and 4:45 AM, then assessed again beginning on 11/21/18 at 8:45 AM, a gap of 28 hours. The neurological assessments were not completed according to the facility's policy. Resident #10's overall cognition declined.</p> <p>A Progress Note, dated 11/20/18 at 5:20 AM, documented Resident #10 was confused and was yelling out "help me." The progress note documented she had weakness and needed verbal reminders to use her walker, and her gait was unsteady. The note documented she complained of pain to the back left-side of her head from when she fell. The note documented Resident #10 verbalized she was having "trouble saying," what she wanted to "say," and she had slow thought processes. Resident #10 complained of head pain on 11/20/18, and neurological assessments were not completed for another 28 hours after she complained of the head pain.</p> <p>The Progress Notes, dated 11/21/18 at 3:00 AM, 10:40 AM, and 9:52 PM, documented Resident #10 was alert to herself with confusion and she was having increased confusion over the past week, and difficulty expressing her words. One of the notes documented she was afraid of her call light and was asking where the "small boy" was.</p>	{F 684}			

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{F 684}	Continued From page 18 A Progress Note, dated 11/22/18, documented Resident #10 was alert to herself with confusion. A Progress Note, dated 11/23/18, documented Resident #10 was alert to herself with confusion. The note documented she called out several times and when staff asked her what she needed, she had a hard time saying what she needed. A Progress Note, dated 11/27/18 at 6:59 AM, documented Resident #10 frequently called out. The note documented she was more confused over the past few weeks resulting in falls. The note documented her mental health provider noticed an overall decline in Resident #10 and she required more time to complete sentences and experienced increased difficulty in completing sentences. vi. An I&A Report, dated 11/29/18 at 1:42 PM, documented Resident #10 experienced an unwitnessed fall from her chair in her room. She was found sitting on the floor with her back against her room chair and her walker was directly to her left. The I&A documented Resident #10 stated she was attempting to go to bed without the use of her walker, and she did not hit her head. The I&A documented neurological assessments were initiated for 72 hours. Neurological assessments were not initiated for an unwitnessed fall. A Progress Note, dated 12/3/18, documented Resident #10 was confused and stated she did not want a snack because she was "late" for her "airplane."	{F 684}			

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

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{F 684}	Continued From page 19 A Progress Note, dated 12/5/18, documented Resident #10 was making inconsistent statements to staff and had a cognitive decline over the past two weeks. The note documented Resident #10 was "not herself," and experienced periods of restlessness where staff was unable to redirected her and / or she was sleeping more. On 12/14/18 at 8:48 AM, RN #1 stated neurological assessments should be completed every 15 minutes for one hour, every 30 minutes for two hours, every hour for four hours, and every four hours for 16 hours. This was not consistent with the facility policy. On 12/14/18 at 9:08 AM, RN #2 stated she was unsure how long to initiate neurological assessments, however the form the facility used would provide the nurses the information. RN #2 obtained a Neurological assessment and stated neurological assessments should be completed for every 15 minutes for one hour, every hour for four hours, and every four hours for 19 hours. This was not consistent with the facility policy. On 12/14/18 at 10:55 AM, the DNS with the Administrator present, stated when a resident fell the staff was to complete an incident report and initiate neurological assessments if the fall was unwitnessed, if the resident hit their head or suspected of head injury. The DNS stated the neurological assessments should be completed per policy and stated the neurological assessments provided the nursing staff with the timeline to use of every 15 minutes for one hour, every hour for four hours, and every four hours for 19 hours. This was not consistent with the	{F 684}			

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{F 684}	<p>Continued From page 20 facility policy.</p> <p>The DNS defined a fall as any unplanned change in elevation. The DNS stated she would look for neurological assessments for the two possible falls on 11/11/18 and 11/14/18 and the fall on 11/29/18. The DNS stated she was unsure why the neurological assessment entries for the 11/19/18 fall were inconsistently completed. The DNS stated the staff should be completing the assessments per policy.</p> <p>The DNS stated when Resident #10 complained of head pain on 11/20/18 and had slow thought processes, the staff should have notified the physician and restarted neurological assessments from the beginning.</p> <p>Resident #10 was harmed when the facility failed to assess, recognize, and act when she had a change in her level of consciousness and cognition and a change in her physical abilities after multiple unwitnessed falls.</p> <p>b. Resident #10's diabetes management was not consistent with standards of practice and the facility policy.</p> <p>According to the American Diabetes Association, Standards of Medical Care in Diabetes - 2016, from the Diabetes Care Journal, Volume 39 Supplement 1, BG levels in the elderly who were very complex with end stage chronic illnesses and poor health should be 100-180 mg/dl before meals. The journal documented older adults with diabetes in a long-term care (LTC) facilities were at higher risk of experiencing hypoglycemic episodes, and providers should be called</p>	{F 684}			

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{F 684}	<p>Continued From page 21</p> <p>immediately in case of hypoglycemic episodes or when BG levels were less than 70 mg/dl.</p> <p>A position statement from the American Diabetes Association documented LTC facilities should increase the frequency of glucose monitoring, call the practitioner, and monitoring frequency should be based on complexity of residents and their risk for hypoglycemia. (Munshi, M. N., Florez, H., Huang, E. S., et al. "Management of Diabetes in Long-term Care and Skilled Nursing Facilities: A Position Statement of the American Diabetes Association." Diabetes Care, vol. 39, Feb. 2016, pp. 308-318.)</p> <p>The facility's Diabetes policy, dated 10/31/17, documented staff were to notify the physician of BG levels below or above the established range. The policy defined hypoglycemia as BG below 70 mg/dl. The policy documented staff were to prevent hyper/hypoglycemia and recognize, treat, or prevent complications associated with diabetes.</p> <p>Resident #10 experienced multiple hypoglycemic episodes without interventions provided and/or timely physician notification. Examples include:</p> <p>The care plan area addressing Resident #10's diabetes, revised 6/4/18, documented goals to include; she would be free of signs and symptoms of hyperglycemia. The care plan directed the staff to assess Resident #10's fasting BG level as ordered by the physician. The care plan documented staff were to monitor, document, and report signs and symptoms of hypoglycemia to the physician and provide her insulin per orders.</p>	{F 684}			

