

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

PRINTED: 05/18/2018
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175189	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/10/2018
NAME OF PROVIDER OR SUPPLIER THE FORUM AT OVERLAND PARK			STREET ADDRESS, CITY, STATE, ZIP CODE 3501 W 95TH ST OVERLAND PARK, KS 66206		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 000	INITIAL COMMENTS The following citations represent the findings of a Health Resurvey and Complaint Investigation #KS00128980, KS00119174, KS00114432, KS00112681, KS00111280, KS00110686.	F 000			
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility	F 578			

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

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 578	Continued From page 1 may give advance directive information to the individual's resident representative in accordance with State Law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: The facility reported a census of 40 residents. The sample included 12 residents. Based on record review, interview, and observation, the facility failed to ensure the resident's code status was documented in the Electronic Medical Record (EMR) for 1 resident (#42). Findings included: - The electronic medical record for resident # 42 documented diagnoses of chronic atrial fibrillation (rapid, irregular heart beat), and pulmonary fibrosis (a respiratory disease in which scars are formed in the lung tissues, leading to serious breathing problems). The admission Minimum Data Set (MDS) dated 02/02/18 documented a Brief Interview for Mental Status (BIMS) score of 14, which indicated intact cognition. The resident required limited to extensive assistance with Activities of Daily Living (ADLs). The care plan revised on 04/30/18 noted the resident was a Full Code (life-sustaining measures to be taken). Staff reviewed the resident's code status during care plan meetings. The resident had a potential and/or actual	F 578			

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F 578	Continued From page 2 functional status limitation for transfers and ambulation. The physician's orders lacked any documentation related to code status. The resident's living will document included he/she did not want life-sustaining measures done in the event his/her heart stopped beating. On 05/09/18 at 4:40 PM, the resident's door name tag was white. On 05/09/18 at 4:35 PM, direct care staff M stated the color of the resident's name tag on their door indicated the code status. A yellow name tag indicated a Do Not Resuscitate (DNR) code status and a white name tag indicated a full code status. On 05/09/18 at 4:50 PM, licensed nursing staff G confirmed the resident's EMR lacked a code status.. On 05/10/18 at 2:09 PM, licensed nursing staff H stated there should be an order in the EMR to document a full code or DNR. On 05/10/18 at 3:47 PM administrative staff D stated every resident should have a code status reflected by the color of their nametag. Staff D further stated a yellow nametag indicated DNR and white nametag indicated a full code. The facility's policy Advance Directives (Patient Self-Determination Act) documented all direct care staff are notified of the existence and location of a resident's Advanced Care Directive.	F 578			

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F 578	Continued From page 3 The facility failed to document the resident's code status in the resident's EMR, and failed to correctly identify this resident's code status with his/her nametag.	F 578			
F 582 SS=D	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(i)-(v) §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section. §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the	F 582			

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F 582	Continued From page 4 facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by: The facility identified a census of 40 residents. There were 12 residents in the sample. Based on record review and interview, the facility failed to provide 1 of 4 residents sampled for Beneficiary notification, a Skilled Nursing Facility Advance Beneficiary Notice (SNFABN), Form CMS-10055, which gave resident #346 the the right to appeal the decision. Finding included: - Review of the SNF Beneficiary Protection Notification Review, Form CMS-20052, provided to the facility during the annual survey, indicated the skilled services for resident #346 ended 2/28/18. The resident remained in the facility until 3/25/18. The facility/provider initiated the discharge from skilled services when the benefit	F 582			

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F 582	Continued From page 5 days were not exhausted. Question 1 of Form CMS-20052 asked if the facility provided a SNFABN, Form CMS-10055 to the resident. The facility selected the option "No". This form indicated an explanation was warranted, which the facility left blank. On 5/09/18 at 8:33 AM, staff GG confirmed he/she was the responsible party for distribution of the Beneficiary Notification forms for the residents. He/she stated when he/she took the resident both of the forms, the resident was unsure if he/she wanted to sign the SNFABN form. Staff GG stated he/she forgot to follow up with the resident. The facility's ABN Policy Procedure: Expedited Process, revised 10/25/05, stated notice was required when all covered skilled services were terminated and the resident had remaining skilled service days available and the resident continued to reside in the facility. The facility failed to confirm the receipt of notification of non-covered skilled services through the signature of the resident.	F 582			
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to	F 584			

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F 584	Continued From page 6 use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: The facility identified a census of 40 residents. The sample included 12 residents. Based of observation, record review, and interview the facility failed to provide services that maintain an accurate inventory documentation for resident personal belongings upon admission and the duration of their stay in the facility for 2 residents	F 584			

