STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085010	A. BUILDING _____ B. WING _____	C 01/17/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 000	INITIAL COMMENTS An unannounced complaint survey was conducted at this facility from January 16, 2020 through January 17, 2020. The deficiencies contained in this report are based on observation, interviews, review of residents' clinical records and review of other facility and pharmacy documentation as indicated. The facility census the first day of the survey was one hundred and twenty two (122). The survey sample totaled eleven (11) plus six (6) additional residents sub-sampled for random observation of call bell access. Abbreviations/Definitions used in this report are as follows: ADL - Activities of Daily Living, such as dressing, hygiene, eating, toileting, bathing; Anti-psychotic - medication to treat psychosis (loss of contact/touch with reality) and other mental/emotional conditions; CNA - Certified Nurse's Aide; Cognitively Intact - able to make own decisions; Controlled drugs - medications with the potential for abuse that are federally regulated (e.g., drugs for pain, anxiety; sleep, etc.); DON - Director of Nursing; eMAR (Electronic Medication Administration Record) - computerized list of daily medications to be administered; Insomnia - inability to sleep; LPN - Licensed Practical Nurse; MDS (Minimum Data Set) - standardized assessment forms used in nursing homes; mg (milligrams) -unit of weight, 1 mg equals 0.0035 ounce; NHA - Nursing Home Administrator;	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		02/03/2020

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 000	Continued From page 1 NP - Nurse Practitioner; Pain Scale - rating of pain severity on a 0 to 10 scale with 0 meaning no pain and 10 meaning the worst pain; Post - after; RN - Registered Nurse; UM - Unit Manager.	F 000		
F 558 SS=E	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observation and interviews it was determined that for six (SS1, SS2; SS3, SS4, SS5 and SS6) randomly selected residents reviewed for call bell accessibility, the facility failed to ensure that the residents' call bells were readily accessible to summon the staff for assistance. Findings include: During random observations during the survey the following was observed: 1. 1/16/20 9:15 AM - During an observation in SS1's room, it was revealed that SS1 was lying in bed. SS1's call bell was high at the top of the side rail and lodged between the bed and wall so that the resident was not able to reach it. 2. 1/16/20 9:22 AM - During an observation and interview in SS2's room, it was revealed that SS2 was seated on the side of the bed facing the	F 558	A. SS1, SS2, SS3, SS4, SS5 and SS6 are positioned where resident can reach call bell. B. All clips attached to call bell cords to keep call bell cords accessible and call bells were within reach to resident 1/31/2020. C. A RCA was completed on 1/28/2020. As a result of the RCA, it was determined that several call bells did not have clips to secure the call bell cord from falling off the bed or away from the patient. Call bells were not always in reach when patient moved to another location. Education is being completed to all staff by the NPE/designee on policy NSG 101 Call Lights (Attachment 1) on or before 2/10/2020.	2/12/20

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F 558	Continued From page 2 door, in the middle of the bed. SS2's call bell was curled up on the night stand. Even though SS2 was seated on the side of the bed where the night stand was located, the call bell was out of his reach. The surveyor pointed to the call bell on the night stand and asked SS2 if he could use it. SS2 stated, "That's what I have been looking for this morning." SS2 reported that he did know how to use the call bell to call staff for help. SS2 took the call bell that the surveyor put in his reach. 3. 1/16/20 9:45 AM - During an observation and interview in SS3's room, it was revealed that SS3 was lying in bed. SS3's call bell was at the foot of the bed and out of SS3's reach. SS3 confirmed that the call bell was out of reach and had the surveyor hand it to her. 4. 1/16/20 10:05 AM - During an observation and interview in SS4's room, it was revealed that SS4 was lying in bed. SS4's call bell was tied to the side rail of the bed, high up over SS4's shoulder, positioned out of vision and reach. When the surveyor asked SS4 if she could reach her call bell, SS4 stated that she did not know where it was. 5. 1/16/20 2:45 PM - During an observation and interview, SS6 was awake in bed. When asked if she could reach and activate her call bell, SS6 stated, "No, I don't have it." The call bell was discovered on the floor on SS6's right side of the bed. 6. 1/17/20 2:29 PM - During an observation and interview in SS5's room, it was revealed that SS5 was lying in bed. SS5's call bell was on the floor between the bed and the wall. SS5 told the surveyor that she did not have her call bell. The	F 558	D. The CNE/designee will complete audits on 25% of resident population of call bells to ensure call bell is with in reach until 100% compliance is achieved on 3 consecutive reviews (attachment 2). Then weekly observation audits will be completed until 100% compliance is achieved on 3 consecutive reviews, and then monthly until 100% compliance is achieved on 3 consecutive reviews. Results of observation audits will be presented to the Quality Assurance Performance Improvement Committee for review and recommendations.	

