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| E 000 | Initial Comments<br><br>An unannounced Emergency Preparedness survey was conducted 11/26/18 through 11/29/18. The facility was in substantial compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities. One complaint was investigated during the survey.<br><br>The census in this 180 certified bed facility was 176 at the time of the survey. The final survey sample consisted of 35 current Resident reviews and 3 closed record reviews. | E 000 | | |
| F 000 | INITIAL COMMENTS<br><br>An unannounced Medicare/Medicaid standard survey was conducted 11/26/18 through 11/29/18. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. One complaint was investiated during the survey. The Life Safety Code survey/report will follow.<br><br>The census in this 180 certified bed facility was 176 at the time of the survey. The final survey sample consisted of 35 current Resident reviews and 3 closed record reviews. | F 000 | | |
| F 550<br>SS=D | Resident Rights/Exercise of Rights<br>CFR(s): 483.10(a)(1)(2)(b)(1)(2)<br><br>§483.10(a) Resident Rights.<br>The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section.<br><br>§483.10(a)(1) A facility must treat each resident with respect and dignity and care for each | F 550 | | 1/1/19 |

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|
| Electronically Signed | | 12/20/2018 |

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 550 | Continued From page 1<br>resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident.<br><br>§483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source.<br><br>§483.10(b) Exercise of Rights.<br>The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States.<br><br>§483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility.<br><br>§483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, staff interview and facility document review the facility staff failed to knock on door or otherwise announce themselves self prior to entering Resident rooms for 2 of 38 Residents, Resident #119 and Resident #165.<br><br>The findings included: | F 550 | The statements made in this plan of correction are not an admission and do not constitute agreement with the alleged deficiencies herein. To remain in compliance with all state and federal regulations, the center has taken or will take the actions set forth in this Plan of | |

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1. For Resident #119 the facility staff failed to knock on door or otherwise announce themselves prior to entering Resident's room.

Resident #119 was admitted to the facility on 09/20/18 and readmitted on 10/12/18. Diagnoses included but not limited to gastroesophageal reflux disorder, multi-drug resistant organism, diabetes mellitus, hyperlipidemia, cerebrovascular accident, hemiplegia, and osteomyelitis.

The most recent MDS (minimum data set) with an ARD (assessment reference date) of 10/19/18 coded the Resident as 15 of 15 in section C, cognitive status. This is a significant change MDS.

The surveyor was speaking with Resident in her room on 11/27/18 at approximately 1030. While surveyor was in the room with Resident #119, a CNA (certified nurse's aide) entered the room without knocking or announcing herself. CNA refilled Resident #119's roommate's water pitcher and exited the room without speaking to Resident #119.

The concern of staff entering Residents rooms without knocking was discussed with the administrative team during a meeting on 11/28/18 at approximately 1650.

On 11/29/18 at approximately 1115, the RNC (regional nurse consultant) informed the surveyor that the facility does not specifically have a policy related to knocking on Residents doors prior to entering, but stated that this is included in Resident's Rights training. RNC provided the

F 550

Correction. In addition, the following plan constitutes the center□s allegation of compliance. All alleged deficiencies have been or will be corrected by the dates indicated.

1. Resident #165 no longer resides in the facility. Staff are currently knocking on Resident #119□s door before entering.
2. Current resident rooms were observed to ensure staff are knocking before entering room. Corrections were made as necessary.
3. Current facility staff were educated regarding Resident privacy rights to include knocking on door before entering. Nursing Administration will conduct facility rounds weekly X 4 to ensure staff are knocking when entering rooms. Any issues will be addressed immediately at the time of identification.
4. Process will be reviewed in QA committee for one quarter.
5. Completion date 1/1/2019

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| F 550 | Continued From page 3 | F 550 | | |

surveyor with a copy of Resident's rights training which read in part "One way to protect Resident's privacy is to knock before entering Resident room. You should always knock, even if the door is open or the Resident can see your or is unable to respond. After knocking, wait for the Resident's response, and ask permission to enter. If the Resident cannot or does not respond, state your name and your purpose before entering".

No further information was provided prior to exit.

2. For Resident #165 the facility staff failed to knock on door or otherwise announce themselves prior to entering Resident's room.

Resident #165 was admitted to the facility on 11/04/18. Diagnoses included but not limited to hypertension, urinary tract infection, thyroid disorder, dementia, and depression.

The most recent MDS (minimum data set) with an ARD (assessment reference date) of 11/09/18 coded the Resident as 6 out of 15 in section C, cognitive patterns. This is an admission MDS.

The surveyor was speaking with Resident #165 in her room on 11/27/18 at approximately 0955. While the surveyor was in the room with Resident, a CNA (certified nurse's aide) entered the room without knocking or announcing herself. CNA informed Resident that she was refilling her water pitcher, did so, and then exited the room.

The concern of staff entering Residents rooms without knocking was discussed with the administrative staff during a meeting on 11/28/18 at approximately 1650.

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| F 550 | Continued From page 4<br>On 11/29/18 at approximately 1115, the RNC (regional nurse consultant) informed the surveyor that the facility does not specifically have a policy related to knocking on Residents doors prior to entering, but stated that this is included in Resident's Rights training. RNC provided the surveyor with a copy of Resident's rights training which read in part "One way to protect Resident's privacy is to knock before entering Resident room. You should always knock, even if the door is open or the Resident can see your or is unable to respond. After knocking, wait for the Resident's response, and ask permission to enter. If the Resident cannot or does not respond, state your name and your purpose before entering".<br><br>No further information was provided prior to exit. | F 550 | | |
| F 578 SS=D | Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir<br>CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v)<br><br>§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.<br><br>§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.<br><br>§483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives).<br>(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 | F 578 | | 1/1/19 |

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F 578 Continued From page 5
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 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:
Based on staff interview and clinical record review, the facility staff failed to ensure an accurate DDNR (Durable Do Not Resuscitate) for 2 of 38 residents in the survey sample (Resident #94 and Resident #21).

The findings included:

1. The facility failed to obtain a DDNR (Durable Do Not Resuscitate) order when Resident #94 was readmitted to the facility.

Resident #94 was readmitted to the facility on 11/26/18 with the following diagnoses of, but not limited to anemia, high blood pressure, aphasia, seizure disorder, depression, manic depression

F 578

1. Resident #94s DDNR was received on 11/28/18. Resident #21s DDNR was corrected to include that a written advanced directive had not been executed.
2. Current residents with orders for DNR were reviewed to ensure accurate DDNR documentation. Corrections were made as necessary.
3. Licensed nursing staff were educated regarding obtaining DNR orders at the time of admission and/or readmission and accurate completion of DDNR forms. Medical Records will review a 10% sample of DNR orders weekly X 4 to ensure accuracy. Any issues will be

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| F 578 | Continued From page 6 | F 578 | | |

and schizophrenia. The most recent MDS (Minimum Data Set) for this resident will be the quarterly MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 10/17/18, coded the resident as having a BIMS (Brief Interview for Mental Status) score of 2 out of a possible score of 15. Resident #94 was also coded as requiring extensive assistance of 1 staff member for dressing and personal hygiene and being totally dependent on 1 staff member for bathing.

The surveyor performed a clinical record review on 11/27 thru 11/29/18. During the review on 11/27/18 at 4:34 pm, the surveyor noted there was no code status listed for this resident.

On 11/28/18 at 12:05 pm, the surveyor notified the director of nursing (DON), administrator and the corporate nurse of the above documented findings regarding the code status of Resident #94. The administrator stated, "I believe the doctor was just in and signed a DNR for the resident." The surveyor requested to interview the admissions nurse that readmitted the resident on 11/26/18.
At 2:02 pm, LPN (licensed practical nurse) #1 stated, "the resident was readmitted back to the facility on late Monday night being a full code." LPN #1 continued to state that there was discussion held between the resident and the family in making the resident a DNR but no paperwork was signed. The surveyor asked if there was any paperwork signed on admission as if the resident was a full code or DNR. LPN #1 stated, "The RP (responsible party) works odd hours and he came in last night and signed the DNR and the doctor came in and signed it this morning."

corrected immediately at the time of identification.
4. Process will be reviewed in QA committee for one quarter.
5. Completion date 1/1/2019

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| F 578 | Continued From page 7 | F 578 | | |

The surveyor reviewed the clinical record to review the physician orders for 11/26/18. The surveyor did not find documentation in the physician orders concerning the code status for this resident.

The surveyor notified the administrative team on 11/28/18 at 3:53 pm and again on 11/29/18 at 12:59 pm of the above documented findings.

No further information was provided to the surveyor prior to the exit conference on 11/29/18.
2. The DDNR (durable do not resuscitate) form for Resident # 21 contained incorrect documentation that stated that a written advance directive had been executed.

Resident # 21 was an 87-year-old male who was admitted to the facility on 6/5/17. Diagnoses included but were not limited to: Alzheimer's disease, functional quadriplegia, psychosis, and muscle weakness.

The clinical record for Resident # 21 was reviewed on 11/27/18 at 11:08 am. The most recent MDS (minimum data set) assessment was a quarterly assessment with an ARD (assessment reference date) of 9/3/18. Section C of the MDS assesses cognitive patterns. In Section C0500, the facility staff documented that Resident # 21 had a BIMS (brief interview for mental status) score of 2 out of 15, which indicated that Resident # 21's cognitive status was severely impaired.

The current plan of care for Resident # 21 was reviewed and revised on 9/16/18. The facility staff documented a focus area as: "The resident is a DDNR." Interventions included but were not

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| F 578 | Continued From page 8 | F 578 | | |

limited to: "Provide support and comfort as needed."

Resident # 21 had current orders that were signed by the physician on 11/11/18. Orders included but were not limited to: "Code status DNR-Comfort care; DNR, No tube feedings, no dialysis one time a day."