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F 584	Continued From page 7 (#36 & #8). Findings included: - The inventory list dated 03/27/18 for resident #36 documented the resident did not bring any items with him/her. The resident and an unknown staff signed the form. The inventory list dated 04/06/18 documented the resident did not have any new items. The resident's family member and an unknown staff signed the form. On 05/10/18 12:34 PM, the resident had personal items in his/her room which included a hair brush, comb, glasses, blanket, personal cards, walker, and wore personal clothing. On 05/07/18 at 2:49 PM, the resident stated he/she had a ring which was missing. On 05/09/18 at 2:05 PM direct care staff N stated staff completed an inventory sheet upon admission with family member. The resident or the family member documented the brand name of clothes, including the size and color. If a resident left or returned to the facility, staff reconciled the new form within 3-5 days. If a resident went back and forth from independent to long term care for skilled services, then staff obtained the inventory list from independent living to reconcile, and then completed a new list. On 05/09/18 at 2:43 PM, licensed nursing staff I stated he/she completed an inventory sheet, with a family member or resident. Staff I further stated he/she completed a new form as the family brought in additional items.	F 584			

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F 584	Continued From page 8 The facility's policy Facility Criteria for the Retention of Personal Possessions policy, undated, documented a complete inventory of all resident's personal belongings including, but not limited to, clothing, furniture, art, work, small appliances, and jewelry would be completed on admission. The facility failed to complete an accurate inventory list of personal items for this resident upon admission and the duration of his/her stay in the facility. - The inventory list dated 2/20/18 for resident #8 documented the resident only brought 4 undergarments to the facility. On 5/9/18 at 8:50 AM, the resident's room contained a dresser full of clothes, an iPad, a personal cell phone and various other personal items. The resident sat in a wheelchair fully dressed and wore shoes. On 5/9/18 at 2:05 PM, direct care staff N stated staff completed an inventory sheet upon admission. The resident or the family member documented the brand name of clothes, including the size and color. On 5/9/18 at 2:43 PM, licensed nursing staff I stated he/she completed an inventory sheet, with a family member or resident. Staff I further stated he/she completed a new form as the family brought in additional items. The facility's policy Facility Criteria for the Retention of Personal Possessions policy, undated, documented a complete inventory of all	F 584			

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F 584	Continued From page 9 resident's personal belongings including, but not limited to, clothing, furniture, art, work, small appliances, and jewelry would be completed on admission. The facility failed to complete an accurate inventory list of personal items for this resident upon admission and failed to update the inventory list for this resident.	F 584			
F 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: The facility identified a census of 40 residents. The sample included 16 residents, with 1 resident reviewed for hydration. Based on observation,	F 692			

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F 692	Continued From page 10 record review, and interview, the facility failed to provide adequate fluid to one resident (#144). Findings included: - The electronic medical record (EMR) for resident #144 documented the facility admitted the resident on 5/1/18. The EMR also documented diagnoses of pneumonitis due to inhalation of food (lung inflammation from breathing in food), acute respiratory failure (lung failure), cerebral infarction (stroke - sudden death of brain cells due to lack of oxygen caused by impaired blood flow to the brain by blockage or rupture of an artery to the brain), and dysphagia (swallowing difficulty). The Minimum Data Set (MDS) and Care Area Assessments had yet to be completed. The care plan dated 5/1/18 directed staff to cue, reorient and supervise the resident as needed, and to use yes or no questions, as the resident had difficulty with communication. The care plan documented the resident required extensive assistance of 1 staff to eat and had left sided paralysis. Staff were to provide the diet as ordered, and monitor and record the intake. The care plan lacked specific times to offer fluids to the resident. The nutrition assessment dated 5/3/18 documented resident needed maximum assistance with dining, and a pureed diet with honey thick liquids. The resident required 2640 milliliters (ml) of fluid daily. The EMR documented on 5/4/18 the resident received 240 ml; on 5/5/18, he/she received 480	F 692			