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F 558	Continued From page 3 surveyor picked the call bell up off of the floor and handed it to SS5. SS5 immediately rang the bell for someone to get her up out of bed. The facility failed to ensure that resident call bells were readily accessible to summon staff for their needs. Findings were reviewed with E1 (NHA) and E2 (DON) during the exit conference on 1/1719 beginning at 3:40 PM.	F 558		
F 697 SS=D	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on record review, interview and review of other facility, hospital and pharmacy documentation it was determined that, for one (R1) out of three residents investigated for medication review, the facility failed to administer routine pain medication, failed to document a PRN pain medication on the eMAR and failed to ensure accuracy of the pain assessment after a dose of PRN pain medication. Findings include: A facility policy entitled Pain Management (last revised 11/1/19) included that the "care plan will be evaluated for effectiveness until satisfactory pain management is achieved. Contact the physician / APP (advanced prescribing practitioner) to report findings and obtain revised	F 697	A. R1 unable to correct the resident discharged on 1/10/2020 from the facility. B. New Admissions and Current residents on pain medications have the potential to be affected. New Admissions and Current residents on routine pain medications are receiving routine medications as ordered. New Admissions and Current residents who receive PRN pain medication are documented on eMAR. New Admission and Current residents with administered PRN pain medication have an accurate pain assessment completed.	2/12/20

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F 697	Continued From page 4 treatment orders, if indicated." Cross Refer F755 Review of R1's clinical record revealed: 12/24/19 - R1 was admitted to the facility after surgery for a broken thigh bone. 12/24/19 - Physicians' orders included pain medications: - Morphine extended release 30 mg and oxycodone 10 mg, both to be taken twice a day (same as R1 took at home). - Oxycodone 5 mg every 6 hours PRN for breakthrough pain. Undated - A facility pain rating form indicated that R1's acceptable level of pain was 5 out of 10. 12/26/19 - A care plan for pain was initiated related to the broken thigh bone. Interventions included "utilize pain scale ... medicate resident as ordered for pain and monitor for effectiveness and monitor for side effects, report to physician as indicated." December 2019 - Review of the eMAR, nursing notes and pain level documentation revealed: a. R1 did not receive routine pain medication from the facility between December 24 (9:00 PM) through December 26 (9:00 AM). On 12/24/19, R1's pain severity rating was 5 to 6 on evening and night shifts. The first routine pain medication was administered by the facility on 12/26/19 after the 12:45 PM delivery from the pharmacy. b. On 12/25/19, R1's pain severity was 7 to 8 on all three shifts and R1 received PRN oxycodone at 10:37 AM for a pain level of 7 (at 1:58 PM the	F 697	C. A Root Cause Analysis (RCA) was completed 1/28/2020. The RCA identified there was no system in place for escalation of notification to pharmacy if medication were not delivered for new residents or new orders. Nurses needed education on removal of medication from Omni cell until medications from pharmacy arrived to center. In addition, it was determined that nurses needed education on the policy NSG 113 Nursing documentation (attachment 3); NSG 227 Pain Management (attachment 4) and NSG 305 Medication Administration: General (attachment 5), escalation process: Escalation Protocol for Omnicare pharmacy (attachment 6) and 5 Step Medication Order Quick Reference Guide (attachment 7) , this process as well as list of medication in the Omni Cell is on each Medication Cart. Education on documentation of PRN pain medication and accuracy of pain assessment after dose of PRN pain medication given. The NPE or designee will complete education with licensed nurses on or before 2/10/2020 D. The Center Nurse Executive (CNE) or designee will complete daily audits on 100% of residents on routine pain medication, PRN pain medication are documented, and accuracy of pain assessment after dose of PRN pain medication is given until 100% compliance is achieved on 3 consecutive reviews (attachment 8) and (attachment 9), then weekly until 100% compliance is achieved on 3 consecutive reviews, then	