On 11/27/18 at 11:08 am, the surveyor review the DDNR form in Resident # 21's clinical record. The surveyor observed an "X" documented on the DDNR form next to the statement "A. While capable of making an informed decision, the patient has executed a written advance directive which directs that life-prolonging procedures be withheld or withdrawn." The surveyor reviewed the clinical record further and did not locate an advance directive in the clinical record for Resident # 21.

On 11/27/18 at 4:48 pm, the surveyor spoke with the facility consultant nurse who had reviewed the clinical record for an advance directive for Resident # 21. The consultant nurse informed the surveyor that no advance directive was located in the clinical record for Resident # 21. The surveyor asked the facility consultant nurse if Resident # 21's DDNR form was inaccurate. The consultant nurse stated, "Yes, we've got to get that corrected."

On 11/28/18 at 4:50 pm, the administrative team was made aware of the findings as stated above.

No further information regarding this issue was presented to the survey team prior to the exit conference on 11/29/18.

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| F 583 | Continued From page 9 | F 583 | | |
| F 583 SS=D | Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii)<br><br>§483.10(h) Privacy and Confidentiality.<br>The resident has a right to personal privacy and confidentiality of his or her personal and medical records.<br><br>§483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident.<br><br>§483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service.<br><br>§483.10(h)(3) The resident has a right to secure and confidential personal and medical records.<br>(i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws.<br>(ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, Resident interview, staff | F 583 | 1. Resident #69s signage on her | 1/1/19 |

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| F 583 | Continued From page 10 interview, and facility document review, the facility staff failed to ensure that medical information was kept confidential for 1 of 38 Residents in the survey sample, Resident # 69.<br><br>The findings included:<br><br>The facility staff had information posted that Resident # 69 had a left heel wound on a bulletin board in her room that was visible to the public.<br><br>Resident # 69 was a 66-year-old female who was admitted to the facility on 6/5/18. Diagnoses included but was not limited to: schizoaffective disorder, hypertension, chronic pain, and major depressive disorder.<br><br>The clinical record for Resident # 69 was reviewed on 11/27/18 at 10:09 am. The most recent MDS (minimum data set) assessment was a quarterly assessment with an ARD (assessment reference date) of 10/3/18. Section C of the MDS assesses cognitive patterns. In Section C0500, the facility staff documented that Resident # 69 had a BIMS (brief interview for mental status) score of 6 out of 15, which indicated that Resident # 69's cognitive status was severely impaired.<br><br>On 11/26/18 at 7:11 pm, the surveyor was in Resident # 69's room conducting an interview. The surveyor observed a sign posted on Resident # 69's bulletin board that contained information that included but was not limited to Resident # 69's name and Precautions (L) (left) heel wound. The surveyor asked Resident # 69 during the interview if she had any sores or open areas on her body that the facility staff had to provide treatment to. Resident # 69 stated to the | F 583 | bulletin board has been modified to remove left heel wound.<br>2. Current residents rooms were observed to ensure that no confidential medical information is visibly present. Corrections were made as necessary.<br>3. Current facility staff were educated regarding Resident privacy rights to include confidential medical information. Nursing Administration will conduct 10% room rounds weekly X 4 to ensure confidential medical information is not visible in resident rooms. Any issues will be addressed immediately at the time of identification.<br>4. Process will be reviewed in QA committee for two quarters.<br>5. Completion date 1/1/19 | |

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| F 583 | Continued From page 11 | F 583 | | |

surveyor, "They did have to take care of one on the bottom of my left foot and (Employee's name withheld) used this honey stuff to clean up the black area."

The surveyor reviewed the clinical record for Resident # 69 further and observed that the physician had initiated orders on 6/15/18 at 8:56 pm that was documented as, "Wash left heel with soap and water, pat dry and apply medihoney wet to dry dressing and cover with dry dressing daily until healed every day shift for wound healing." The physician discontinued this order on 8/5/18.

On 11/28/18 at 3:24 pm, the director of nursing and consultant nurse went into Resident # 69's room with the surveyor and observed the sign posted on the bulletin board that contained information regarding a left heel wound for Resident # 69. The director of nursing and the consultant nurse agreed that patient medical information was visible for the public to see.

The facility policy on "Confidentiality" contained documentation that included bit was not limited to: ..."Procedure
1. Protect all medical information of our patients and employees. Protection of medical information is everybody's business. Be careful of where you about it, to whom you speak, what you speak about, and of how you protect patient information.

4. The condition of an individual patient, records regarding that patient's status and records and information concerning a patient's family, are confidential and should not be disclosed to non-caregivers, other patients, or the public at large." ...

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| F 583 | Continued From page 12<br>On 11/28/18 at 4:50 pm, the administrative team was made aware of the findings as stated above.<br><br>No further information was provided to the survey team prior to the exit conference on 11/29/18. | F 583 | | |
| F 622 SS=E | Transfer and Discharge Requirements<br>CFR(s): 483.15(c)(1)(i)(ii)(2)(i)-(iii)<br><br>§483.15(c) Transfer and discharge-<br>§483.15(c)(1) Facility requirements-<br>(i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless-<br>(A) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility;<br>(B) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility;<br>(C) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident;<br>(D) The health of individuals in the facility would otherwise be endangered;<br>(E) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or<br>(F) The facility ceases to operate. | F 622 | | 1/1/19 |

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| F 622 | Continued From page 13<br>(ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose.<br><br>§483.15(c)(2) Documentation.<br>When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider.<br>(i) Documentation in the resident's medical record must include:<br>(A) The basis for the transfer per paragraph (c)(1)(i) of this section.<br>(B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s).<br>(ii) The documentation required by paragraph (c)(2)(i) of this section must be made by-<br>(A) The resident's physician when transfer or discharge is necessary under paragraph (c) (1)(A) or (B) of this section; and<br>(B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section.<br>(iii) Information provided to the receiving provider | F 622 | | |

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| F 622 | Continued From page 14<br>must include a minimum of the following:<br>(A) Contact information of the practitioner responsible for the care of the resident.<br>(B) Resident representative information including contact information<br>(C) Advance Directive information<br>(D) All special instructions or precautions for ongoing care, as appropriate.<br>(E) Comprehensive care plan goals;<br>(F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care.<br>This REQUIREMENT is not met as evidenced by:<br>Based on staff interview, facility document review and clinical record review the facility staff failed to provide a copy of the comprehensive care plan goals to the receiving facility when a Resident was transferred for 7 of 38 Residents #119, #176, #137, #91, #143, #54, and #94.<br><br>The findings included:<br><br>1. For Resident #119 the facility staff failed to provide a copy of the comprehensive care plan goals to the receiving facility when the Resident was transferred.<br><br>Resident #119 was admitted to the facility on 09/20/18 and readmitted on 10/12/18. Diagnoses included but not limited to gastroesophageal reflux disorder, multi-drug resistant organism, diabetes mellitus, hyperlipidemia, cerebrovascular accident, hemiplegia, and osteomyelitis.<br><br>The most recent MDS (minimum data set) with | F 622 | 1. Resident #176 no longer resides at the facility. Residents #119, #137, #91, #143, #54, #94 were treated at receiving facility and readmitted. Documentation is present in the clinical record of current residents transferred to include contact information of practitioner, Resident representative contact information, advance directive information, special instructions, comprehensive care plan goals, and all other necessary information.<br>2. Current residents who were transferred in the last 14 days were reviewed to ensure transfer form completion to include all required information. Corrections were made as necessary.<br>3. Licensed nursing staff were educated regarding transfer form completion to include comprehensive care plan goals and sending to receiving facility. Nurse discharging a resident will complete | |

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| F 622 | Continued From page 15<br>an ARD (assessment reference date) of 10/19/18 coded the Resident as 15 of 15 in section C, cognitive status. This is a significant change MDS.<br><br>Resident #119's clinical record was reviewed on 11/28/18. It contained a notice of transfer/discharge dated 10/15/18 that indicated the Resident had been transferred to the hospital on 10/05/18 for emergency services.<br><br>The surveyor spoke with the ADON (assistant director of nursing) on 11/28/18 at approximately 1505 regarding documentation that is sent to receiving facility when a Resident is transferred. ADON stated that a copy of Resident's face sheet, physician's order summary, and 2 weeks of progress notes were sent, along with staff calling a report to the receiving facility.<br><br>On 11/29/18 at approximately 0800, the DON (director of nursing) provided the surveyor with a copy of a form entitled "Nursing Home to Hospital Transfer Form" for Resident #119. This form contained the following information: Resident's name, date of birth, contact person/responsible party, contact person at transferring facility, primary physician, reason for transfer, name of transferring facility, and name of receiving facility. DON stated that the facility does not generally send copies of Resident's care plan when they are sent to emergency room.<br><br>The concern of the facility not sending copies of the Resident's comprehensive care plan goals when Resident was transferred was discussed with the administrative team during a meeting on 11/29/18 at approximately 1300. | F 622 | transfer form to include comprehensive care plan goals. Transfer form will be sent to receiving provider at the time of transfer. Nursing leadership will review residents transferred weekly X 4 to ensure accuracy of transfer information. Any issues will be addressed immediately at the time of identification.<br>4. Process will be reviewed in QA committee for one quarter.<br>5. Completion date 1/1/19 | |

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No further information was provided prior to exit.

2. For Resident #176, the facility staff failed to provide a copy of the comprehensive care plan goals to receiving facility.

Resident #176 was admitted to the facility on 10/30/18 and readmitted on 11/20/18. Diagnoses included but not limited to hypertension, hyperlipidemia, atrial fibrillation, anxiety, osteoporosis, dysphagia, chronic obstructive pulmonary disease, and gastroesophageal reflux disease.

The most recent MDS (minimum data set) with an ARD (assessment reference date) of 11/12/18 coded the Resident as 5 out of 15 in section C, cognitive patterns. This is an admission MDS.

Resident #176's clinical record was reviewed on 11/28/18. It contained progress notes, which indicated that Resident had been transferred to the hospital on 10/31/18 and 11/12/18.