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F 692	Continued From page 11 ml; on 5/6/18, he/she received 480 ml; and on 5/9/18, he/she received 680ml. The EMR lacked further documentation of fluid intake. On 5/7/18 at 12:24 PM, the resident had dry lips and mouth. A glass of clear liquid sat on the table out of the resident's reach. On 5/10/18 at 12:59 PM, the resident sat in his/her room. There were no fluids in his/her room. On 5/10/18 at 11:14 AM, direct care staff P stated the resident received a pureed diet and honey thick liquids. He/she said direct care staff were responsible to document fluid intake for the residents on their assignment. Staff P further stated the resident received 2 glasses of fluids at each meal, and staff offered fluids every time they provided care to the resident. Staff P said staff kept a glass of thickened water in the resident's room, or they could obtain it from the dining room. On 5/10/18 at 2:36 PM, licensed nursing staff J stated the resident received a pureed diet with honey thick liquids. He/she said staff provided fresh water twice a day, after breakfast and lunch. Staff J further stated staff offered fluids to dependent residents frequently during the day. On 5/10/18 at 4:10 PM, administrative nursing staff D stated he/she expected staff to provide the resident with the diet and fluids the doctor ordered, and to provide fluids between meals and outside of medication pass. The facility's policy Thickened Liquids: Management of Hydration, dated 6/30/10, documented staff would obtain orders to provide	F 692			

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F 692	Continued From page 12 hydration at specific intervals, which would be included in the care plan.	F 692			
F 725 SS=F	The facility failed to provide adequate fluids to this dependent resident who required thickened liquids. Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by:	F 725			

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F 725	Continued From page 13 The facility identified a census of 40 residents. Based on observation and interview, the facility failed to ensure adequate staffing to meet the needs of all of the residents in the facility. Findings Included: - Based on observation, record review, and interview, the facility failed to provide adequate fluids to resident #144. On 5/7/18 at 10:45 AM, resident #17 laid in his/her bed awake. On 5/07/18 at 2:38 PM resident #36's call light was on and the resident called out for help. Direct care staff K acknowledged the light was on and the resident was calling out at 3:17 PM Staff K proceeded into the resident's room and closed the door. On 5/7/18 at 9:18 AM, resident #5 stated he/she did not think there were enough staff, because he/she would put the call light on for help to the bathroom, would have to wait so long that he/she soiled his/her brief. This resident further stated at other times, the staff answered the call light and left him/her in the bathroom or in the room without helping him/her. On 5/7/18 at 10:45 AM, resident #17 stated he/she had been waiting for the staff to come back and assist him/her with dressing, and take him/her to breakfast. On 5/7/18 at 2:05 PM, direct care staff N stated he/she felt the facility was short staffed. On 5/7/18 at 2:38 PM, resident #36 stated when			F 725			

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F 725	Continued From page 14 the nurse answered the call light, he/she told the resident that he/she was the fourth in line. On 5/10/18 at 1:52 PM administrative nursing staff D stated the system provided the staff to resident ratio based on the resident census and acuity level. He/she stated he/she staffed four direct care staff, two nurses and two medication aides twelve as needed staff members that could be utilized to fill staff shortages. The facility failed to provide requested staffing policy for review. The facility failed to ensure adequate staffing to meet the needs for all residents in the facility.	F 725			
F 732 SS=F	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a	F 732			

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F 732	Continued From page 15 daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: The facility reported a census of 40 residents. Based on interview, observation, and record review, the facility failed to ensure staffing information was posted in a prominent place readily accessible to residents and visitors during three out of 4 onsite days of the survey. The facility also failed to maintain the daily nurse staffing data for a minimum of 18 months. Findings Included: - On 5/7/18, 5/8/18 and 5/9/18, the daily staffing census forms were not posted in the facility. On 5/9/18 at 10:01 AM, administrative staff A stated the facility did not retain the staffing sheets, and was unaware to retain the staffing sheets for 18 months. The Facilities, Posting of Nurse Staffing	F 732			

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F 732	Continued From page 16 Information policy dated 12/27/05 was reviewed.	F 732			
F 756 SS=D	The facility failed to post the full-time hours worked by license and direct care staff in a prominent, readily accessible area and did not maintain the daily staffing data for 18 months. Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record.	F 756			

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F 756	Continued From page 17 §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: The facility identified a census of 40 residents. The sample included 12 residents, with 5 residents sampled for medication review. Based on record review, interview, and observation, the facility's consultant pharmacist failed to notify the facility of the need to hold blood pressure medications when blood pressure and pulse readings were below parameters for 3 residents (#10, #8, #37). Findings included: - The electronic medical record for resident #10 documented diagnoses of hypertension (elevated blood pressure). The admission MDS assessment dated 11/19/17 documented a BIMS score of 15, which indicated cognitively intact. The resident needed extensive assistance with ADLs. The quarterly Minimum Data Set (MDS) dated 02/09/18 documented a Brief Interview for Mental Status (BIMS) score of 14, which indicated cognitively intact. The resident required extensive assistance with Activities of Daily Living (ADLs). The Care Area Assessment (CAA) for Cognitive Loss/Dementia dated 11/09/17 documented the resident had a BIMS of 15, which indicated no	F 756			