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F 697	Continued From page 5 pain level was 8 and by 3:54 PM R1's pain level was down to zero). R1 received PRN pain medication at 5:58 PM for pain level of 8 (at 6:51 PM the pain level was down to 2). The pharmacy form that indicated when each dose of PRN medication was authorized for release from the dispensing machine documented that three doses were released on 12/25/19. The third dose, released at 11:40 PM, was not reflected on the eMAR. A nursing note written by the night shift included that the pain level for this third dose started out as 10 and reduced to a level of 4. c. R1's pain rating on 12/26/19 was 10 on the day shift and R1 was given PRN oxycodone at 10:13 AM. The eMAR recorded the pain scale after the PRN medication as ineffective. However, R1's pain level was recorded as 4 in a nursing note with an effective date of 12/26/19 (7:26 AM). 1/17/20 (2:40 PM) - During an interview, E3 (RN, UM) confirmed that R1 did not receive her routine pain medications until 12/26/19. E3 added that a nurse informed E3 that R1 had taken pain medication from home without facility knowledge. There was no evidence of this in the clinical record. 1/17/20 (3:30 PM) - During an interview, E2 (DON) confirmed that R1's PRN pain medication (authorized to be released from the medication dispensing machine at 12/25/19 at 11:40 PM) was not included on the eMAR. Findings were reviewed with E1 (NHA) and E2 (DON) during the exit conference on 1/1719 beginning at 3:40 PM.	F 697	monthly until 100% compliance is achieved on 3 consecutive reviews. Results of audits will be presented to the QAPI Committee for review & recommendations.	
F 755	Pharmacy Srvcs/Procedures/Pharmacist/Records	F 755		2/12/20

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F 755 SS=D	Continued From page 6 CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on record review, interview and review of other documentation from the facility and the pharmacy providing medications to the facility, it was determined that the facility failed to ensure	F 755	A. R1 unable to correct, the resident discharged on 1/10/2020 from the facility. B. Current residents on routine or prn	

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F 755	Continued From page 7 routine medications were available for one (R1) out of three residents sampled for medication review. For R1, the facility failed to obtain and administer all routine medications for at least the first 35 hours at the facility. In addition a seizure medication was ordered with an incorrect dose. Findings include: Review of a facility policy entitled Controlled Drugs: Management of (last revised 11/1/19) included that the purpose of the policy was to "provide proper ordering, storage, disposal and security of controlled drugs." The automated medication dispensing system "may also house an emergency supply of controlled drugs. Nurses must follow federal and state regulations to access emergency supplies of controlled drugs." A review of a pharmacy policy entitled Physician / Prescriber Authorization and Communication of Orders to Pharmacy (last revised 10/31/16) documented that the "facility should reconcile transfer / transition and admission orders before they are communicated to Pharmacy." Review of R1's clinical record revealed: 12/24/19 - R1 was admitted to the facility for rehabilitation after a fall that broke R1's thigh bone above the hardware from a previous knee replacement. 12/24/19 (4:54 PM) - An admission nursing note documented that the medication list was "reconciled and verified with provider." R1's "high risk medications included antidepressant, antipsychotic and opioid pain management." 12/24/19 - Review of R1's hospital discharge	F 755	medications have the potential to be effected. Current residents routine medications available and administered as ordered; any medication not available proper procedure was followed: a change in the order, hold the order until available or remove from Omni Cell. C. A Root Cause Analysis (RCA) was completed 1/28/2020. The RCA identified there was no system in place for escalation of notification to pharmacy if medication were not delivered for new residents or new orders for routine or pain medications. Facility nurse management review all admissions and new order for accuracy of medications. It was identified that Nurses needed education on removal of medication from Omni cell until medications from pharmacy arrived to center. Nurses also needed education if medication is not in Omni Cell to begin escalation process. In addition, it was determined that nurses needed education on the policy NSG 113 Nursing documentation (attachment 3); NSG 227 Pain Management (attachment 4) and NSG 305 Medication Administration: General (attachment 5), escalation process: Escalation Protocol for Omnicare pharmacy (attachment 6) and 5 Step Medication Order Quick Reference Guide (attachment 7) this process as well as list of medication in the Omni Cell is on each Medication Cart. Education on documentation of PRN pain medication and accuracy of pain assessment after dose of PRN pain medication given. The NPE or designee will complete education	