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{F 684}	<p>Continued From page 22</p> <p>Resident #10's December 2018 recapitulated Physician's Orders included the following:</p> <ul style="list-style-type: none"> - Monitor BGs twice daily and notify the physician if BG was less than 60 or greater than 500 mg/dl, ordered 6/14/18. - Novolog (Insulin Aspart) 12 units subcutaneously at lunch and dinner for diabetes, ordered 6/14/18. - Hypoglycemia Protocol: follow the 15/15 rule of 15 grams of carbohydrates when the BG is below 70 mg/dl and recheck the BG in 15 minutes, ordered 7/25/18. - Tresiba (Insulin Degludec) 50 units subcutaneously in the morning for diabetes, ordered 7/25/18 and discontinued 12/4/18. - Tresiba (Insulin Degludec) 45 units subcutaneously at bedtime for diabetes, ordered 7/25/18, and discontinued 12/4/18. - Tresiba (Insulin Degludec) 45 units subcutaneously in the morning for diabetes, ordered 12/4/18. - Tresiba (Insulin Degludec) 40 units subcutaneously at bedtime for diabetes, ordered 12/4/18. <p>Resident #10's insulin orders and MAR did not provide direction for staff if her BG was below a certain level her insulin should be held.</p> <p>Resident #10's 11/1/18 through 12/13/18 MAR, documented staff were to monitor her BG two times a day, notify the physician when her BG was less than 60 or greater than 500 mg/dl, and implement the hypoglycemia protocol when BG results were less than 70 mg/dl.</p>	{F 684}			

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{F 684}	<p>Continued From page 23</p> <p>Resident #10 had BG results of less than 70 mg/dl, and she was given insulin when there were physician instructions to implement the hypoglycemic protocol, on the following days:</p> <ul style="list-style-type: none"> - 11/4/18: 68 mg/dl in the morning - 11/9/18: 63 mg/dl in the morning - 11/11/18: 64 mg/dl in the morning - 11/12/18: 67 mg/dl in the morning - 11/20/18: 68 mg/dl in the morning - 11/28/18: 66 mg/dl in the morning - 12/1/18: 64 mg/dl in the morning <p>Resident #10's 11/1/18 through 12/13/18 MAR, documented her Novolog and Tresiba were administered as ordered and not held when she experienced low BG on 11/4/18, 11/6/18, 11/9/18, 11/11/18, 11/12/18, 11/20/18, 11/28/18, 11/29/18, 11/30/18, 12/1/18, 12/2/18, and 12/4/18.</p> <p>Resident #10's 11/1/18 through 12/13/18 Nurse's Progress Notes documented the hypoglycemia protocol was not followed as ordered. Examples include:</p> <ul style="list-style-type: none"> - 11/29/18: MAR documented a BG of 59 mg/dl in the morning, and the Nursing Progress Note documented she was provided 4 ounces of carbohydrates and her BG was rechecked in 30 minutes. The protocol documented staff should re-evaluate the BG in 15 minutes. - 12/2/18: MAR documented a BG of 55 mg/dl in the morning, and the Nursing Progress Note documented she was provided 4 ounces ensure a and her BG was rechecked in 30 minutes. The protocol documented staff should re-evaluate the BG in 15 minutes. It was unclear in the progress 	{F 684}			

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{F 684}	<p>Continued From page 24 note if the physician was notified.</p> <p>On 12/14/18 at 11:30 AM, the DNS stated the facility staff were to notify the physician of abnormal BG levels per parameters identified by the physician. The DNS stated when a resident experiencing a hypoglycemic episode, staff re-evaluated the BG 15 minutes after administering 15 grams of carbohydrates and that this process would be repeated until the BG level reached 70 mg/dl or greater. The DNS stated she would look into Resident #10's low BGs and try and find notifications to the physicians and / or evidence of the hypoglycemia protocol initiated.</p> <p>The facility failed to implement clinical standards of practice of holding insulin, following facility procedure of hypoglycemia and notify the physician when and why the insulin was held.</p> <p>c. Resident #10's physician ordered orthostatic BP to be assessed. Orthostatic blood pressures are taken when the resident is laying down, sitting up, and then standing to evaluate for any significant changes. The facility failed to clarify and implement physician orders. Examples include:</p> <p>A Change of Condition MRR Report, dated 11/23/18, documented 3 of Resident #10's medications were reviewed, Latuda, Clonazepam, and Sinemet. The report documented these medications increased a residents' fall risk and could cause potential hypotension (low blood pressure). The pharmacist recommended orthostatic BPs be obtained "periodically."</p>	{F 684}			

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{F 684}	Continued From page 25 The physician responded to the recommendation on 11/26/18, with an order for orthostatic BP and pulse with laying, sitting, and standing. The order did not include the frequency for monitoring of orthostatic BP and pulse. A notification to the physician, dated 11/27/18, documented the staff obtain Resident #10's orthostatic BP and pulse on 11/27/18. Resident #10's 12/1/18 through 12/13/18 physician orders did not include orthostatic BP and pulse. The order was not transcribed or clarified for 18 days, as of 12/14/18. Resident #10's vital sign report for 11/1/18 through 12/14/18, documented her BP and pulse were not consistently monitored following the 11/26/18 order. Resident #10's BP and pulse were monitored once on 11/26/18, 11/30/18, 12/1/18, 12/3/18, and 12/9/18, and twice on 12/2/18 and 12/4/18. The vital sign report did not identify if she was laying, sitting, or standing when her BP and pulse were obtained 7 out of 18 opportunities. On 12/14/18 at 11:30 AM, the DNS stated the staff should have clarified the order. 2. Resident #143 was admitted to the facility on 12/5/18, with diagnoses of myocardial infarction (MI), cardiac arrest resulting in anoxic brain damage and expressive aphasia (difficulty speaking). Resident #143's 12/11/18 admission MDS assessment documented the resident was	{F 684}			