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F 756	Continued From page 18 cognitive impairment. The CAA for ADLs dated 11/09/17 documented the resident requires assistance with her ADLS due to visual impairment and pain. The care plan last revised on 03/30/18 documented the resident received medications including Metoprolol. The physician's order dated 11/02/17 instructed the staff to administer Metoprolol (a medication for hypertension) 50 milligrams (mg) two times daily. This same physician's order instructed staff to hold blood pressure medications if the systolic blood pressure (the top number on the blood pressure reading) measured below 110 millimeters per Mercury (mm/H), if the diastolic blood pressure (the bottom number on the blood pressure reading) measured below 55mm/H, or if the pulse rate measured below 60 beats per minute (bpm). The Medication Administration Record dated 02/01/18 through 05/01/18 documented on the following dates the pulse rate measured outside of the parameters: 02/01/18 (pulse of 54bpm), 02/03/18 (pulse of 58bpm), 02/09/18 (pulse of 56bpm), 02/11/18 (pulse of 58bpm), 2/13/18 (pulse of 59bpm), 02/27/18 (pulse of 59bpm), and 03/31/18 (pulse of 56bpm). The MARs documented staff administered the Metoprolol on the above dates. The pharmacy consultant reviews lacked any recommendations related to pulse parameters and holding medication. On 5/14/18 at 2:15 PM, consultant staff II stated	F 756			

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F 756	Continued From page 19 he/she reviewed the resident's medications once a month. Staff II stated in March, he/she sent a report to the facility, flagging the fact that medications were being administered below parameters. Staff II further stated he/she advised the director of nursing to provide education to the staff. The facility's policies Medication Management Guidelines, dated 5/28/02, and Medication Management Program Guidelines, dated 11/14/15, failed to document information related to medication administration according to blood pressure and pulse parameters. The facility failed to provide a policy regarding the facility's consultant pharmacist's responsibilities related to parameters and blood pressure medication administration. The facility's consultant pharmacist failed to notify the facility of the need to hold blood pressure medication related to pulse measurements outside of the parameters for this resident. - The electronic medical record (EMR) for resident #8 included diagnoses of hypertension (high blood pressure) and heart failure. The Admission Minimum Data Set (MDS) dated 2/26/18 documented a Brief Interview for Mental Status (BIMS) score of 14 which indicated intact cognition. The resident required limited to extensive assistance with all Activities of Daily Living (ADLs). The Care Area Assessment (CAA) dated 2/26/18 for ADLs documented the resident required limited to extensive assistance with ADLs. The	F 756			

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F 756	Continued From page 20 CAA for medications documented staff monitored the effectiveness and for adverse reactions, and reported any concerns to the physician. The care plan dated 3/20/18 directed staff to assist the resident with ADLs. The physician's order dated 4/6/18 directed staff to administer Metoprolol (medication for high blood pressure) 50 milligrams (mg) twice daily and Losartan (medication for high blood pressure) 100 mg daily. The order also directed staff to hold the medications if the resident's systolic blood pressure (the top number on the blood pressure reading) measured below 110 millimeters of Mercury (mm/H), if the diastolic blood pressure (the bottom number on the blood pressure reading) measured below 60 mm/H, or if the pulse measured less than 60 beats per minute (bpm). This same physician's order directed staff to administer Lasix (medication to help the body get rid of excess fluid) 40 mg daily and to weigh the resident daily. The March 2018 Medication Administration Record (MAR) documented blood pressure readings of 110/53 mm/H on 3/3/18, 97/67 mm/H on 3/7/18, 105/73 mm/H on 3/12/18, 103/65 mm/H on 3/16/18, and a pulse rate of 55 bpm on 3/26/18. The MAR documented staff administered the Metoprolol and Losartan on these days. The clinical record lacked documentation of blood pressure readings twice daily on 4/8/18, 4/15/18, and 4/24/18; only 1 reading documented on 4/7/18, 4/10/18, 4/14/18, 4/17/18, 4/28/18, and 4/30/18. No pulse rate documented twice daily on 4/15/18 or 4/24/18; only 1 reading on 4/14/18,	F 756			