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F 755	Continued From page 8 records and facility physicians' orders revealed ordered medications and times administered in the hospital on 12/24/19 on the day of discharge to the facility: - Eliquis (blood thinner) twice a day to prevent blood clots (9:34 AM). - Gabapentin three times a day for nerve pain (5:25 AM and 12:54 PM). - Lamotigrine twice a day to prevent seizures (8:14 AM). - Morphine extended release 30 mg twice a day for pain (11:24 AM). - Oxycodone 10 mg twice a day for pain (5:25 AM and 2:25 PM). - Oxycodone 5 mg every 6 hours PRN for pain (IV opioid PRN pain medication given at 9:40 AM). - Synthroid (thyroid medication) once a day (8:14 AM) - Topiramate 50 mg twice a day to prevent seizures (8:14 AM). - Lexapro (antidepressant) once a day (9:34 AM). - Wellbutrin (antidepressant) once a day (8:14 AM). Topiramate was initially ordered at the facility for 25 mg (an incorrect dose). December 2019 - Review of R1's eMAR and nursing notes revealed the following routine medications were not administered as ordered and not explained in the nursing notes: - Eliquis: December 24 (10:00 PM). - Gabapentin: December 24 (10:00 PM). Not signed off by nursing on December 25, 26 and 17 at 6:00 AM). - Lamotigrine: December 24 (9:00 PM) and 25 (9:00 AM and 9:00 PM). - Morphine extended release: December 24 (9:00 PM) and December 25 (9:00 AM and 9:00	F 755	with licensed nurses on or before 2/10/2020. It was also identified in RCA that communication with Pharmacy manager is needed, weekly calls with Pharmacy Manager and Management of Center to discuss improvement of processes. D. The Center Nurse Executive (CNE) or designee will complete daily audits on 100% of new admissions to ensure the process was followed to obtain and administer all routine medication including prn pain medication and dosing is transcribed correctly until 100% compliance is achieved on 3 consecutive reviews (attachment 16),(attachment 8),(attachment 9). The CNE or designee will then complete weekly audits until 100% compliance for 3 consecutive reviews, then monthly audits until 100% compliance for 3 consecutive reviews. Results of audits will be presented to the QAPI Committee for review & recommendations.	

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F 755	Continued From page 9	F 755		

PM).
- Oxycodone 10mg: December 24 (9:00 PM) and 25 (9:00 AM and 9:000 PM).
- Synthroid: December 25 and 26 (6:00 AM)...not signed off by nursing.
- Topiramate: December 24 (10:00 PM) and 25 (10:00 AM and 10:00 PM).

Review of a printout of medications available at the facility from the automatic medication dispensing machine revealed three of R1's routine medications (Morphine extended release, oxycodone and gabapentin) were available at a lower strength than prescribed.

1/17/20 (2:40 PM) - During an interview with E3 (RN, UM), to review the process for obtaining medications, including controlled medications, from the pharmacy, E3 acknowledged that R1's medications were not received from the pharmacy until 12/26/19. When asked if a local pharmacy was ever used to obtain medications needed prior to delivery, E3 responded that [name of facility corporate management company] does not do that. The interview revealed that in order to remove medications from the automatic medication dispensing machine a signed physicians' order is required using the strength available in the machine and for the number of pills needed to meet the resident's ordered dose. However, when the medication is a controlled medication (e.g., opioid pain medication) the provider must contact the pharmacy and indicate the quantity of drug (number of tablets) to be available for nursing to remove from the medication dispensing machine. Each time a medication would be dispensed from the machine, the nurse obtains an authorization number from the pharmacy to release the

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F 755	Continued From page 10	F 755		

medication from the medication dispensing machine. E3 explained that R1's family had brought in R1's pain medication from home without staff knowledge and R1 took her own medication. It was not clear how many doses of home medication R1 took at the facility. The surveyor explained that there was no evidence of taking medications from home in the clinical record. E3 stated she was informed by one of the nurses that R1 received medication from the facility after R1 had taken her own medication and received a double dose of morphine and oxycodone on 12/26/19, but E3 could not locate any evidence.