The surveyor spoke with the ADON (assistant director of nursing) on 11/28/18 at approximately 1505 regarding documentation that is sent to receiving facility when a Resident is transferred. ADON stated that a copy of Resident's face sheet, physician's order summary, and 2 weeks of progress notes were sent, along with staff calling a report to the receiving facility.

On 11/29/18 at approximately 0800, the DON (director of nursing) provided the surveyor with a copy of a form entitled "Nursing Home to Hospital Transfer Form" for Resident #119. This form contained the following information: Resident's name, date of birth, contact person/responsible

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party, contact person at transferring facility, primary physician, reason for transfer, name of transferring facility, and name of receiving facility. DON stated that the facility does not generally send copies of Resident's care plan when they are sent to emergency room.

The concern of the facility not sending copies of the Resident's comprehensive care plan goals when Resident was transferred was discussed with the administrative team during a meeting on 11/29/18 at approximately 1300.
3. The facility staff failed to provide the receiving provider the comprehensive care plan goals for Resident #137 when the resident was admitted to the hospital on 8/31/18.

The clinical record of Resident #137 was reviewed 11/26/18 through 11/29/18. Resident #137 was admitted initially to the facility 10/30/2013 and readmitted 9/7/2018 with diagnoses that included but not limited to seizures, dysphagia, weakness, pain, hypoglycemia, cardiac arrest, chronic ischemic heart disease, rheumatoid arthritis, hypertension, sepsis, pyelonephritis, urinary tract infection, allergic rhinitis, protein-calorie malnutrition, hypokalemia, constipation, and gastro-esophageal reflux disease.
Resident #137's quarterly minimum data set (MDS) with an assessment reference date (ARD) of 11/1/18 assessed the resident with a BIMS (brief interview for mental status) as 15/15.

Review of the progress note 8/31/18 at 01:40 revealed the following: "Rsds (residents) skin cool, respirations 26, HR (heart rate)-88, O2 (oxygen) sats (saturations) 95% RA (room air), B/P (blood pressure) 95/58. Rsd (resident) with

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blank stare. T/C (telephone call) to on-call doctor (name omitted) regarding rsds BS (blood sugar) and mental status change. Ordered to send rsd to emergency room for eval (evaluation) and treat. T/C to 911 for transport. This writer returning to rsds room, noted skin cold with purplish discoloration at mouth, finger tips, feet, with scattered purplish spots at forearms, abd (abdomen) and lower legs. Rsd not responding to voice or tactile stimulation. Rsd with 15 second episode of not breathing with spontaneous respirations after. Rsd placed on NRB (non rebreather) and readied for transport. Transport at bedside within minutes, medics briefed on rsds "HIGH" BSs, unresponsiveness cold skin, episode of no respirations (2 minutes prior transports arrival). Rsd transferred to stretcher, NRB continues, paperwork with rsd. Transport exiting facility."

Progress note of 8/31/18 at 3:26 p.m. read "Rsd admitted to hospital."

The surveyor interviewed licensed practical nurse #1 on 11/29/18 at 9:27 a.m. regarding paperwork sent with residents to the hospital. L.P.N. #1 stated a face sheet, medication list, history and physical, staff contact, consultant sheet, progress notes of the incident, any ongoing concerns, give report to EMS (emergency medical services) and hospital, and a call back number.

The surveyor interviewed the unit manager registered nurse #1 on 11/29/18 at 9:41 a.m. The unit manager R.N. #1 stated the paperwork sent to hospital included an eInteract transfer form, face sheet, medication list, last 24-hour notes, vital signs, and DNR (do not resuscitate form). The staff call the responsible party (RP) and MD

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(medical doctor). When asked if the care plan goals are sent in writing, the unit manager R.N. #1 stated, "I don't think we send the comprehensive care plan goals with the resident."

The surveyor informed the administrative staff of the above concern in the end of the day meeting on 11/29/18 at 12:58 p.m.

No further information was provided prior to the exit conference on 11/29/18.

4. The facility staff failed to provide documentation that the receiving provider received the following information when Resident #91 was sent to the hospital on 8/31/18: contact information of the practitioner responsible for the resident's care, resident representative information including contact information, Advance Directive information, all special instructions or precautions for ongoing care, and comprehensive care plan goals.

The clinical record of Resident #91 was reviewed 11/26/18 through 11/29/18. Resident #91 was admitted to the facility 4/6/17 and readmitted 10/15/18 with diagnoses that included but not limited to Alzheimer's disease, peripheral vascular disease, schizoaffective disorder, hypothyroidism, cellulitis of left lower limb, muscle weakness, urinary tract infection, major depressive disorder, unspecified dementia without behavioral disturbances, hyperlipidemia, bipolar disorder, angina pectoris, heart failure, transient ischemic attacks, and constipation.

Resident #91's quarterly minimum data set (MDS) assessment with an assessment reference date (ARD) of 11/12/18 assessed the

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resident with a BIMS (brief interview for mental status) as 9/15.

Review of the progress note dated 8/31/2018 at 10:40 revealed the following: "Resident with COC (change of condition) this morning. O2 sats (oxygen saturation levels) @ (at) 88 via nasal cannula going at 2l (liters) per min (minute). Without oxygen, her O2 sats are at 79. Fingertips are purple. Resident with pain in left lower leg along incision. Incision is leaking purulent drainage. Gave oxy 9oxycodone) 7.5 mg (milligrams) at 9:17 a.m. Called medical doctor (name omitted) and was told to send resident to the hospital (name omitted) via transport. Responsible Party (RP) notified. NP (nurse practitioner) aware."

The clinical record did not reveal documentation that any information was sent with the resident on 8/31/18 from the 8/31/18 notes provided by the facility.

The surveyor interviewed the unit manager registered nurse #1 on 11/29/18 at 9:42 a.m. The unit manager R.N. #1 stated the paperwork sent to the hospital included an eInteract transfer form, face sheet, medication list, last 24 hour notes, vital signs, and DNR (do not resuscitate form). The staff call the responsible party (RP) and MD (medical doctor). None of the above information the unit manager R.N. #1 told the surveyor during the interview was documented in the electronic clinical record. The unit manager R.N. #1 stated the facility was not including comprehensive care plan goals as part of the information sent to the hospital.

The surveyor informed the administrative staff of

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the above concern in the end of the day meeting on 11/29/18 at 12:58 p.m.

No further information was provided prior to the exit conference on 11/29/18.
5. The facility staff failed to provide a copy of the comprehensive care plan goals for Resident # 143 upon transfer to the emergency room.

Resident # 143 was a 70-year-old male who was originally admitted to the facility on 3/1/18, with a readmission date of 8/15/18. Diagnoses included but were not limited to: anemia, major depressive disorder, muscle weakness, and paraplegia.

The clinical record for Resident # 143 was reviewed on 11/27/18 at 9:50 am. The most recent MDS (minimum data set) assessment for Resident # 143 was a significant change assessment with an ARD (assessment reference date) of 11/5/18. Section C of the MDS assesses cognitive patterns. In Section C0500, the facility staff documented that Resident # 143 had a BIMS (brief interview for mental status) score of 13 out of 15, which indicated that Resident # 143 was cognitively intact.

On 11/28/18 at 1:30 pm, the surveyor reviewed Resident # 143's progress notes. The surveyor observed a progress note in the clinical record documented on 11/7/18 at 5:24 pm. The progress note was documented as, "transport rsd (resident) to (facility's name withheld) to reinsert foley catheter and return to (facility's name withheld) per hospice nurse, r/t (related to) staff and hospice nurse attempted multiple times, (transportation company's name withheld) notified, (responsible party's name withheld) notified. (Physician's name withheld) notified."

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The surveyor did not locate any documentation that the comprehensive care plan goals were sent with Resident # 143 upon his transfer to the emergency room.

On 11/28/18 at 4:50 pm, the administrative team was made aware of the findings as stated above.

On 11/29/18 at 8:35 am, the facility administrator provided the surveyor with a copy of a "Nursing Home to Hospital Transfer Form" that was sent with Resident # 143 when he was transferred to the emergency room on 11/7/18. The surveyor reviewed the transfer form did not observe documentation that the comprehensive care plan goals were sent with Resident # 143 upon being transferred to the emergency room on 11/7/18. The facility administrator agreed that the facility did not send comprehensive care plan goals with Resident # 143 when he was transferred to the emergency room on 11/7/18.

On 11/29/18 at 1:45 pm, the administrative team was made aware of the findings as stated above.

No further information regarding this issue was provided to the survey team prior to the exit conference on 11/29/18.
6. The facility staff failed to provide a copy of the comprehensive care goals and/or plan to the receiving facility for Resident #54.

Resident #54 was readmitted to the facility on 8/13/18 with the following diagnoses of, but not limited to high blood pressure, dementia, depression, psychotic disorder and respiratory failure. On the quarterly MDS (Minimum Data Set) with ARD (Assessment Reference Date) of 9/24/18, the resident was coded as having a

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| F 622 | Continued From page 23 | F 622 | | |

BIMS (Brief Interview for Mental Status) of 3 out of a possible score of 15. Resident #54 was also coded as requiring extensive assistance of 1 staff member for dressing and personal hygiene and being totally dependent on 1 staff member for bathing.

The surveyor performed a clinical record review on 11/27 thru 11/29/18 on Resident #54. During this review, the surveyor noted that the resident had been discharged to the hospital on 8/8/18. There was no documentation in the clinical record that when the resident had been transferred to the hospital on 8/8/18, the receiving facility (hospital) had not been provided a copy of the comprehensive care goals and/or plan.

The surveyor notified the administrative team on 11/28/18 at 3:53 pm of the documented findings.

On 11/29/18 at 8:30 am, the administrator provided the surveyor with documentation that read in part, " ... Care plans have not been sent to the emergency room with transferring ..."

The surveyor notified the administrative staff of the above documented findings on 11/29/18 at 12:59 am.

No further information was provided to the surveyor prior to the exit conference on 11/29/18.