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{F 684}	<p>Continued From page 26</p> <p>moderately impaired for daily decision making, related to the anoxic brain injury.</p> <p>a. An Incident Report, dated 12/6/18 at 4:09 AM, documented Resident #143 had an unwitnessed fall, fall #1, and a nurse found him on the floor between his bed and the window.</p> <p>A Nurse's Progress Note, dated 12/6/18 at 4:24 AM, documented neurological checks with vital signs were initiated per facility protocol.</p> <p>The Neurological Assessment Flow Sheet for fall #1, dated 12/6/18 at 4:45 PM, documented Resident #143 was at a care conference. The Nurse's Progress Note documented the nurse was unable to do vital signs for the neurological assessment as he was at a care conference with family and would resume when the care conference was over.</p> <p>b. An Incident Report, dated 12/6/18 at 4:00 PM, documented Resident #143 had a second unwitnessed fall, fall #2. The incident report documented he was observed sitting in the doorway of a room by social service personnel. He was unable to describe how the event occurred.</p> <p>A Nurse's Progress Note, dated 12/6/18 at 4:00 PM, documented Resident #143 was placed on vital signs and neurological assessments per protocol. After fall #2 he was participating in a care conference with family.</p> <p>The Neurological Assessment Flow Sheet for the second fall, on 12/6/18 at 4:00 PM, did not document Resident #143's level of</p>	{F 684}			

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{F 684}	<p>Continued From page 27</p> <p>consciousness, pupil response, motor functions, pain response or have the nurse's signature. The Neurological Assessment Flow Sheet for the fall #2, documented on 12/6/18 at 4:15 PM and 4:30 PM (the second and third 15-minute checks) that he was at a care conference. The nurse's progress note dated 12/6/18 at 4:45 PM, documented the nurse was unable to do vital signs for the neurological assessment (fall #1) as he was at a care conference with family and would resume when the care conference was over.</p> <p>c. An Incident Report, dated 12/6/18 at 5:25 PM, documented Resident #143 had a third unwitnessed fall, fall #3, and was found by a CNA on the floor of his bathroom and had hit his head. The nurse noted an abrasion with slight edema on the front right area of his head.</p> <p>The Neurological Assessment Flow Sheet for fall #3, documented on 12/7/18 at 2:30 AM, a check and subsequent checks after, were marked out and not completed. The flowsheet documented, "... see #4 ..."</p> <p>No documentation could be found to indicate why there were no neurological assessments from 2:30 AM until the resident had a fourth unwitnessed fall on 12/7/18 at 7:15 AM.</p> <p>d. An Incident Report, dated 12/7/18 at 7:15 AM, documented Resident #143 had a fourth unwitnessed fall and was found lying on the floor beside his bed and neurological checks were started.</p> <p>Resident #143's Neurological Assessment Flow</p>	{F 684}			

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

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{F 684}	<p>Continued From page 28</p> <p>Sheet for fall #4, documented on 12/7/18 at 7:15 AM the first hour of 15-minute checks were completed and an assessment was completed at 8:30 AM and 9:00 AM and then completed hourly until 2:00 PM and subsequent checks after, were marked out and not completed.</p> <p>e. An Incident Report, dated 12/8/18 at 3:15 PM, documented Resident #143 had a fifth unwitnessed fall in the common area near the second nurse's station and neurological checks were started.</p> <p>Resident #143's Neurological Assessment Flow Sheet for fall #5, documented at the 8:30 PM assessment no vital signs were documented. At 4:30 AM on 12/9/18, the nurse documented he was sleeping soundly and neurological checks were not completed. There were no assessments completed at 12:30 AM, 8:30 AM, and 12:30 PM, on 12/9/18. His Nurse's Progress Note, dated 12/9/18 at 4:30 AM, documented neurological checks were held at that time because he was asleep.</p> <p>f. An Incident Report, dated 12/9/18 at 5:00 PM, documented Resident #143 had a sixth unwitnessed fall and had stood up and did not hit his head.</p> <p>A Nurse's Progress Note, dated 12/9/18 at 11:22 PM, documented Resident #143 had an unwitnessed fall at 5:00 PM near the back nursing station. A bruise and redness were noted at his gluteal cleft, he denied hitting his head, and neurological checks were started.</p> <p>Resident #143's Neurological Assessment Flow</p>	{F 684}			

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{F 684}	Continued From page 29 Sheet for fall #6, documented the first assessment was started at 7:00 PM, and no documentation was found in his Nurse's Progress Notes that indicated a rationale for the delay in beginning the neurological assessments. At the 7:45 PM, 8:45 PM, and 9:45 PM assessments, no vital signs were documented. No assessments were completed on 12/10/18 at 3:45 PM or 7:45 PM. No additional documentation could be found in his Nurse's Progress Note that indicated a rationale for the missing neurological assessments.	{F 684}			
{F 689} SS=G	On 12/14/18 at 10:45 AM, the DNS said she would look into the situation. Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2) Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on staff interview, policy review, and record review, it was determined the facility failed to provide adequate supervision to meet residents' needs. This was true for 2 of 3 residents (#10 and #144) reviewed for supervision and accidents. Resident #10 was harmed when she fell and suffered a decline in level of consciousness/cognition when staff failed to implement interventions and provide adequate supervision. Resident #144 had the potential for	{F 689}	F689 <input type="checkbox"/> Free of Accident Hazards / Supervision / Devices Resident Specific Interdisciplinary Team (IDT) reviewed progress notes and I&A reports for resident #10 and 143 to validate falls have been reviewed, root cause identified, and fall interventions implemented are reflected in the care	1/22/19	