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F 756	Continued From page 21 4/17/18, 4/28/18, and 4/30/18. The April MAR documented staff administered the Metoprolol and Losartan on these days. The clinical record lacked weights for the resident on 4/20/18, 4/21/18, 4/22/18, 4/24/18, and 4/29/18. The consultant pharmacist reviews dated 2/21/18, 3/9/18, 4/16/18, and 5/8/18 failed to identify the need to hold medications when blood pressure or pulse readings measured outside of the parameters, and failed to identify the need to monitor weights. On 5/9/18 at 8:50 AM, the resident sat in a wheelchair in his/her room. He/she was alert and clean. On 5/10/18 at 10:28 AM, direct care staff P stated he/she obtained the resident's weight every day, and gave the reading to the nurse to record. On 5/10/18 at 2:27 PM, licensed nursing staff J stated staff obtained the blood pressure and pulse for this resident every day. On 5/10/2018 at 3:54 PM, administrative nursing staff D stated he/she expected staff to hold medications if the blood pressure or pulse readings measured outside of the parameters. On 5/14/18 at 2:15 PM, consultant staff II stated he/she reviewed the resident's medications once a month. Staff II stated in March, he/she sent a report to the facility, flagging the fact that medications were being administered below parameters. Staff II further stated he/she advised the director of nursing to provide education to the	F 756			

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F 756	Continued From page 22 staff. The facility's policies Medication Management Guidelines, dated 5/28/02, and Medication Management Program Guidelines, dated 11/14/15, failed to document information related to medication administration according to blood pressure and pulse parameters. The facility failed to monitor the effectiveness of medications for this resident. - Resident #37's electronic medical record (EMR) documented diagnoses of Parkinson's disease (progressive disorder of the nervous system that affects movement) and major depressive disorder (mental health disorder that includes persistent feelings of sadness and loss of interest). The Quarterly Minimum Data Set (MDS) dated 4/4/18 documented a Brief Interview for Mental Status (BIMS) score of 8, which indicated moderate cognitive loss. The resident received antipsychotics (class of medications used to treat psychosis [a gross impairment in reality testing] and other mental emotional conditions) and antidepressants (class of medications used to treat mood disorders and relieve symptoms of depression). The Care Area Assessment (CAA) dated 4/4/18 for cognition indicated the resident scored an 8 on the BIMS assessment, exhibited some forgetfulness, confusion, anxiousness and anxiety, at times was unable to follow directions or verbal cues. He/she spoke softly and was difficult to understand at times. Staff to give simple instructions and allow him/her time to process and respond.	F 756			

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F 756	Continued From page 23 The CAA dated 4/4/18 for medication use indicated the resident had a diagnosis of depression, and he/she received medication for symptom management. Staff monitored for medication effectiveness and for signs/symptoms of adverse reactions to include the Black Box Warnings (BBW - a warning issued by the FDA (US Food and Drug Administration) of serious or life-threatening risks located on the label of prescription drug). He/she received an antipsychotic medication once during the look back period for behaviors. The POS dated 3/29/18 documented the following medications with BBW: Mirtazapine (antidepressant) and Trazodone (antidepressant). The care plan lacked documentation of a BBW for Mirtazapine and Trazodone. According to www.fda.gov, Mirtazapine had a BBW of increased risk of suicidal thinking and behavior, and patients of all ages who were started on antidepressant therapy should be monitored appropriately and observed closely for clinical worsening, suicidality, or unusual changes in behavior. According to www.fda.gov, Trazodone had a BBW of increased risk of suicidal thinking and behavior, and patients of all ages who were started on antidepressant therapy should be monitored appropriately and observed closely for clinical worsening, suicidality, or unusual changes in behavior. On 5/10/18 at 4:11 P.M., Administrative Nursing Staff D indicated that the black box warning should populate and be identified on the care			F 756			

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F 756	Continued From page 24 plan. On 5/14/18 at 2:10 P.M., consultant staff II stated that he/she makes sure that black box medications are flagged in Point Click Care. If they are not flagged there, they he/she can't see them. He/she stated that on 3/30/18 he/she sent a report to the facility that the Mirtazapine needed to be on the care plan and/or the medication administration record (MAR). The facility's policies Medication Management Guidelines, dated 5/28/02, and Medication Management Program Guidelines, dated 11/14/15, failed to document information related to medication administration according to blood pressure and pulse parameters. The facility's policy Monitoring for Adverse Drug Reactions, undated, indicated Black Box Warnings and potential adverse effects will be identified on the resident's individual medication care plan. The facility's policy Medication Management Guidelines, dated 5/28/02, indicated the Pharmacy Consultant will perform monthly reviews of resident medication regimes in accordance with specific state guidelines. The facility's consultant pharmacist failed to notify the facility of the need to have black box warnings on the resident's care plan for this cognitively impaired resident.	F 756			
F 757 SS=D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General.	F 757			