7. The facility staff failed to provide a copy of the comprehensive care goals and/or plan to the receiving facility for Resident #94.

Resident #94 was readmitted to the facility on 11/26/18 with the following diagnoses of, but not limited to anemia, high blood pressure, aphasia,

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| F 622 | Continued From page 24<br>seizure disorder, depression, manic depression and schizophrenia. The most recent MDS (Minimum Data Set) for this resident will be the quarterly MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 10/17/18, coded the resident as having a BIMS (Brief Interview for Mental Status) score of 2 out of a possible score of 15. Resident #94 was also coded as requiring extensive assistance of 1 staff member for dressing and personal hygiene and being totally dependent on 1 staff member for bathing.<br><br>The surveyor performed a clinical record review on 11/27 thru 11/29/18 for Resident #94. During this review, the surveyor noted that the resident had been discharged to the hospital on 8/8/18. There was no documentation in the clinical record that when the resident had been transferred to the hospital on 11/22/18, the receiving facility (hospital) had not been provided a copy of the comprehensive care goals and/or plan.<br><br>The surveyor notified the administrative team on 11/28/18 at 3:53 pm of the documented findings.<br><br>On 11/29/18 at 8:30 am, the administrator provided the surveyor with documentation that read in part, " ... Care plans have not been sent to the emergency room with transferring ..."<br><br>The surveyor notified the administrative staff of the above documented findings on 11/29/18 at 12:59 am.<br><br>No further information was provided to the surveyor prior to the exit conference on 11/29/18. | F 622 | | |
| F 623 SS=E | Notice Requirements Before Transfer/Discharge<br>CFR(s): 483.15(c)(3)-(6)(8) | F 623 | | 1/1/19 |

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| F 623 | Continued From page 25<br><br>§483.15(c)(3) Notice before transfer.<br>Before a facility transfers or discharges a resident, the facility must-<br>(i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman.<br>(ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and<br>(iii) Include in the notice the items described in paragraph (c)(5) of this section.<br><br>§483.15(c)(4) Timing of the notice.<br>(i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged.<br>(ii) Notice must be made as soon as practicable before transfer or discharge when-<br>(A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section;<br>(B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;<br>(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;<br>(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or | F 623 | | |

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| F 623 | Continued From page 26 | F 623 | | |

(E) A resident has not resided in the facility for 30 days.

§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:
(i) The reason for transfer or discharge;
(ii) The effective date of transfer or discharge;
(iii) The location to which the resident is transferred or discharged;
(iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;
(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;
(vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and
(vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act.

§483.15(c)(6) Changes to the notice.

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| F 623 | Continued From page 27<br>If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available.<br><br>§483.15(c)(8) Notice in advance of facility closure<br>In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l).<br>This REQUIREMENT is not met as evidenced by:<br>Based on staff interview and clinical record review, the facility staff failed to provide a written notice of transfer for 4 of 38 residents in the survey sample Resident's (#54, #119, #176, and #143).<br><br>The findings included:<br><br>1. The facility staff failed to provide a written notice of transfer for Resident #54.<br><br>Resident #54 was readmitted to the facility on 8/13/18 with the following diagnoses of, but not limited to high blood pressure, dementia, depression, psychotic disorder and respiratory failure. On the quarterly MDS (Minimum Data Set) with ARD (Assessment Reference Date) of 9/24/18, the resident was coded as having a BIMS (Brief Interview for Mental Status) of 3 out of a possible score of 15. Resident #54 was also coded as requiring extensive assistance of 1 staff | F 623 | 1. Written notices of transfer were provided to Responsible Representatives for Residents #54, #119, #176, #143.<br>2. Current residents who were transferred in the last 14 days were reviewed to ensure written notices were provided. Corrections were made as necessary.<br>3. Nursing, Discharge Planning, and Medical records staff were educated regarding requirement to send written notices of transfer. DON will review weekly X 4 to ensure completion and notices were sent. Any issues will be addressed immediately at the time of identification.<br>4. Process will be reviewed in QA committee for one quarter.<br>5. Completion date 1/1/19 | |

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| F 623 | Continued From page 28<br>member for dressing and personal hygiene and being totally dependent on 1 staff member for bathing.<br><br>The surveyor performed a clinical record review on 11/27 thru 11/29/18 on Resident #54. During the review, the surveyor noted there was no documentation of a written notice of transfer when Resident #54 was transferred to the emergency room on 8/8/18.<br><br>The surveyor notified the administrative team of the above documented findings on 11/28/18 at 3:53 pm.<br>On 11/29/18 at 8:30 am, the administrator provided a copy of the "Notice of Transfer/Discharge" and the "Date of Notice" was documented as "11/28/18". The administrator also provided a copy " ...Notice of transfer forms needed to be completed timely on all discharges from the facility to the emergency room" which read in part, " ...A review of all transfers to the emergency room department since 7/1/18 was completed on 11/28/18 ..."<br><br>The surveyor notified the administrative team of the above documented findings on 11/29/18 at 12:59 pm.<br><br>No further information was provided to the surveyor prior to the exit conference on 11/29/18.<br>2. For Resident #119 the facility staff failed to provide a written notice of transfer to the Resident/representative in a timely manner.<br><br>Resident #119 was admitted to the facility on 09/20/18 and readmitted on 10/12/18. Diagnoses included but not limited to gastroesophageal reflux disorder, multi-drug resistant organism, | F 623 | | |

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diabetes mellitus, hyperlipidemia, cerebrovascular accident, hemiplegia, and osteomyelitis.

The most recent MDS (minimum data set) with an ARD (assessment reference date) of 10/19/18 coded the Resident as 15 of 15 in section C, cognitive status. This is a significant change MDS.

Resident #119's clinical record was reviewed on 11/28/18. It contained a notice of transfer/discharge dated 10/15/18 that indicated the Resident had been transferred to the hospital on 10/05/18 for emergency services. This notice had a handwritten note at the top which read "Rsd (Resident own R.P. (responsible part). Hand delivered and scanned". Surveyor spoke with the DON (director of nursing) on 11/28/18 at approximately 1500 regarding the timing of the transfer/discharge notice. Surveyor asked the DON if 10 days was considered an adequate time frame in which to provide the notice, and the DON stated that she thought the facility had 30 days in which to notify the Resident.

On 11/29/18 at approximately 0800, the administrator provided the surveyor with a copy of a notice of transfer/discharge dated 10/08/18. Administrator stated that this form had been completed on that date, but it was unclear if Resident has actually received it, therefore the second form dated 10/15/18 had been completed and hand-delivered to the Resident.

The surveyor requested and was provided with a copy of a facility policy entitled "Discharge Planning", which read in part "4. Provide proper advance written notification of the

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| F 623 | Continued From page 30 | F 623 | | |

transfer/discharge....ii. If a transfer/discharge is involuntary and for the following reason, notification shall be made as soon as reasonably possible: 1) The Patient's welfare and needs cannot be met in the Center".

The concern of not notifying the Resident/representative of a transfer/discharge in a timely manner was discussed with the administrative team during a meeting on 11/2918 at approximately 1300.

No further information was provided prior to exit.

3. For Resident #176 the facility staff failed to provide a written notice of transfer to the Resident/representative.

Resident #176 was admitted to the facility on 10/30/18 and readmitted on 11/20/18. Diagnoses included but not limited to hypertension, hyperlipidemia, atrial fibrillation, anxiety, osteoporosis, dysphagia, chronic obstructive pulmonary disease, and gastroesophageal reflux disease.

The most recent MDS (minimum data set) with an ARD (assessment reference date) of 11/12/18 coded the Resident as 5 out of 15 in section C, cognitive patterns. This is an admission MDS.

Resident #176's clinical record was reviewed on 11/28/18. Surveyor could not locate notice of transfer/discharge forms for hospital admissions on 10/31/18 and 11/12/18.

The administrator provided the surveyor with copies of notice of transfer/discharge forms on 11/29/18 at approximately 0800. The form for the

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discharge on 10/31/18 was dated 11/28/18 and had a notation at the top of form that it had been hand delivered to the Resident's RP (responsible party). The form for the 11/12/18 discharge was dated 11/13/18 and had a notation at the top of form that it had been hand delivered to the Resident's RP on 11/28/18. The administrator informed the surveyor that the facility had just missed completing and delivering these forms.

The surveyor requested and was provided with a copy of a facility policy entitled "Discharge Planning", which read in part "4. Provide proper advance written notification of the transfer/discharge....ii. If a transfer/discharge is involuntary and for the following reason, notification shall be made as soon as reasonably possible: 1) The Patient's welfare and needs cannot be met in the Center".

The concern of not notifying the Resident/representative of a transfer/discharge in a timely manner was discussed with the administrative team during a meeting on 11/2918 at approximately 1300.

No further information was provided prior to exit.
4. The facility staff failed to provide written notice of transfer for Resident # 143.

Resident # 143 was a 70-year-old male who was originally admitted to the facility on 3/1/18, with a readmission date of 8/15/18. Diagnoses included but were not limited to: anemia, major depressive disorder, muscle weakness, and paraplegia.

The clinical record for Resident # 143 was reviewed on 11/27/18 at 9:50 am. The most recent MDS (minimum data set) assessment for

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Resident # 143 was a significant change assessment with an ARD (assessment reference date) of 11/5/18. Section C of the MDS assesses cognitive patterns. In Section C0500, the facility staff documented that Resident # 143 had a BIMS (brief interview for mental status) score of 13 out of 15, which indicated that Resident # 143 was cognitively intact.

On 11/28/18 at 1:30 pm, the surveyor reviewed Resident # 143's progress notes. The surveyor observed a progress note in the clinical record documented on 11/7/18 at 5:24 pm. The progress note was documented as, "transport rsd (resident) to (facility's name withheld) to reinsert foley catheter and return to (facility's name withheld) per hospice nurse, r/t (related to) staff and hospice nurse attempted multiple times, (transportation company's name withheld) notified, (responsible party's name withheld) notified. (Physician's name withheld) notified." The surveyor did not locate documentation in Resident # 143's clinical record that verified that Resident # 143 and Resident # 143's representative was made aware of the reason for Resident # 143's transfer to the emergency room on 11/7/18 in writing.