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{F 689}	<p>Continued From page 30</p> <p>harm when staff failed to follow care planned interventions to prevent falls. Findings include:</p> <p>The facility's Accidents and Supervision to Prevent Accidents policy, dated 11/28/17, documented a fall was defined as unintentionally coming to rest of the ground and/or floor.</p> <p>The facility's Fall Response and Management policy, dated 11/28/17, documented staff were to investigate the cause of the fall after the resident was stable. The policy documented staff were to document the fall in the resident's medical record and implement immediate interventions to prevent a repeat fall. The policy further stated if there was an unwitnessed fall or resident injury staff were to monitor neurological assessments. Staff were also to complete a post-fall investigation, an event report, revise the care plan as appropriate, and document the incident or injury in the resident's medical record.</p> <p>An undated Fall Incident Reports Protocol, documented the steps staff needed to complete after a resident fell. The steps were:</p> <ul style="list-style-type: none"> - Complete an I&A report - Complete a Post Fall Investigation Report - Document in the progress notes that the physician and the family were notified - Complete neurological assessments - Identify care plan changes that need implemented - Place the resident on alert charting - Order any treatments if needed <p>These policies and protocol were not followed.</p>	{F 689}	<p>plan. Increased supervision has been implemented as indicated.</p> <p>Other Residents IDT reviewed other residents who have fallen since December 1st for a thorough investigation of the falls, to include potential medical causes, implementation of a plan to prevent further occurrences, for appropriate incident and accident report documentation, and intervention implementation and adequate supervision. Adjustments have been made as indicated.</p> <p>Facility Systems Nursing staff and IDT have been educated on supervision to prevent falls, diabetic management, post fall evaluation, care plan interventions and implementation, and order clarifications. Re-education was provided by the Director of Clinical Operations, the DNS and/or designee to include but not limited to, thorough fall investigation packet fall response post each fall to include complete assessment of blood glucose levels, orthostatic blood pressure, oxygen saturations, neurological assessment and other medical factors that impact falls. Communication of the resident plan of care and updates through Point of Care for the line staff. Increased supervision is reviewed to include licensed nurses and IDT to validate interventions are implemented at the bedside.</p>		

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{F 689}	<p>Continued From page 31</p> <p>1. Resident #10 was readmitted to the facility on 1/8/18, with diagnoses which included repeat falls, Parkinson's disease, muscle weakness, schizophrenia, diabetes, and major depression single episode.</p> <p>A Mental Health Progress Note, dated 10/2/18, documented Resident #10's thought process was intact, and her associations were logical. The note documented she had normal thought content and no hallucinations. The note documented she was oriented to situation, place, and person and her memory was intact.</p> <p>A quarterly MDS assessment, dated 10/18/18, documented Resident #10 was cognitively intact and required supervision while walking in her room or the corridor. The MDS assessment documented Resident #10 required extensive assistance of one staff member with bed mobility, transfers, toileting, and locomotion on and off the unit. The MDS documented Resident #10 experienced one fall without injury since the prior assessment.</p> <p>The care plan area addressing Resident #10's risk for falls, revised 8/28/18, documented she had a cognitive impairment, a history of falls, impaired balance, Parkinson's disease, and the use of psychotropic medications. The care plan documented the following interventions:</p> <ul style="list-style-type: none"> - Resident #10 was to wear nonskid footwear, initiated 6/4/18. - Resident #10's medications were reviewed by the physician and the pharmacist, initiated 6/4/18. - Resident #10 was to be offered the use of the 	{F 689}	<p>The system is amended to include oversight by the Director of Nursing with review of completion of fall investigation packet, medical factors assessment, interventions that address root cause of fall, care plan updates, and supervision by IDT to validate fall prevention plan is consistently implemented at the bedside.</p> <p>Monitor The Administrator, Director of Nursing and/or designee will audit 3 residents two times weekly for implementation of post fall interventions, adequate supervision, proper BG monitoring and management, completion of neurological assessment and accurate documentation of falls in the residents' medical record until no deficiency is identified.</p> <p>Starting the week of January 6, 2018, the review will be documented on the audit tool until no deficiency is identified. Any concerns will be addressed immediately and discussed with the IDT Team. The QAPI committee may adjust the frequency of the monitoring after 12 weeks, as it deems appropriate.</p>		

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{F 689}	<p>Continued From page 32</p> <p>restroom before bed, initiated 10/8/18.</p> <ul style="list-style-type: none"> - Resident #10 liked to sleep with the light on, initiated 11/17/18. - Resident #10 was to have brightly colored signs as visual cues to remind her to ask for assistance with transfers, initiated 11/17/18. - Resident #10 used a front wheeled walker and the walker was to be placed close to her for easy access, revised 11/19/18. - Resident #10's bedroom door was to be left open unless she requested it closed for better visualization from the nurses' station, revised 11/21/18. <p>Resident #10's Fall Risk Assessments, dated 11/16/18 and 12/3/18, documented she was at high risk for falls.</p> <p>Resident #10's clinical record documented she experienced 7 falls between 11/11/18 and 12/4/18.</p> <p>The I&A Reports, Nursing Progress Notes, and Post Fall Investigation reports documented the following:</p> <ul style="list-style-type: none"> i. Resident #10's clinical record documented she experienced a fall on 11/11/18 on a Post Fall Investigation report, dated 11/29/18. Resident #10's clinical record did not contain a progress note, an I&A, a Post Fall Investigation report, care plan changes, neurological assessments, and /or alert charting, regarding the fall on 11/11/18 to include the location of the fall, if she hit her head, and if it was unwitnessed. Resident #10 also had a low BG level documented on her 11/11/18 MAR of 64 mg/dl in the morning. Resident #10's clinical record did not include 	{F 689}			