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F 757	Continued From page 25 Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: The facility identified a census of 40 residents. The sample included 12 residents, with 5 residents sampled for medication review. Based on record review, interview, and observation, the facility failed to hold blood pressure medications when blood pressure and pulse readings were below parameters for 2 residents (#10, #8,) and failed to document black box warnings (BBW - a warning issued by the FDA [US Food and Drug Administration] of serious or life-threatening risks located on the label of prescription drugs).for one resident (#37). Findings included: - The electronic medical record for resident #10	F 757			

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F 757	Continued From page 26 documented diagnoses of hypertension (elevated blood pressure). The admission MDS assessment dated 11/19/17 documented a BIMS score of 15, which indicated cognitively intact. The resident needed extensive assistance with ADLs. The quarterly Minimum Data Set (MDS) dated 02/09/18 documented a Brief Interview for Mental Status (BIMS) score of 14, which indicated cognitively intact. The resident required extensive assistance with Activities of Daily Living (ADLs). The Care Area Assessment (CAA) for Cognitive Loss/Dementia dated 11/09/17 documented the resident had a BIMS of 15, which indicated no cognitive impairment. The CAA for ADLs dated 11/09/17 documented the resident requires assistance with her ADLS due to visual impairment and pain. The care plan last revised on 03/30/18 documented the resident received medications including Metoprolol. The physician's order dated 11/02/17 instructed the staff to administer Metoprolol (a medication for hypertension) 50 milligrams (mg) two times daily. This same physician's order instructed staff to hold blood pressure medications if the systolic blood pressure (the top number on the blood pressure reading) measured below 110 millimeters per Mercury (mm/H), if the diastolic blood pressure (the bottom number on the blood pressure reading) measured below 55mm/H, or if the pulse rate measured below 60 beats per minute (bpm).	F 757			

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F 757	Continued From page 27 The Medication Administration Record dated 02/01/18 through 05/01/18 documented on the following dates the pulse rate measured outside of the parameters: 02/01/18 (pulse of 54bpm), 02/03/18 (pulse of 58bpm), 02/09/18 (pulse of 56bpm), 02/11/18 (pulse of 58bpm), 2/13/18 (pulse of 59bpm), 02/27/18 (pulse of 59bpm), and 03/31/18 (pulse of 56bpm). The MARs documented staff administered the Metoprolol on the above dates. On 5/10/18 at 2:27 PM, licensed nursing staff J stated staff obtained the blood pressure and pulse for this resident every day. On 5/10/18 at 4:15 PM, administrative nursing staff D stated he/she expected staff to obtain a blood pressure and pulse readings prior to the administration of Metoprolol. Staff D further stated if staff held a medication more than once, then he/she expected staff to notify the physician. On 5/14/18 at 2:15 PM, consultant staff II stated he/she reviewed the resident's medications once a month. Staff II stated in March, he/she sent a report to the facility, flagging the fact that medications were being administered below parameters. Staff II further stated he/she advised the director of nursing to provide education to the staff. The facility's policies Medication Management Guidelines, dated 5/28/02, and Medication Management Program Guidelines, dated 11/14/15, failed to document information related to medication administration according to blood pressure and pulse parameters.	F 757			

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F 757	Continued From page 28 The facility failed to hold blood pressure medication related to pulse measurements outside of the parameters for this resident. - The electronic medical record (EMR) for resident #8 included diagnoses of hypertension (high blood pressure) and heart failure. The Admission Minimum Data Set (MDS) dated 2/26/18 documented a Brief Interview for Mental Status (BIMS) score of 14 which indicated intact cognition. The resident required limited to extensive assistance with all Activities of Daily Living (ADLs). The Care Area Assessment (CAA) dated 2/26/18 for ADLs documented the resident required limited to extensive assistance with ADLs. The CAA for medications documented staff monitored the effectiveness and for adverse reactions, and reported any concerns to the physician. The care plan dated 3/20/18 directed staff to assist the resident with ADLs. The physician's order dated 4/6/18 directed staff to administer Metoprolol (medication for high blood pressure) 50 milligrams (mg) twice daily and Losartan (medication for high blood pressure) 100 mg daily. The order also directed staff to hold the medications if the resident's systolic blood pressure (the top number on the blood pressure reading) measured below 110 millimeters of Mercury (mm/H), if the diastolic blood pressure (the bottom number on the blood pressure reading) measured below 60 mm/H, or if the pulse measured less than 60 beats per minute (bpm). This same physician's order directed staff to administer Lasix (medication to help the body get rid of excess fluid) 40 mg daily	F 757			