Findings were reviewed with E1 (NHA) and E2 (DON) on 1/17/20 beginning at 3:40 PM, during which it was revealed that the back up (local) pharmacy was closed on 12/25/19.

1/21/20 - Review of information e-mailed to the surveyor by the pharmacy, in response to specific questions, revealed that the facility had access to enough morphine and oxycodone to cover the evening dose on December 24, both doses on December 25 and the morning dose on December 26.
- On 12/24/19 (5:07 PM) the facility faxed the three pain medication prescriptions (morphine and oxycodone twice a day and the PRN oxycodone) to the pharmacy. The facility also sent the authorization forms to pull the drugs from the medication dispensing machine at 11:58 PM, however the routine medications were not written using the doses available (authorization forms must be written and signed by the provider with the medication strength in the dispensing machine in order to be released for use). There were no telephone calls to the pharmacy from the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 755	Continued From page 11 facility on 12/24/19 about R1. - On 12/25/19 the facility sent another authorization for the PRN oxycodone to the pharmacy and this was used to obtain four separate doses of PRN oxycodone between 12/25/19 (10:35 AM) through 12/26/19 (10:08 AM). - On 12/25/19 (7:10 PM, 7:12 PM and 8:04 PM) the facility faxed new prescriptions and authorization forms to the pharmacy with the doses available in the medication dispensing machine. The pharmacy could not locate in their recorded telephone conversations that the facility requested R1's routine pain medications STAT (as soon as possible) on this 12/25/19. - R1's routine pain medications were not delivered to the facility until 12/26/19 at 12:45 PM.	F 755		
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	F 758		2/12/20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085010	A. BUILDING _____ B. WING _____	C 01/17/2020

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F 758	Continued From page 12 in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §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 record review, interview and review of other facility documentation, it was determined that for two (R10 and R1) out of three residents investigated for medication review, the facility failed to document an adequate indication for antipsychotic medication use. For R10, the facility also failed to monitor for side effects. For R1, the facility also failed to ensure a PRN order for an antipsychotic was limited to 14 days.	F 758	A. R10 antipsychotic has been discontinued, R10 AIMS completed. R1 unable to correct resident discharged on 1/10/2020 from facility. B. Current resident on antipsychotic□s have the potential to be affected. Current residents on anti-psychotic□s medications were reviewed and have an adequate	

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F 758	Continued From page 13 Findings include: A pharmacy policy entitled Psychotropic Medication Use (last revised 11/28/16) defines psychotropic drug as "any medication that affects brain activities associated with mental processes and behavior." The procedure section included that the "facility should comply with the Psychopharmacologic Dosage Guidelines created by the Centers for Medicare and Medicaid Services ("CMS"), The State Operations Manual, and all other Applicable Law relating to the use of psychopharmacologic medications including gradual dose reductions...PRN orders for anti-psychotic drugs should be limited to 14 days and should not be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication." 1. A review of R10's clinical record revealed: 12/13/19 - R10 was admitted to the facility with an infected left hip repair surgical wound. 12/14/19 - A physician's order included: Seroquel (Quetiapine Fumarate - which was an anti-psychotic medication) 50 mg by mouth at bedtime for insomnia. Insomnia was not an appropriate indication for Seroquel usage. 12/19/19 - An admission MDS documented that R10 was cognitively intact. December 2019 - January 2020 - A review of R10's nursing assessments and eMAR's lacked evidence of side effect monitoring, including the lack of an AIMS test to monitor for abnormal movements.	F 758	indication for antipsychotic use, prn antipsychotic orders are limited to 14 days and there is documentation of monitoring side effects. Current residents on Antipsychotic medication has a complete AIM□s test completed. Current residents on prn antipsychotic medications were reviewed and prior to receiving prn antipsychotic medication were offered non-pharmacological interventions. C. A Root Cause Analysis (RCA) was completed 1/28/2020. The RCA identified the system was not followed when a resident is on an Antipsychotic medication. It was determined that nurses and NP□s needed education on the policy on Pharmacy 3.8 Psychotropic Medication Use Policy (attachment 13) which includes the use of non-pharmacological interventions prior to the use of prn antipsychotic medication and NSG 206 Behaviors: Management of Symptoms(attachment14) and AIM□s schedule (attachment 17). The NPE or designee will complete education with licensed nurses on or before 2/10/2020. D. The Center Nurse Executive (CNE) or designee will complete weekly audits (attachment 15) on 100% of residents with a new prn psychotropic medications until 100% compliance for on 3 consecutive reviews. Then audits will be completed monthly until 100% compliance achieved on 3 consecutive reviews. Results of audits will be presented to the QAPI Committee for review & recommendations.	