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{F 689}	<p>Continued From page 33</p> <p>documentation if her BG was low at the time of the fall or if staff re-assessed her BG after the fall.</p> <p>ii. An I&A Report, dated 11/12/18 at 7:40 PM, documented Resident #10 experienced an unwitnessed fall in her room tripping over the legs of her front wheeled walker. The I&A documented she hit her head on the floor. The I&A documented she did not have socks or shoes on her feet. The report documented Resident #10 stood up and she was unsteady on her feet and fell down, Resident #10 stated she felt "stupid" for falling. Resident #10's clinical record did not contain a Post Fall Investigation report, care plan changes, or completed neurological assessment per policy. Resident #10 also had a low BG level documented on her 11/12/18 MAR of 67 mg/dl in the morning. Resident #10's clinical record did not include documentation if her BG was low at the time of the fall or if staff re-assessed her BG after the fall. The facility did not follow up to this fall until 11/20/18, eight days after the fall, with the intervention of ensuring Resident #10 was wearing non-skid footwear. This intervention was already in place on the care plan on 6/4/18.</p> <p>iii. An I&A Report, dated 11/13/18 at 11:50 PM, documented Resident #10 experienced an unwitnessed fall from bed. She was found kneeling next to her bed and denied hitting her head. The I&A documented she had a 5cm by 3cm bruise on the pad of her left hand near her thumb. The I&A documented she was able to remember her full name and date of birth but was unable to remember her location. The I&A documented she was attempting to go to the bathroom and she got dizzy and fell to the floor.</p>	{F 689}			

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{F 689}	<p>Continued From page 34</p> <p>Resident #10's clinical record did not contain a Post Fall Investigation report, care plan changes, or completed neurological assessment per policy. The facility did not follow up to this fall until 11/20/18, seven days after the fall.</p> <p>iv. Resident #10's clinical record documented she experienced a fall on 11/14/18, in a Progress Note, dated 11/16/18 at 2:55 AM and on a Post Fall Investigation report, dated 11/19/18. Resident #10's clinical record did not contain a progress note, an I&A, a Post Fall Investigation report, care plan changes, neurological assessments, and /or alert charting, regarding the fall on 11/14/18 to include the location of the fall, if she hit her head, or if it was unwitnessed. Resident #10's clinical record did not include documentation if her BG was low at the time of the fall or if staff re-assessed her BG after the fall.</p> <p>v. An I&A Report, dated 11/19/18 at 10:20 AM, documented Resident #10 experienced an unwitnessed fall from her chair in her room. She was found lying on her stomach with her head on her arms. The I&A documented Resident #10 was trying to "find her apartment" and fell out of her chair. Resident #10's clinical record did not include documentation if her BG was low at the time of the fall or if staff re-assessed her BG after the fall.</p> <p>A Progress Note, dated 11/20/18 at 5:20 AM, documented Resident #10 was confused and was yelling out "help me." The progress note documented she had weakness and needed verbal reminders to use her walker, and her gait was unsteady. The note documented she</p>	{F 689}			

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{F 689}	<p>Continued From page 35</p> <p>complained of pain to the back left-side of her head from when she fell. The note documented Resident #10 verbalized she was having "trouble saying," what she wanted to "say," and she had slow thought processes. Resident #10 complained of head pain on 11/20/18, and neurological assessments were not completed for another 28 hours after she complained of the head pain. Resident #10's clinical record did not contain documentation the physician was notified about her change of condition with head pain and slow thought process.</p> <p>The Progress Notes, dated 11/21/18 at 3:00 AM, 10:40 AM and 9:52 PM, documented Resident #10 was alert to herself with confusion and she was having increased confusion over the past week and difficulty expressing her words. One of the notes documented she was afraid of her call light and was asking where the "small boy" was.</p> <p>A Progress Note, dated 11/22/18, documented Resident #10 was alert to herself with confusion.</p> <p>A Progress Note, dated 11/23/18, documented Resident #10 was alert to herself with confusion. The note documented she called out several times and when staff asked her what she needed, she had a "hard" time "saying" what she needed.</p> <p>A Progress Note, dated 11/27/18 at 6:59 AM, documented Resident #10 was frequently calling out. The note documented she was more confused over the past few weeks resulting in falls. The note documented her mental health provider noticed an overall decline in Resident #10's cognition. The note documented Resident</p>	{F 689}			

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{F 689}	<p>Continued From page 36</p> <p>#10 required more time to complete sentences and experienced an increased difficulty completing sentences.</p> <p>vi. An I&A Report, dated 11/29/18 at 1:42 PM, documented Resident #10 experienced an unwitnessed fall from her chair in her room. She was found sitting on the floor with her back against her chair and her walker was directly to her left. The I&A documented Resident #10 stated she was attempting to go to bed without the use of her walker, and she did not hit her head. Resident #10's clinical record did not contain care plan changes or a completed neurological assessment per policy. Resident #10 also had a low BG level documented on her 11/29/18 MAR of 59 mg/dl in the morning. Resident #10's clinical record did not include documentation if her BG was low at the time of the fall or if staff re-assessed her BG after the fall.</p> <p>A Progress Note, dated 12/3/18, documented Resident #10 was confused and stated she did not want a snack because she was "late" for her "airplane."</p> <p>vii. A Progress Note, dated 12/4/18 at 11:35 PM, documented during Residents #10's HS medication pass she was assisted to the bathroom and had to be lowered to the floor. The Progress Note documented she had lower leg weakness and she was assessed following the assisted fall. Resident #10's vitals where WNL except for her BG which was 53 mg/dl. Resident #10's clinical record did not contain an I&A, a Post Fall Investigation report, care plan changes, neurological assessments, and /or alert charting,</p>	{F 689}			

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{F 689}	<p>Continued From page 37 regarding the assisted fall on 12/4/18.</p> <p>On 12/14/18 at 8:48 AM, RN #1 defined a fall as any unplanned change in elevation. RN #1 stated when a resident fell, she would assess the resident for injuries, ROM, vital signs to included BP, pulse, respiration, and PERRLA (Pupils are equal, round, and reactive to light, and accommodation). RN #1 stated if the resident was diabetic she assessed their BG level. RN #1 stated when a resident fell the process staff completed, after assessing the resident, consisted of completing an I&A report, documenting in the progress notes the physician and the family were notified, complete neurological assessments if needed, identify care plan changes that needed to be implemented, and placing the resident on alert charting.</p> <p>On 12/14/18 at 9:08 AM, RN #2 defined a fall as any unplanned change in elevation. RN #2 stated when a resident fell, she would assess the resident for injuries, ROM, vital signs to included BP, pulse, respiration, and PERRLA. RN #2 stated if the resident was diabetic she assessed their BG level. RN #2 stated the facility had a fall protocol which outlined the process staff were to follow.</p> <p>On 12/14/18 at 10:55 AM, the DNS with the Administrator present, stated when a resident fell the staff should follow the policy and the fall protocol for all the steps they should complete. The DNS defined a fall as any unplanned change in elevation. The DNS stated she would look into if there were I&As completed for the two possible falls on 11/11/18 and 11/14/18 and the staff assisted fall on 12/4/18. The DNS stated when</p>	{F 689}			