On 11/28/18 at 4:50 pm, the administrative team was made aware of the findings as stated above.

On 11/29/18 at 8:35 am, the facility administrator spoke with the surveyor and confirmed that the facility did not notify Resident # 143 and Resident # 143's representative in writing regarding Resident # 143's reason for transfer to the emergency room on 11/7/18.

On 11/29/18 at 1:45 pm, the administrative team

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| F 623 | Continued From page 33<br>was made aware of the findings as stated above.<br><br>No further information regarding this issue was provided to the survey team prior to the exit conference on 11/29/18. | F 623 | | |
| F 641<br>SS=D | Accuracy of Assessments<br>CFR(s): 483.20(g)<br><br>§483.20(g) Accuracy of Assessments.<br>The assessment must accurately reflect the resident's status.<br>This REQUIREMENT is not met as evidenced by:<br>Based on staff interview and clinical record review, facility staff failed to accurately code the resident's discharge status for 1 of 38 residents in the survey sample (Resident #173).<br><br>The findings included:<br><br>Resident # 173 was admitted to the facility on 8/13/18. Diagnoses included acute kidney failure, atrial fibrillation, dysphagia, hypertension, dementia. On the discharge return not anticipated minimum data set assessment (MDS) the resident scored 7/15 on the brief interview for mental status and was assessed as without signs of delirium, psychosis, or behaviors affecting care.<br><br>On 11/28/18 at 11:29 AM, the surveyor conducted a closed record review for Resident # 173. The record indicated the resident was admitted 8/13/18 and discharged 9/1/18. Progress notes indicated that the resident was discharged to home with family. On the discharge return not anticipated MDS dated 9/1/18 section A2100 documented that the resident was discharged to | F 641 | 1. The discharge status for Resident #174 was modified on 11/28/18 to reflect a discharge to the community.<br>2. Question A2100 was reviewed for all residents discharged in the last 30 days to ensure that the proper status was coded.<br>3. MDS Coordinators were educated regarding RAI rules for coding the question A2100.<br>4. Process will be reviewed in QA committee for one quarter. MDS Consultant or designee will audit 3 discharge residents weekly X4 to ensure question A2100 is properly coded.<br>5. Completion date 1/1/19 | 1/1/19 |

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| F 641 | Continued From page 34<br>acute care hospital. The self-care section (GG) of the MDS was not completed because the questions were disabled by question A2100 (which was incorrectly coded as acute hospital).<br><br>The discharge summary signed 9/13/18 indicated that the resident was discharged after improvement under therapy and instructions had been given to the family. Discharge planning began 8/14 and instructions were given on discharge on 9/1. Instructions indicated arrangements had been made for home health care, therapy, and for prescriptions to be sent to the pharmacy.<br><br>11/28/18 11:53 AM The surveyor spoke with the MDS nurse who completed the assessment. She was shown the incorrect code and said she would look into it and come back. The administrator and director of nursing were notified of the concern during a summary conference on 11/28/18. | F 641 | | |
| F 655 SS=D | Baseline Care Plan<br>CFR(s): 483.21(a)(1)-(3)<br><br>§483.21 Comprehensive Person-Centered Care Planning<br>§483.21(a) Baseline Care Plans<br>§483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must-<br>(i) Be developed within 48 hours of a resident's admission.<br>(ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- | F 655 | | 1/1/19 |

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(A) Initial goals based on admission orders.
(B) Physician orders.
(C) Dietary orders.
(D) Therapy services.
(E) Social services.
(F) PASARR recommendation, if applicable.

§483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan-
(i) Is developed within 48 hours of the resident's admission.
(ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section).

§483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to:
(i) The initial goals of the resident.
(ii) A summary of the resident's medications and dietary instructions.
(iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility.
(iv) Any updated information based on the details of the comprehensive care plan, as necessary.
This REQUIREMENT is not met as evidenced by:
Based on staff interview and clinical record review, the facility staff failed to develop and/or provide the baseline care plan for 2 of 38 Residents in the survey sample, Resident # 143 and Resident # 54.

The findings included:

1. For Resident #143, the facility staff failed to

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1. A summary of the baseline care plan was provided to Resident #143 and #54s representatives.
2. Current residents who were admitted in the last 14 days were reviewed to ensure baseline care plans have been developed within 48 hours. Corrections were made as necessary.
3. Members of the interdisciplinary care

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provide a copy of the baseline care plan.

Resident # 143 was a 70-year-old male who was originally admitted to the facility on 3/1/18, with a readmission date of 8/15/18.
Diagnoses included but were not limited to: anemia, major depressive disorder, muscle weakness, and paraplegia.

The clinical record for Resident # 143 was reviewed on 11/27/18 at 9:50 am. The most recent MDS (minimum data set) assessment for Resident # 143 was a significant change assessment with an ARD (assessment reference date) of 11/5/18. Section C of the MDS assesses cognitive patterns. In Section C0500, the facility staff documented that Resident # 143 had a BIMS (brief interview for mental status) score of 13 out of 15, which indicated that Resident # 143 was cognitively intact.

On 11/28/18 at 1:30 pm, the surveyor reviewed Resident # 143's progress notes. The surveyor did not locate any documentation that verified that Resident # 143 and Resident # 143's representative was provided a summary of Resident # 143's baseline care plan from the 8/15/18 admission.

On 11/28/18 at 1:40 pm, the surveyor spoke with the facility administrator regarding Resident # 143 and Resident # 143's representative being provided a summary of Resident # 143's baseline care plan from the 8/15/18 admission.

On 11/28/18 at 4:22 pm, the facility administrator informed the surveyor that she was unable to prove that a summary of the baseline care plan from Resident # 143's admission on 8/15/18 was

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planning tram were educated regarding development of baseline care plans and providing summary of baseline care plan to Resident representative. Admitting nurse will initiate baseline care plan. Nursing leadership will review to ensure completion within 48 hours. Nursing leadership will audit 10% admissions weekly X 4 to ensure accuracy. Any issues will be addressed immediately at the time of identification.
4. Process will be reviewed in QA committee for one quarter.
5. Completion date 1/1/19

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provided to Resident # 143 and Resident # 143's representative.

On 11/29/18 at 1:45 pm, the administrative team was made aware of the findings as stated above.

No further information was provided to the survey team prior to the exit conference on 11/29/18.
2. The facility staff failed to develop a baseline care plan Resident #54.

Resident #54 was readmitted to the facility on 8/13/18 with the following diagnoses of, but not limited to high blood pressure, dementia, depression, psychotic disorder and respiratory failure. On the quarterly MDS (Minimum Data Set) with ARD (Assessment Reference Date) of 9/24/18, the resident was coded as having a BIMS (Brief Interview for Mental Status) of 3 out of a possible score of 15. Resident #54 was also coded as requiring extensive assistance of 1 staff member for dressing and personal hygiene and being totally dependent on 1 staff member for bathing.

The surveyor performed a clinical record review on 11/27 thru 11/29/18 on Resident #54. During this review, the surveyor noted that there was not a baseline care plan developed and not provided to the resident or representative. The resident had been readmitted to the facility on 8/13/18.

The surveyor notified the director of nursing and corporate nurse of the above documented findings on 11/29/18 at 10 am. The corporate nurse stated that she would like to review the print out of the "Care Plan Focus Summary" for this resident with the surveyor. This was performed and the surveyor asked the corporate

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| F 655 | Continued From page 38<br>nurse if she could tell when the baseline care plan was started. The corporate nurse stated, "I am looking at this and the baseline care plan was started on 8/13/18 but in the middle of this there are other dates listed here that has nothing to do with the baseline care plan. So it is hard to tell what is really going on with this base line care plan."<br><br>The surveyor notified the administrative team of the above documented findings on 11/29/18 at 12:59 pm.<br><br>No further information was provided to the surveyor prior to the exit conference on 11/29/18. | F 655 | | |
| F 657 SS=D | Care Plan Timing and Revision<br>CFR(s): 483.21(b)(2)(i)-(iii)<br><br>§483.21(b) Comprehensive Care Plans<br>§483.21(b)(2) A comprehensive care plan must be-<br>(i) Developed within 7 days after completion of the comprehensive assessment.<br>(ii) Prepared by an interdisciplinary team, that includes but is not limited to--<br>(A) The attending physician.<br>(B) A registered nurse with responsibility for the resident.<br>(C) A nurse aide with responsibility for the resident.<br>(D) A member of food and nutrition services staff.<br>(E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. | F 657 | | 1/1/19 |

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(F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.
(iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.
This REQUIREMENT is not met as evidenced by:
Based on staff interview, clinical record review, and facility document review the facility staff failed to develop a comprehensive care plan and failed to ensure that the interdisciplinary team included the necessary disciplines for 2 of 38 residents in the survey sample, Resident #104 and Resident #163.

The findings included:

1. The facility staff failed to ensure that the interdisciplinary team included a nursing assistant responsible for providing care for Resident # 104.

Resident # 104 was a 92-year-old-female who was originally admitted to the facility on 2/4/14, with a readmission date of 11/15/17. Diagnoses included but were not limited to: hypertension, major depressive disorder, anemia, and hypokalemia.