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F 757	Continued From page 29 and to weigh the resident daily. The March 2018 Medication Administration Record (MAR) documented blood pressure readings of 110/53 mm/H on 3/3/18, 97/67 mm/H on 3/7/18, 105/73 mm/H on 3/12/18, 103/65 mm/H on 3/16/18, and a pulse rate of 55 bpm on 3/26/18. The MAR documented staff administered the Metoprolol and Losartan on these days. The clinical record lacked documentation of blood pressure readings twice daily on 4/8/18, 4/15/18, and 4/24/18; only 1 reading documented on 4/7/18, 4/10/18, 4/14/18, 4/17/18, 4/28/18, and 4/30/18. No pulse rate documented twice daily on 4/15/18 or 4/24/18; only 1 reading on 4/14/18, 4/17/18, 4/28/18, and 4/30/18. The April MAR documented staff administered the Metoprolol and Losartan on these days. On 5/9/18 at 8:50 AM, the resident sat in a wheelchair in his/her room. He/she was alert and clean. On 5/10/18 at 2:27 PM, licensed nursing staff J stated staff obtained the blood pressure and pulse for this resident every day. On 5/10/2018 at 3:54 PM, administrative nursing staff D stated he/she expected staff to hold medications if the blood pressure or pulse readings measured outside of the parameters. The facility's policies Medication Management Guidelines, dated 5/28/02, and Medication Management Program Guidelines, dated 11/14/15, failed to document information related to medication administration according to blood	F 757			

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F 757	Continued From page 30 pressure and pulse parameters. The facility failed to monitor the effectiveness of medications for this resident. - Review of resident #37's electronic medical record (EMR) documented diagnoses of Parkinson's disease (progressive disorder of the nervous system that affects movement) and major depressive disorder (mental health disorder that includes persistent feelings of sadness and loss of interest). The Admission Minimum Data Set (MDS) dated 4/4/18 documented a Brief Interview for Mental Status (BIMS) score of 8, which indicated moderate cognitive loss. Resident needs extensive assist with 2+ person physical assist for bed mobility, locomotion on unit, toilet use, and personal hygiene. Total dependence with 2+ person physical assist for transfer. Extensive assist with one-person physical assist for locomotion off unit and dressing. Supervision with set up help only for eating. Not steady, only able to stabilize with staff assistance. One-sided lower extremity ROM impairment, uses wheelchair. The resident received antipsychotics (class of medications used to treat psychosis [a gross impairment in reality testing] and other mental emotional conditions) and antidepressants (class of medications used to treat mood disorders and relieve symptoms of depression). The Care Area Assessment (CAA) dated 4/4/18 for Cognitive Loss/Dementia indicated the resident scored 8 on his/her BIMS assessment, exhibited some forgetfulness, confusion, anxiousness and anxiety, and at times was unable to follow directions or verbal cues. He/she spoke softly and was difficult to understand at	F 757			

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F 757	Continued From page 31 times. Staff to give simple instructions and allow him/her time to process and respond. The CAA dated 4/4/18 for medication use indicated the resident had a diagnosis of depression and received medication for symptom management. Staff monitored for effectiveness and for signs/symptoms of adverse reactions to include the Black Box Warnings (BBW - a warning issued by the FDA [US Food and Drug Administration] of serious or life-threatening risks located on the label of prescription drugs). He/she received an antipsychotic medication once during the look back period for behaviors. The Physician's Order Sheet (POS) dated 3/29/18 and 5/8/18 documented the following medications had black box warnings for Mirtazapine (antidepressant) and Trazodone (antidepressant), which required daily monitoring for behaviors, number of episodes, interventions, outcome and side effects. The indication for Mirtazapine was for restlessness. The indication for Trazodone was for insomnia/sleeplessness. The care plan dated 3/29/18 directed staff to monitor for side effects and effectiveness of medications and document every shift. The care plan lacked documentation of a BBW for Mirtazapine and Trazodone. According to www.fda.gov, Mirtazapine had a BBW of increased risk of suicidal thinking and behavior, and patients of all ages who are started on antidepressant therapy should be monitored appropriately and observed closely for clinical worsening, suicidality, or unusual changes in behavior. According to www.fda.gov, Trazodone had a	F 757			