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{F 689}	<p>Continued From page 38</p> <p>Resident #10 complained of head pain on 11/20/18, and had slow thought processes, the staff should have notified the physician and restarted neurological assessments from the beginning. The DNS stated she could not recall if Resident #10 was sent out of the facility for evaluation following her falls, and she would look into if Resident #10 did receive an evaluation such as a CT scan. The DNS stated she would look for the Post Fall Investigation reports missing for the falls on 11/11/18, 11/12/18, 11/13/18, 11/14/18, and 12/4/18. The DNS stated she would look into why care planned interventions were not followed.</p> <p>2. Resident #144 was admitted to the facility on 2/16/18 with multiple diagnoses, including repeated falls and dementia.</p> <p>Resident #144's current care plan, dated with the following interventions, directed staff to:</p> <ul style="list-style-type: none"> * 6/5/18-Wear non-skid footwear. * 6/22/18-Not to be left in activity room, dining room or bedroom unattended (Unless in bed). * 7/11/18-Stay with her or redirect her to common areas to be more visible by staff. * 11/6/18-Adjust bed in the lowest position. * 11/26/18-Be in line of sight of staff. <p>Resident #144's 8/26/18 quarterly MDS assessment documented she was moderately cognitively impaired, had two falls without major injury since admission, and required two-person extensive assistance for transfers.</p> <p>Resident #144's Fall Incident report, dated 10/20/18 at 1:35 PM, documented she had wandered in her wheelchair, was found on the</p>	{F 689}			

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{F 689}	<p>Continued From page 39</p> <p>floor in an unoccupied resident room in an unoccupied area of the facility, and she sustained a skin tear to her left elbow. The report included education to staff regarding her current care plan.</p> <p>Resident #144's Fall Incident report, dated 10/29/18 at 5:40 PM, documented she was found next to her wheelchair in an activity room under the activity table lying on her stomach and was uninjured. The report included education to staff regarding her care plan and the importance of staff supervision.</p> <p>Resident #144's Fall Assessments, dated 10/29/18 and 12/4/18, documented she was at risk for falls.</p> <p>Resident #144's Fall Incident report, dated 11/5/18 at 3:30 PM, documented she was found in her room sitting on the floor next to her bed without non-skid socks on and was uninjured. The report included the resident was assisted back to bed with non-skid socks and an intervention to have the bed in the lowest position.</p> <p>Resident #144's Fall Incident report, dated 11/20/18 at 6:35 PM, documented she was found next to her wheelchair in an activity room slightly under the activity table, no staff were present, and she sustained an abrasion to her right thigh. The report included that it was unclear how she ended up in the activity room without supervision and staff were educated regarding her care plan to not leave her alone in an activity room.</p> <p>Resident #144's physician's order, dated 11/21/18, directed staff to keep her in line of sight</p>	{F 689}			

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{F 689}	<p>Continued From page 40 and not to be left alone in the activity room or dining room.</p> <p>On 12/14/18 at 9:40 AM, 10:08 AM, and 11:45 AM Resident #144 was asleep in her low positioned bed with tube type socks on that did not have a non-skid surface on them.</p> <p>On 12/14/18 at 9:42 AM, RN #1 said Resident #144 would self-propel her wheelchair, wandered away from staff, and staff tried to keep eyes on her. RN #1 said the resident was supposed to wear gripper socks or other non-skid footwear all the time, except while in bed.</p> <p>On 12/14/18 at 10:02 AM and 11:40 AM, RN #2 said Resident #144 was not adequately supervised because she has been found out of line of sight of staff and was found alone on the floor in an activity room and in an empty room in the back hallway. RN #2 said according to Resident #144's care plan, she was supposed to wear gripper socks while in bed because she had fallen in the past while trying to get out of bed and slipped.</p> <p>On 12/14/18 at 10:05 AM, CNA #1 and CNA #2 both said they assisted Resident #144 back to bed after breakfast and did not know what her care plan said about gripping footwear. At 10:08 AM, CNA #1 and CNA #2 observed her tube type socks and said they did not have a grip type surface on them.</p> <p>On 12/14/18 at 10:15 AM, CNA #3 said Resident #144 did not wear gripper socks on while in bed. CNA #3 said she went without gripper socks about 20 percent of the time because her sock</p>	{F 689}			

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{F 689}	Continued From page 41 size was not always available in the facility. On 12/14/18 at 11:50 AM, the DNS said Resident #144 was a high fall risk and her care plan interventions were in place to help keep her safe. The DNS said on the 11/5/18 fall, the care plan was not followed and Resident #144 should have been wearing non-skid socks at that time. She said on the 11/20/18 fall, the care plan was not followed and Resident #144 should not have been left alone and unsupervised. The DNS said staff should know her care plan when working with her to make sure fall interventions were in place.	{F 689}			
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	F 758		1/22/19	

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F 758	<p>Continued From page 42</p> <p>drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs;</p> <p>§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</p> <p>§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.</p> <p>§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: Based on staff interview and record review, it was determined the facility failed to ensure an emergent MRR was completed as requested by the facility for a resident with increasing falls. This was true for 1 of 3 residents (Resident #10) who were reviewed for unnecessary medications. This created the potential for residents to experience adverse reactions from unnecessary psychotropic medications and increased falls. Findings include:</p>	F 758	<p>F758 <input type="checkbox"/> Free from Unnec Psychotropic Meds / PRN Use</p> <p>Resident Specific The pharmacist and attending physician have reviewed medication risks and benefits that impact potential falls, medication adjustments have been made as indicated for resident #10. IDT reviewed resident #10 behavioral care plans, target behaviors, and medication</p>		