The clinical record for Resident # 104 was reviewed on 11/27/18 at 12:00 pm. The most recent MDS (minimum data set) assessment was a quarterly assessment with an ARD (assessment reference date) of 10/22/18. Section C of the MDS assesses cognitive patterns. In Section C0500, the facility staff documented that Resident # 104 had a BIMS (brief interview for mental status) score of 4 out of 15, which

Provider's Plan of Correction:

1. The interdisciplinary team for Resident #104 currently includes a nursing assistant. The hospice care plan and care documentation is current and accessible for Resident #163.
2. Current residents with upcoming care plan reviews were reviewed to ensure input is received from the nursing assistant responsible for the resident. Current residents under the care of hospice were reviewed to ensure integration of the hospice care plan and that hospice care notes are accessible to staff. Corrections were made as necessary.
3. Members of the interdisciplinary care planning team were educated regarding inclusion of nursing assistant in care plan development and integration of hospice care plan. Current nursing staff were educated regarding accessibility of hospice care notes. Nursing leadership will review 10 % care plan reviews weekly X 4 to ensure hospice integration as indicated and nursing assistant input. Any issues will be addressed immediately at the time of identification.
4. Process will be reviewed in QA committee for one quarter.
5. Completion date 1/1/19

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indicated that Resident # 104's cognitive status was severely impaired.

On 11/27/18 at 1:15 pm, the surveyor reviewed the progress notes for Resident # 104. The surveyor observed a "Care Plan Meeting" progress note documented on 11/9/18 at 11:22 am. The care plan meeting progress note was documented as "Care plan meeting held. Family and resident declined attending. Those in attendance were: (Employee's name withheld) UM (unit manager); (Employee's name withheld), MDS; (Employee's name withheld), activities director; (Employee's name withheld), therapy manager; (Employee's name withheld) RD (registered dietitian); (Employee's name withheld) DP/SW (social worker). No concerns voiced at this time. Continue current plan of care." The surveyor did not identify any documentation that supported that a nursing assistant was involved as an interdisciplinary care plan team member for Resident # 104.

On 11/27/18 at 2:49 pm, the surveyor interviewed the assistant director of nursing about how the nursing assistants were included in the care planning process for Resident # 104. The assistant director of nursing stated, "They (nursing assistants) don't come to our meetings." The assistant director of nursing stated, "We talk to them, but they don't generally come to our care plan meetings." The surveyor asked the assistant director of nursing how she can prove that nursing assistants provided input when developing the care plans for Resident # 104. The assistant director of nursing stated, "I don't know."

On 11/27/18 at 3:04 pm, the assistant director of

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nursing provided the surveyor with a sample of a "QI/QM (quality improvement/quality measures) Assessment" for a different resident. The assistant director of nursing stated, "This paper is done for every resident prior to the care plan meeting." The surveyor reviewed the QI/QM Assessment" form provided by the assistant director of nursing and did not locate any signatures or section headings on the form and was unable to determine where the handwritten documentation on the form was obtained. The surveyor asked the assistant director of nursing if the "QI/QM Assessment" form was part of the clinical record. The assistant director of nursing stated, "No." The surveyor asked the assistant director of nursing if she felt that based on what she provided if she felt that she had proven that the facility included nursing assistants in the care planning process for Resident # 104. The assistant director of nursing stated, "No."

The facility policy on "Resident Assessment & Care Planning" contained documentation that included but was not limited to:
..."4. The comprehensive assessment and plan of care will include at a minimum, input obtained from the attending physician, the nurse and nurse assistant who has responsibility for the patient; a member of the food and nutrition services staff, other appropriate staff or professionals as needed or requested by the patient, and to the extent practicable, the participation of the patient and the patient's representative (s)." ...

On 11/28/18 at 4:50 pm, the administrative team was made aware of the findings as stated above.

No further information regarding this issue was provided to the survey team prior to the exit

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conference on 11/29/18.
2. For Resident #163, facility staff failed to integrate the hospice care plan with the nursing care plan and to maintain the hospice care plan and care documentation accessible to staff.

Resident #163 was admitted to the facility on 5/8/18. Diagnoses included cerebral infarction with hemiplegia and hemiparesis of non-dominant side and other sequelae of cerebral infarction, hypertension, diabetes mellitus, and schizophrenia. On the significant change minimum data set assessment with assessment reference date 11/9/18, the resident scored 4/15 on the brief interview for mental status and was assessed as without symptoms of delirium, psychosis, or behaviors affecting care.

On 11/27/18 at 11:57 AM the surveyor observed a hospice aid bathing the resident with the assistance of 2 facility nursing assistants (CNA). The aid said she comes on Tuesday and Thursday for bathing. The resident was complaining of pain, and not wanting to be turned so new linens could be placed under her.

During clinical record review on 11/27/18, the surveyor was unable to locate evidence of hospice care integration in the resident's record. There was an order to admit to hospice effective 11-1-18 signed by the physician 11-2-18. The only documents pertaining to hospice in the record (a section for Resident #163 in the hospice binder) was the cover sheet with hospice contact numbers and web address, a form titled Hospice/Nursing Facility Plan of Care, and a Summary of Hospice Contact in the Facility.

The Hospice/Nursing Facility Plan of Care listed

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the names of the registered nurse and social worker assigned to the resident and a pre-printed problem list: Durable Medical Equipment, Primary plan of Care, Resuscitation, Treatment Schedule, Visit Schedule, CNA assignment, Emergency Preparedness Care Plan. Hospice POC (plan of care) was handwritten. No narrative, goals, or interventions were documented for any of the problems.

The surveyor asked the resident's nurse if there was any documentation of hospice care plan or responsibility. She pulled the hospice book and said all the care plans were there. There was no care plan or contract for Resident #163. The surveyor asked how staff knew what the hospice was supposed to do and what had been done. She said that hospice staff left notes when they were there and the nurses talked with facility nurses when they came.

The surveyor asked for hospice records and received, at the end of the day, a contract and care plan and a printout of notes that the hospice faxed to the facility on 11/27/18 at 14:56.

The resident's facility comprehensive care plan only mentioned hospice on the ADL focus with no interventions attributed to hospice staff and under the terminal prognosis focus with the intervention: work cooperatively with hospice team as ordered to ensure the resident's spiritual, emotional, intellectual, physical and social needs are met. When the surveyor asked the MDS nurse responsible for the care plan how that is accomplished and how staff know what hospice responsibilities are, she said they look in the hospice book.

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| F 657 | Continued From page 44 The surveyor informed the administrator and director of nursing of the concern on 11/27/18. | F 657 | | |
| F 689 SS=E | Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2)<br><br>§483.25(d) Accidents.<br>The facility must ensure that -<br>§483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and<br><br>§483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation and staff interview the facility staff failed to ensure a hazard free environment on 3 of 3 units.<br><br>The findings included:<br><br>The facility failed to keep the crash carts locked. These crash carts included medications, alcohol preps, equipment that would be used to draw blood (butterflies), and IV start kits.<br><br>On 11/28/18 at 3:40 p.m., the surveyors observed a cart sitting in a corner in the hallway next to the clean utility room on unit 3. A yellow box was positioned on the top of this cart. The surveyors were able to open the yellow box. Inside this box, the surveyors observed 1-5mls of heparin, 3-10 mls of saline, various alcohol preps, and 5 IV start kits. The unit manager of this unit (unit 3) identified this cart as being the crash cart and stated it always sat in this area. The unit manager verbalized to the surveyors that the yellow box should have a zip tie on it (to lock it). | F 689 | 1. Crash carts on all 3 units were locked during survey at time of observation.<br>2. Crash carts on all three units were observed to ensure locks in use. Corrections were made as necessary.<br>3. Current licensed nursing staff were educated regarding crash cart storage and locks. Nursing staff assigned on each unit will check crash carts daily to ensure locked. Nursing leadership will audit crash carts weekly X 4 to ensure locks in place. Any issues will be addressed immediately at the time of identification.<br>4. Process will be reviewed in QA committee for one quarter.<br>5. Completion 1/1/19 | 1/1/19 |

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On 11/28/18 at 3:47 p.m., the surveyors observed the unit 2 crash cart inside the nurses station. On the top of this cart, the surveyors again observed a yellow box. The surveyors were able to open the box. Inside this box, the surveyors observed 5-10 mls of normal saline, 12 IV start kits, and various alcohol preps. The inside of the unlocked cart included 3-250 mls of normal saline and 1-100 mls of normal saline. While checking this cart the unit manager and RN (registered nurse) #2 exited the medication room with a zip tie for the yellow box.

On 11/28/18 at 3:53 p.m., the surveyors checked the crash cart on unit 1. This cart was located just outside the nurses station. The yellow box on top of the cart included 6-IV start kits, 9 butterflies (to draw blood), a 21-gauge needle (to draw blood), various alcohol pads, 1-10 mls of saline, and 2-15 mls of saline. The surveyors were able to open the crash cart. Inside this cart, the surveyors observed 2-250 mls of saline.

All three of these yellow boxes included instructions on the underside of the lid to restock and reseal after each use. There were no Residents in the immediate vicinity of the crash carts.

When the DON (director of nursing) was asked if these boxes should have been locked. The DON verbalized to the survey team that the one with the heparin should have been locked.

On 11/29/18 at 7:35 a.m., the unit manager verbalized to the surveyor that the crash carts were now kept in the medication rooms.

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| F 689 | Continued From page 46<br>The facility policy/procedure titled "5.3 Storage and Expiration of Medications, Biologicals, Syringes and Needles" with an effective date of 12/01/07 read in part, " ...Facility should ensure that all medications and biologicals, including treatment items, are securely stored in a locked cabinet/cart or locked medication room that is inaccessible by residents and visitors ..."<br><br>The administrative staff were notified of the issues regarding the crash carts during a meeting with the survey team on 11/29/18 at 12:58 p.m.<br><br>No further information regarding this issue was provided to the survey team prior to the exit conference. | F 689 | | |
| F 757 SS=D | Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6)<br><br>§483.45(d) Unnecessary Drugs-General.<br>Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used-<br><br>§483.45(d)(1) In excessive dose (including duplicate drug therapy); or<br><br>§483.45(d)(2) For excessive duration; or<br><br>§483.45(d)(3) Without adequate monitoring; or<br><br>§483.45(d)(4) Without adequate indications for its use; or<br><br>§483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or | F 757 | | 1/1/19 |

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§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:
Based on staff interview and clinical record review, the facility staff failed to ensure 1 of 38 residents (Resident #16) was free of an unnecessary medication. The facility staff administered Metoprolol outside of the physician ordered parameters.