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F 757	Continued From page 32 BBW of increased risk of suicidal thinking and behavior, and patients of all ages who are started on antidepressant therapy should be monitored appropriately and observed closely for clinical worsening, suicidality, or unusual changes in behavior. The Treatment Administration Record (TAR) lacked documentation for 39 out of 57 shifts from 4/10/18 to 4/30/18 and 17 out of 22 shifts from 5/1/18 through 5/9/18. The behavior monitoring records dated 4/10/18 through 5/9/18 lacked complete documentation. On 5/10/18 at 12:30 P.M., licensed nursing staff J stated the medication aids administered all routine medications and the nurse was responsible for monitoring side effects. He/she stated this documentation could be located in the TAR and the expectation was for the medication aid to report to a nurse if any abnormal behaviors were observed with the resident. On 5/10/18 at 4:11 P.M., administrative nursing staff D indicated the black box warning populated automatically, and identified on the care plan.. The facility provided a 'Monitoring for Adverse Drug Reactions' policy, undated, which indicated Black Box Warnings and potential adverse effects would be identified on the resident's individual medication care plan. Additionally, parameters for recommended monitors would be established per the facility's protocol and Medical Director's recommendations. The facility failed to monitor for the effectiveness and side effects of medications for this cognitively impaired resident.	F 757			

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F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: The facility presented a census of 40 residents. There were 4 medication carts. The facility failed to label drugs and biologicals in accordance with accepted professional principles and include the expiration date. The facility further failed to store medications properly by maintaining expired medications in 2 of 4 medication carts. - On 5/7/18 at 9:00 A.M., of the West hall nurse medication cart #1 revealed expired glucose test	F 761			

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F 761	Continued From page 34 strips. According to www.medline.com, the "date opened" should be recorded on the bottle label of glucometer test strips. The bottle and any remaining test strips should be discarded 6 months from date of opening. On 5/7/18 at 9:03 A.M., Licensed Nursing Staff L confirmed that the glucose test strips were out dated, placed them in his/her pocket, and stated he/she would replace them. On 5/7/18 at 9:35 A.M., of the West hall medication aid medication cart #2 revealed Zinc Sulfate expired 2/18, Flaxseed Oil expired 2/17, B-12 expired 2017, Vi-Daily Multivitamin Supplement expired 2/18 On 5/7/18 at 9:38 A.M., Direct Care Staff Q confirmed the expired medication and removed them from medication cart #2. The facility provided 'Medication Management Program Guidelines' policy, dated 11/14/05, which indicated 'No discontinued, outdated or deteriorated drugs may be retained for use. All drugs must be returned to the issuing pharmacy or destroyed in accordance with state regulations governing the destruction or medication.' The policy failed to identify a plan for routine inspection of medication storage area to identify expired medications. The facility failed to label drugs and biologicals in accordance with accepted professional principles and include the expiration date. The facility further failed to store medications properly by maintaining expired medications in 2 of 4 medication carts.	F 761			

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F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: The facility identified a census of 40 residents. Based on observation and interview, the facility failed to distribute food in a sanitary manner. Findings included: - On 5/9/18 at 10:50 AM, direct care staff P carried 2 bowls of ice cream from the kitchen, uncovered, halfway down the hall and into a resident's room. On 5/9/18 at 12:45 PM, unidentified dietary staff A plated food for lunch. He/she assembled a hamburger on a plate. The hamburger bun started to fall off of the plate and staff touched the top of the bun with a bare hand. He/she then	F 812			

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F 812	Continued From page 36 served the hamburger and same bun to a resident. On 5/9/18 at 5:57 PM, unidentified dietary staff B served dessert to multiple residents while wearing gloves. He/she took coffee cups from residents to refill, touched his/her clothes and glasses, filled the coffee cups, and continued to serve dessert bowls by sticking his/her fingers down inside the bowls without changing his/her gloves. On 5/9/18 at 10:50 AM, direct care staff P stated he/she retrieved the ice cream from the kitchen, and it should be covered. On 5/9/18 at 11:58 AM, dining services manager BB stated all foods should be covered when they left the kitchen. On 5/9/18 at 12:45 PM, unidentified dietary staff A stated he/she knew not to handle food with bare hands. On 5/9/18 at 6:00 PM, unidentified dietary staff B did not answer when asked when he/she changed gloves during serving residents. On 5/9/18 at 6:06 PM, dining services manager BB stated he/she expected staff to change gloves between tasks and if they touch their clothes. The facility failed to provide a policy about food distribution, as requested. The facility failed to distribute food in a sanitary manner.	F 812			