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F 758	<p>Continued From page 43</p> <p>The facility's Unnecessary Medications and Psychotropic Drugs/ Antipsychotic Medication policy, dated 11/28/17, documented the pharmacist reviewed residents' medications monthly and in emergent situations. The policy was not followed.</p> <p>Resident #10 was readmitted to the facility on 1/8/18, with diagnoses which included repeat falls, Parkinson's disease, muscle weakness, schizophrenia, diabetes, and major depression single episode.</p> <p>A quarterly MDS assessment, dated 10/18/18, documented Resident #10 was cognitively intact and required supervision while walking in her room or the corridor. The MDS assessment documented Resident #10 required extensive assistance of one staff member with bed mobility, transfers, toileting, and locomotion on and off the unit.</p> <p>The care plan area addressing Resident #10's risk for falls, revised 8/28/18, documented she had a cognitive impairment, a history of falls, impaired balance, Parkinson's disease, and the use of psychotropic medications. The care plan documented Resident #10's medications were reviewed by the physician and the pharmacist, initiated 6/4/18.</p> <p>Resident #10's clinical record documented she experienced 7 falls between 11/11/18 and 12/4/18.</p> <p>Resident #10's 12/1/18 through 12/13/18 Active Physician orders, documented she received the following medications:</p>	F 758	<p>use for specific target behaviors that are harmful to the residents and/or others. It has been updated as indicated to include the physician directives for drug use, target behaviors that result in danger/distress to themselves or others, and person-centered behavioral interventions.</p> <p>Other Residents The pharmacist, attending physician, and IDT reviewed other residents with repeat falls for medication regimen plans, behavioral care plans, and target behaviors. Adjustments have been made as indicated.</p> <p>Facility Systems Licensed nurses, resident liaison (social services if licensed) is re-educated to the facility's Unnecessary Medications and Psychotropic Drugs/ Antipsychotic Medication policy, by the Director of Nursing and/or designee to include but not limited to, seeking emergent pharmacy review for residents with increasing falls, accurately reflecting the physicians rationale for medication use on the behavior monitor, validate medications are only used for behaviors when residents are a danger to themselves and/or others, care plans and monitors reflect consistent behaviors and interventions are person-centered.</p> <p>The system is amended to include oversight by the Director of Nursing with review in the clinical meeting for residents</p>		

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F 758	Continued From page 44 - Monitor BGs twice daily and notify the physician if BG was less than 60 or greater than 500 mg/dl, ordered 6/14/18. - Novolog (Insulin Aspart) 12 units subcutaneously at lunch and dinner for diabetes, ordered 6/14/18. - Buspar 15 mg by mouth three times a day for anxiety, ordered 7/25/18 - Clonazepam 0.25 mg by mouth at bedtime for anxiety, ordered 7/25/18 - Cymbalta 60 mg by mouth in the morning for depression, ordered 7/25/18 - Norco 5-325 mg tablet by mouth at bedtime for pain, ordered 7/25/18 - Lyrica 50 mg by mouth two times a day for neuralgia, ordered 7/25/18 - Hypoglycemia Protocol: follow the 15/15 rule of 15 grams of carbohydrates when the BG is below 70 mg/dl and recheck the BG in 15 minutes, ordered 7/25/18. - Latuda 80 mg by mouth one time a day for schizophrenia, ordered 7/25/18 and discontinued 12/4/18 - Latuda 40 mg by mouth one time a day for schizophrenia, ordered 12/4/18 - Tresiba (Insulin Degludec) 50 units subcutaneously in the morning for diabetes, ordered 7/25/18 and discontinued 12/4/18. - Tresiba (Insulin Degludec) 45 units subcutaneously at bedtime for diabetes, ordered 7/25/18, and discontinued 12/4/18. - Tresiba (Insulin Degludec) 45 units subcutaneously in the morning for diabetes, ordered 12/4/18. - Tresiba (Insulin Degludec) 40 units subcutaneously at bedtime for diabetes, ordered 12/4/18.	F 758	with increasing falls to include validation of complete emergent MMR pharmacy reviews, review of target behaviors that support resident is a danger to themselves and/or others, and care plans that are person-center with behavioral interventions. Monitor Director of Nursing and/or designee will audit residents with increasing falls for emergent MMR pharmacy reviews and coordinating target behavior monitoring with person-centered care plan until no deficiency is identified. Starting the week of January 6, 2018, the review will be documented on the audit tool. Any concerns will be addressed immediately and discussed with the IDT Team. The QAPI committee may adjust the frequency of the monitoring after 12 weeks, as it deems appropriate.		

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F 758	Continued From page 45 An I&A Report, dated 11/19/18 at 10:20 AM, documented Resident #10 experienced an unwitnessed fall from her chair in her room. She was found lying on her stomach with her head on her arms. The follow-up note, dated 11/20/18, documented nursing requested the pharmacist evaluate all of her medications. A Change of Condition MRR Report, dated 11/23/18, documented Resident #10 was experiencing a new onset of worsening falls, dizziness, and impaired coordination. The medication review was based on the current pharmacy records and a complete chart review "was not performed." The review documented three of Resident #10's medications were reviewed, Latuda, Clonazepam, and Sinemet. The report documented these medications increased a residents' fall risk and could cause potential hypotension (low blood pressure). The pharmacist documented Resident #10's Latuda and Clonazepam were for schizophrenia and a reduction had "potential" contraindications. The pharmacist did not include Resident #10's insulin, Cymbalta, Lyrica, Norco, and Buspar in the evaluation or the low BG levels she was experiencing. According to the Nursing 2018 Drug Handbook, Buspar side effects included dizziness, drowsiness, light-headedness, tremors, decreased concentration, and confusion. The handbook documented Cymbalta's side effects included dizziness, anxiety, lethargy, and hypoglycemia. The handbook documented Clonazepam's side effects included confusion, hallucinations, slurred speech, dizziness, and	F 758			