The findings included:

The facility staff failed to follow the physician ordered parameters for the blood pressure medicine Metoprolol for Resident #16.

The clinical record of Resident #16 was reviewed 11/26/18 through 11/29/18. Resident #16 was admitted to the facility 8/10/15 and readmitted 4/19/17 with diagnoses that included but not limited to transient ischemic attacks, hypothyroidism, type 2 diabetes mellitus, major depressive disorder, anxiety, hyperlipidemia, atherosclerotic heart disease, muscle weakness, dizziness and giddiness, and gastroesophageal reflux disease.

Resident #16's quarterly minimum data set (MDS) assessment with an assessment reference date (ARD) of 8/24/18 assessed the resident with a BIMS (brief interview for mental status) as 15/15.

Resident #16's current comprehensive care plan identified the focus area for hypertension created on 4/23/17 and revised 7/21/17. Interventions included meds (medications) as ordered and vital

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1. Resident #16 is currently receiving Metoprolol as ordered by the physician.
2. Current residents receiving Metoprolol were reviewed to ensure receipt of medication as ordered by the physician. Corrections were made as necessary.
3. Licensed nursing staff were educated regarding medication administration to include following physician ordered medication parameters. Nursing leadership will audit hypertensive medication administration records for Residents with parameters weekly X 4 to ensure accuracy. Any issues will be addressed immediately at the time of identification.
4. Process will be reviewed in QA committee for one quarter.
5. Completion 1/1/19.

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signs as needed.

Resident #16 had physician's orders that began 9/24/18 and read "Metoprolol Tartrate 25 mg (milligrams) Give 1 tablet by mouth two times a day related to essential hypertension hold for sbp (systolic blood pressure) less than 110."

The surveyor reviewed both the September 2018 and October 2018 electronic medication administration records (eMARS). Resident #16 received Metoprolol 25 mg on the days when the systolic blood pressure was less than 110:
9/24/18 at 0800-BP=102/75
9/28/18 at 0800-BP=102/60
10/2/18 at 0800-BP=108/64
10/5/18 at 0800-BP=100/64
10/9/18 at 0800-BP=102/63
10/10/18 at 2000 (8:00 p.m.)-BP=95/60
10/11/18 at 0800-BP=102/68
10/14/18 at 0800-BP=105/69
10/16/18 at 0800-BP=101/79

The chart codes at the bottom of the September and October 2018 eMAR indicated a " (check mark) had been documented in each of the boxes along with the nurse's initials that the medication had been administered on the above days and times.

The surveyor reviewed the progress notes for September 2018 and October 2018 and found no documentation on 9/24/18, 9/28/18, 10/2/18, 10/5/18, 10/9/18, 10/10/18, 10/11/18, 10/14/18 or 10/16/18 that Metoprolol had been held.

The surveyor informed the director of nursing, the corporate registered nurse, and registered nurse #2 of the above concern on 11/28/18 at 2:37 p.m.

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| F 757 | Continued From page 49<br><br>No further information was provided prior to the exit conference on 11/29/18. | F 757 | | |
| F 761<br>SS=E | Label/Store Drugs and Biologicals<br>CFR(s): 483.45(g)(h)(1)(2)<br><br>§483.45(g) Labeling of Drugs and Biologicals<br>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.<br><br>§483.45(h) Storage of Drugs and Biologicals<br><br>§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.<br><br>§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.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, staff interview, facility document review, and clinical record review, the facility staff failed to date opened medications on 2 of 9 medication carts, and in 1 of 3 medication rooms, and failed to dispose expired medications | F 761 | 1. Insulin vials and Tuberculin vials were discarded during the survey. Expired docusate sodium and regular strength EC aspirin, and antacid were discarded during the survey. Opened undated packages of | 1/1/19 |

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on 4 of 9 medication carts.

The findings included:

1(a). The facility staff failed to date 2 vials of Influenza vaccine and 2 vials of tuberculin solution that had been opened, and stored in the unit 1 medication room refrigerator.

1(b). The facility staff on unit 2 pod 2 failed to dispose of expired docusate sodium and expired regular strength enteric-coated aspirin, and failed to date opened packages of albuterol sulfate inhalation solution, ipratropium bromide and albuterol sulfate solution, Breo Ellipta inhaler, and Ventolin HFA inhaler.

1(c). The facility staff on unit 2 pod 3 failed to date opened packages of ipratropium bromide and albuterol sulfate solution and budesonide inhalation suspension.

On 11/28/18 at 8:05 am, the surveyor inspected the unit 1 medication room. Upon inspecting the refrigerator, the surveyor observed 2 vials of alfluria quadrivalent influenza vaccine that were opened and undated, and 2 vials of aplisol tuberculin solution that were opened and undated. The director of nursing was in the unit 1 medication room with the surveyor and observed and agreed that the 2 influenza vaccine vials, and 2 vials of tuberculin solution had been opened and were undated.

The package insert for the afluria quadrivalent influenza vaccine contained documentation that included but was not limited to:
..."16.2 Storage and Handling
Once the stopper of the multi-dose vial has been

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albuterol sulfate inhalation, ipratropium bromide, albuterol sulfate solution, and budesonide inhalation were discarded during the survey. Breo Ellipta, Symbicort for Resident #95, Ventolin inhalers, brimonidine, and prednisone eye drops that were not dated were discarded during the survey.

2. Medication refrigerators and all medication carts were observed to determine the presence of expired and/or undated insulins, tuberculin vials, docusate sodium, EC aspirin, antacid liquid, albuterol, ipratropium, budesomide, Breo Ellipta, Ventolin, and eye drops. Corrections were made as necessary.

3. Licensed nursing staff were educated regarding medication storage to include dating of medications upon opening and expiration dates. Nurses will store medications according to pharmacy and/or manufacturer guidelines and will discard expired medications. Nursing leadership will observe medication carts and medication rooms from each unit weekly X4 to ensure medications are stored properly based on expiration dates. Any issues will be addressed immediately at the time of identification.

4. Process will be reviewed in QA committee for one quarter.

5. Completion 1/1/2019

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pierced the vial must be discarded within 28 days." ...

The package insert for the aplisol tuberculin solution contained documentation that included but was not limited to:
... "Storage
Vials in use more than 30 days should be discarded due to possible oxidation and degradation which may affect potency." ...

On 11/28/18 at 8:18 am, the surveyor inspected the medication cart for unit 2 pod 2. Upon inspection of the medication cart, the surveyor observed a bottle of docusate sodium 100 mg (milligram) stool softener with an expiration date of 10/18 printed on the bottle, and a bottle of regular strength enteric-coated aspirin 325 mg with an expiration date of 1/18 printed on the bottle. The surveyor also observed a package of ipratropium bromide and albuterol sulfate inhalation solution 0.5 mg/3 mg per ml (milliliter), and a package of albuterol sulfate inhalation solution 0.63 mg/3 ml that had been opened and was undated. The surveyor observed a Breo Ellipta 200/25 inhaler that had been opened and was undated, and a Ventolin HFA inhaler that had been opened and was undated. The surveyor reviewed all medications with RN (registered nurse) # 1. RN # 1 agreed that the docusate sodium 100 mg stool softener and the regular strength enteric coated aspirin 325 mg was available for use on the medication cart past the expiration date printed on the bottles, and agreed that the albuterol sulfate inhalation solution, ipratropium bromide solution, albuterol sulfate 0.63mg inhalation solution, Breo Elilipta 200/25 inhaler, and Ventolin HFA inhaler had been opened and was undated.

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The package of ipratropium bromide and albuterol sulfate inhalation solution 0.5 mg/3 mg per ml had instructions documented on the package that included but was not limited to: ..." Once removed from the foil pouch the individual vials should be used within two weeks." ...

The package of albuterol sulfate inhalation solution 0.63 mg had instructions printed on the package that included but was not limited to: ..."Once removed from the foil pouch, use the vial(s) within one week." ...

The Breo Ellipta 200/25 inhaler manufacturer's package insert contained documentation that included but was not limited to:
..."Important Notes:
Write the "Tray opened" and "Discard" dates on the inhaler label. The "Discard" date is 6 weeks from the date you open the tray." ...

The manufacturer's package insert for the Ventolin HFA inhaler contained documentation that included but was not limited to:
..."The inhaler should be discarded when the counter reads 000 or 12 months after removal from the moisture-protective foil pouch, whichever comes first." ...

On 11/28/18 at 8:34 am, the surveyor inspected the medication cart for unit 2 pod 3 with LPN # 1 (licensed practical nurse). Upon inspection of the medication cart, the surveyor observed a package of budesonide inhalation suspension 0.5 mg/2ml that had been opened and was undated, and a package of ipratropium bromide and albuterol sulfate 0.5 mg/3 mg per 3 ml solution

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that had been opened and was undated. The surveyor reviewed the packages and instructions with LPN # 1 and LPN # 1 agreed that packages had been opened and were not labeled.

The package of budesonide inhalation suspension 0.5 mg/2ml had instructions printed on the package that included but was not limited to:
..."Once the foil envelope is opened, use the vials within 2 weeks." ...

The package of ipratropium bromide and albuterol sulfate inhalation solution 0.5 mg/3 mg per ml had instructions documented on the package that included but was not limited to:
..." Once removed from the foil pouch the individual vials should be used within two weeks." ...

The facility policy on "General Dose Preparation and Medication Administration" contained documentation that included but was not limited to:
..."4.1 Facility staff should:
Check the expiration date on the medication." ...

The facility policy on "Storage and Expiration of Medications, Biologicals, Syringes and Needles" contained documentation that included but was not limited to:
..."4. Facility should ensure that medications and biologicals:
4.1 Have an expiration date on the label
4.2 Have not been retained longer than recommended by manufacturer or supplier guidelines." ...

On 11/28/18 at 4:50 pm, the administrative team

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was made aware of the findings as stated above.