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F 758	Continued From page 14 1/17/20 11:03 AM - During an interview with E2 (DON) it was confirmed that the clinical record lacked evidence of an appropriate indication for the use of R10's Seroquel usage, that the facility failed to perform an AIMS test on R10 prior to the initial administration of the Seroquel, and to assure that R10 was monitored for adverse side effects from the anti-psychotic medication Seroquel. 2. Review of R1's clinical record revealed: 12/24/19 - R1 was admitted to the facility for rehabilitation after surgery for a broken leg. 12/24/19 - Physicians' orders on admission included the anti-psychotic medication Seroquel to be given at bedtime PRN for insomnia. Insomnia was not an appropriate indication for an anti-psychotic medication. 12/26/19 - Physicians' orders included Seroquel PRN every 24 hours for agitation / mood disorder. This order remained active until R1 was discharged on 1/10/20, over 14 days after the original PRN order. R1 never received PRN Seroquel from the facility during her stay. 1/17/19 (1:40 PM) - During an interview E3 (RN, UM) confirmed the PRN anti-psychotic order remained active over 14 days and insomnia was not an adequate indication for use. Findings were reviewed with E1 (NHA) and E2 (DON) during the exit conference on 1/1719 beginning at 3:40 PM.	F 758		

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DELAWARE HEALTH AND SOCIAL SERVICES
Division of Health Care Quality
Office of Long Term Care Residents Protection

DHSS - DHCQ
3 Mill Road, Suite 308
Wilmington, Delaware 19806
(302) 421-7400

STATE SURVEY REPORT

NAME OF FACILITY: Milford Center

DATE SURVEY COMPLETED: January 17, 2020

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	The State Report incorporates by reference and also cites the findings specified in the Federal Report. An unannounced complaint survey was conducted at this facility from January 16, 2020 through January 17, 2020. The deficiencies contained in this report are based on observation, interviews, review of residents' clinical records and review of other facility and pharmacy documentation as indicated. The facility census the first day of the survey was one hundred and twenty two (122). The survey sample totaled eleven (11) plus six (6) additional residents sub-sampled for random observation of		
3201	call bell access.		
3201.1.0	**Regulations for Skilled and Intermediate Care Facilities**		
3201.1.2	**Scope**		
	Nursing facilities shall be subject to all applicable local, state and federal code requirements. The provisions of 42 CFR Ch. IV Part 483, Subpart B, requirements for Long Term Care Facilities, and any amendments or modifications thereto, are hereby adopted as the regulatory requirements for skilled and intermediate care nursing facilities in Delaware. Subpart B of Part 483 is hereby referred to, and made part of this Regulation, as if fully set out herein. All applicable code requirements of the State Fire Prevention Commission are hereby adopted and incorporated by reference.		
	This requirement is not met as evidenced by: Cross Refer to the CMS 2567-L survey completed January 17, 2020: F558, F697, F755 and F758.	Cross Refer 2567 for F558, F697, F755 and F758	2/12/2020

Provider's Signature Marilyn M Kelly Title CEO Date 2/3/2020