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F 758	<p>Continued From page 46</p> <p>abnormal coordination. The handbook documented Latuda's sides effects included dizziness, parkinsonism, and anxiety. The handbook documented Lyrica's side effects included dizziness, abnormal thinking, confusion, and hypoglycemia. The handbook documented Norco's side effects included dizziness, sedation, drowsiness, anxiety, hypoglycemia, hypoglycemic coma, and hypotension.</p> <p>On 12/14/18 at 11:25 AM, the DNS with the Administrator present, stated the Latuda, Cymbalta, Clonazepam, Lyrica, Norco, and Buspar could potentially increase a residents' fall risk and she would look into why the pharmacist did not complete a full chart review.</p> <p>Resident #10's behavior monitors were not specific for Resident #10 and did not inform staff of what Resident #10's behaviors were to monitor.</p> <p>A Mental Health Progress Note, dated 10/2/18, documented Resident #10's thought process was intact, and her associations were logical. The note documented she had normal thought content and no hallucinations. The note documented she was oriented to situation, place, and person and her memory was intact.</p> <p>Resident #10's 12/1/18 through 12/13/18 Active Physician orders, documented she received the following medications:</p> <ul style="list-style-type: none"> - Buspar 15 mg by mouth three times a day for anxiety, ordered 7/25/18 - Clonazepam 0.25 mg by mouth at bedtime for anxiety, ordered 7/25/18 	F 758			

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F 758	<p>Continued From page 47</p> <ul style="list-style-type: none"> - Cymbalta 60 mg by mouth in the morning for depression, ordered 7/25/18 - Latuda 40 mg by mouth one time a day for schizophrenia, ordered 12/4/18 <p>Resident #10's care plan did not include specific behaviors and did not identify or include depression.</p> <p>The care plan area addressing Resident #10's psychotropic medications, revised 8/28/18, documented she received Buspar for anxiety, Cymbalta for pain and depression, Clonazepam for anxiety, and Latuda for Schizophrenia related to her behavior management. The care plan documented an intervention to include the facility was to monitor Resident #10 for target behaviors of calling out to staff and not using her call light when staff pass by her room, falsely accusing staff of things, and perseverating on staff, revised 6/1/18. The care plan did not identify which medications the target behaviors were for and did not document she experienced hallucinations or delusions.</p> <p>Resident #10's care plan addressed cognition, dated 8/28/18, documented a goal of Resident #10 being free of hallucinations. The care plan documented staff would administer her medications as ordered.</p> <p>Resident #10's care plan did not identify if Resident #10's hallucinations and/or delusions were tactile (touch), visual, auditory, and/or olfactory (smell). Her care plan was not resident specific and did not document clearly how her hallucinations or delusions presented. The care plan did not document if her hallucinations or</p>	F 758			

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

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F 758	<p>Continued From page 48 delusions were harmful to her.</p> <p>Resident #10 did not have a care plan specific to her anxiety or depression. The facility did not identify how Resident #10's anxiety or depression presented.</p> <p>Resident #10's behavior monitors did not match the target behaviors identified in her care plan. Examples include:</p> <p>Resident #10's 11/1/18 through 12/13/18 ADL Flowsheets documented behaviors witnessed by CNA staff. The CNA staff documented different behaviors than identified on the care plan. The following behaviors were monitored by the CNAs.</p> <ul style="list-style-type: none"> - The flowsheets sheets directed staff to document Yes or No if Resident #10 experienced hallucinations. Resident #10 experienced hallucinations on 11/4/18, 11/12/18, 11/13/18, 11/16/18, 12/2/18, 12/4/18, and 12/10/18. - The flowsheets sheets directed staff to document Yes or No if Resident #10 experienced delusions. Resident #10 experienced delusions on 11/4/18, 11/8/18, 11/12/18, 11/13/18, 11/14/18, 11/16/18, 11/27/18, 11/29/18, 12/2/18, 12/3/18, 12/4/18, and 12/10/18. <p>The behavior monitors did not identify how her hallucinations or delusions presented or how they were harmful to her.</p> <p>The flowsheets directed staff to document when Resident #10 had repetitive negative statements and/or questions/noises, sought attention, repetitive physical movement, unrealistic fears,</p>	F 758			

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F 758	<p>Continued From page 49</p> <p>paranoid behavior/delusions, and/or restless pacing. The flowsheets documented the following:</p> <ul style="list-style-type: none"> - Repetitive negative statements on 11/30/18 - Repetitive questions/noises on 12/6/18 - Seeks attention 11/1/18, 11/5/18, 11/7/18, 11/9/18, 11/11/18, 11/16/18, 11/17/18, 11/22/18, 11/23/18, and 12/11/18 - Repetitive physical movement on 11/3/18 and 11/9/18 - Unrealistic fears on 11/3/18, 11/4/18, 11/5/18, 11/13/18, 11/14/18, 11/26/18, 11/27/18, and 11/10/18 - Paranoid behavior/delusions on 11/8/18, 11/16/18, and 12/2/18 <p>Resident #10's record did not identify how her anxiety presented.</p> <p>Resident #10's clinical record did not include a behavior monitor for depression.</p> <p>On 12/14/18 at 11:45 AM, the DNS with the Administrator present, stated the CNAs were monitoring Resident #10 for delusions, hallucinations, and anxiety. The DNS stated she would look for documentation on how Resident #10's delusions, hallucinations, and anxiety presented. The DNS stated she would look into where the target behaviors identified on the care plan were monitored.</p> <p>The CNAs and nursing staff were not monitoring Resident #10 for calling out to staff and not using her call light when staff pass by her room, falsely accusing staff of things, and perseverating on staff.</p>	F 758			