No further information was provided to the survey team prior to the exit conference on 11/29/18.
2. The medication cart on hall 1-pod 1 (upper hall) included an expired bottle of liquid antacid.

On 11/28/18 at 8:35 a.m., the surveyor checked the medication cart on unit 1-pod 1 (upper hall) with LPN (licensed practical nurse) #1. This medication cart included an opened 12-ounce bottle of liquid antacid. This bottle was labeled with an expiration date of 04/2018. The bottle was marked as being opened on 11/13/____. After reviewing the expiration date with the surveyor LPN #1 verbalized to the surveyor that she was going to throw the bottle away.

The facility policy/procedure titled "5.3 Storage and Expiration of Medications, Biologicals, Syringes and Needles" with an effective date of 12/01/07 read in part, "...Once any medication...is opened. Facility should follow manufacture/supplier guidelines with respect to expiration dates for opened medications..."

The administrative staff were notified of the expired liquid antacid during a meeting with the survey team on 11/27/18 at 3:52 p.m.

No further information regarding this issue was provided to the survey team prior to the exit conference.

3. On 11/28/18 at 08:35 AM, the surveyor inspected the medication cart for pod 1 on unit 3 with the LPN assigned to that pod. The surveyor found advanced antacid liquid opened 8-18-18. The LPN said that it was good for 30 days after

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opening. A Symbicort 160-4.5 inhaler labeled for Resident #95 had no open date. A Symbicort 160-4.5 box labeled for Resident #144 had no name or opening date on the inhaler and the inhaler had 0 doses remaining. A Ventolin 90 mcg (microgram) inhaler was labeled 6/12/18. The LPN was unable to say how long after opening the inhaler could be used.

Administrative staff were made aware of the concern with open and expiration dates during a summary meeting on 11/28/18.
4. The facility staff failed to label eye drops when opened on med cart POD #3.

On 11/29/18 at 8:35 am, the surveyor observed the following eye drops not labeled when opened by the facility staff:
"Brimonidine Tartrate 0.2% eye drops --was opened as evidenced by no seal on eye drops--no open date documented on bottle or on bottle label from pharmacy
"Prednisolone Acet 1% deops ML--was opened as evidenced by no seal on eye drops--no open date documented on bottle or on bottle label from pharmacy

The surveyor interviewed RN (registered nurse) #1 at approximately 8:45 am. The surveyor asked RN #1 what was the process to follow when eye drops were opened and then when the last dose was given. RN #1stated, "If they are eye drops such as this we have to destroy them and not send back to pharmacy. They are destroyed when they are completed or d/cd. When they are opened I would date then."

According to the package insert, these eye drops as documented above are good only for 4 weeks

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| F 761 | Continued From page 56<br>after they are opened. The surveyor could not find the opened date on either of the above eye drops.<br><br>The director of nursing and the corporate nurse were notified of the above findings at approximately 10 am by the surveyor.<br><br>No further information was provided to the surveyor prior to the exit conference on 11/29/18. | F 761 | | |
| F 812 SS=F | Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2)<br><br>§483.60(i) Food safety requirements.<br>The facility must -<br><br>§483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities.<br>(i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations.<br>(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.<br>(iii) This provision does not preclude residents from consuming foods not procured by the facility.<br><br>§483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, facility document review and staff interview, the facility staff failed to wear beard restraints to prevent hair from contaminating food. | F 812 | 1) Both employees were immediately educated and instructed to cover beard and mustache with beard guard.<br>2) Education provided to dietary | 1/1/19 |

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| F 812 | Continued From page 57<br><br>The findings included:<br><br>The facility staff failed to wear beard restraints to prevent facial hair from contaminating food. During the initial tour to the facility kitchen on 11/26/18 at approximately 6:40 pm, the surveyor observed dietary aide #1 having a beard guard over the lower jaw line but did not cover the mustache area above his lip.<br><br>On 11/27/18 am, the surveyor observed dietary aide #1 and #2 in the kitchen area where the food was being cooked as well as being at the tray line area when the food was being transferred from the cooking area to the tray line area of the kitchen. While the dietary manager was assisting in the transfer of the food as described above, the dietary manager had all areas of the beard covered with a beard guard. This included the mustache on the upper lip and the lower jaw line beard.<br><br>The surveyor notified the dietary manager of the above documented findings on 11/27/18 at 4:30 pm. The surveyor requested a copy of the facility's policy on regarding the use of beard guards of dietary staff.<br><br>The surveyor received a copy of the facility's policy at 4:50 pm titled, "Personal Hygiene and Dress Code". The policy read in part, " ...6. All persons in the food preparation and food storage areas shall wear hair restraints such as hair coverings, hair nets, or beard guards where necessary, that are designed and worn effectively keep their hair from contacting exposed food, clean equipment, utensils, linens and unwrapped single-use articles ..." | F 812 | department staff that individuals with facial hair are to cover mustache and beard with beard guard.<br>3) Dietary manager or designee to monitor dietary staff for compliance 5 times per week on both shifts for four weeks. Any noncompliance will not be tolerated.<br>4) Process will be reviewed in QA committee for one quarter.<br>5) Completion date 1/1/2019 | |

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| F 812 | Continued From page 58<br><br>The surveyor notified the administrative team on 11/28/18 at 3:53 pm and again on 11/29/18 at 12:59 in the conference room.<br><br>No further information was provided to the surveyor prior to the exit conference on 11/29/18. | F 812 | | |
| F 849 SS=D | Hospice Services<br>CFR(s): 483.70(o)(1)-(4)<br><br>§483.70(o) Hospice services.<br>§483.70(o)(1) A long-term care (LTC) facility may do either of the following:<br>(i) Arrange for the provision of hospice services through an agreement with one or more Medicare-certified hospices.<br>(ii) Not arrange for the provision of hospice services at the facility through an agreement with a Medicare-certified hospice and assist the resident in transferring to a facility that will arrange for the provision of hospice services when a resident requests a transfer.<br><br>§483.70(o)(2) If hospice care is furnished in an LTC facility through an agreement as specified in paragraph (o)(1)(i) of this section with a hospice, the LTC facility must meet the following requirements:<br>(i) Ensure that the hospice services meet professional standards and principles that apply to individuals providing services in the facility, and to the timeliness of the services.<br>(ii) Have a written agreement with the hospice that is signed by an authorized representative of the hospice and an authorized representative of the LTC facility before hospice care is furnished to any resident. The written agreement must set out at least the following: | F 849 | | 1/1/19 |

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| F 849 | Continued From page 59<br>(A) The services the hospice will provide.<br>(B) The hospice's responsibilities for determining the appropriate hospice plan of care as specified in §418.112 (d) of this chapter.<br>(C) The services the LTC facility will continue to provide based on each resident's plan of care.<br>(D) A communication process, including how the communication will be documented between the LTC facility and the hospice provider, to ensure that the needs of the resident are addressed and met 24 hours per day.<br>(E) A provision that the LTC facility immediately notifies the hospice about the following:<br>(1) A significant change in the resident's physical, mental, social, or emotional status.<br>(2) Clinical complications that suggest a need to alter the plan of care.<br>(3) A need to transfer the resident from the facility for any condition.<br>(4) The resident's death.<br>(F) A provision stating that the hospice assumes responsibility for determining the appropriate course of hospice care, including the determination to change the level of services provided.<br>(G) An agreement that it is the LTC facility's responsibility to furnish 24-hour room and board care, meet the resident's personal care and nursing needs in coordination with the hospice representative, and ensure that the level of care provided is appropriately based on the individual resident's needs.<br>(H) A delineation of the hospice's responsibilities, including but not limited to, providing medical direction and management of the patient; nursing; counseling (including spiritual, dietary, and bereavement); social work; providing medical supplies, durable medical equipment, and drugs | F 849 | | |

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| F 849 | Continued From page 60<br>necessary for the palliation of pain and symptoms associated with the terminal illness and related conditions; and all other hospice services that are necessary for the care of the resident's terminal illness and related conditions.<br>(I) A provision that when the LTC facility personnel are responsible for the administration of prescribed therapies, including those therapies determined appropriate by the hospice and delineated in the hospice plan of care, the LTC facility personnel may administer the therapies where permitted by State law and as specified by the LTC facility.<br>(J) A provision stating that the LTC facility must report all alleged violations involving mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown source, and misappropriation of patient property by hospice personnel, to the hospice administrator immediately when the LTC facility becomes aware of the alleged violation.<br>(K) A delineation of the responsibilities of the hospice and the LTC facility to provide bereavement services to LTC facility staff.<br><br>§483.70(o)(3) Each LTC facility arranging for the provision of hospice care under a written agreement must designate a member of the facility's interdisciplinary team who is responsible for working with hospice representatives to coordinate care to the resident provided by the LTC facility staff and hospice staff. The interdisciplinary team member must have a clinical background, function within their State scope of practice act, and have the ability to assess the resident or have access to someone that has the skills and capabilities to assess the resident. | F 849 | | |

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| F 849 | Continued From page 61<br>The designated interdisciplinary team member is responsible for the following:<br>(i) Collaborating with hospice representatives and coordinating LTC facility staff participation in the hospice care planning process for those residents receiving these services.<br>(ii) Communicating with hospice representatives and other healthcare providers participating in the provision of care for the terminal illness, related conditions, and other conditions, to ensure quality of care for the patient and family.<br>(iii) Ensuring that the LTC facility communicates with the hospice medical director, the patient's attending physician, and other practitioners participating in the provision of care to the patient as needed to coordinate the hospice care with the medical care provided by other physicians.<br>(iv) Obtaining the following information from the hospice:<br>(A) The most recent hospice plan of care specific to each patient.<br>(B) Hospice election form.<br>(C) Physician certification and recertification of the terminal illness specific to each patient.<br>(D) Names and contact information for hospice personnel involved in hospice care of each patient.<br>(E) Instructions on how to access the hospice's 24-hour on-call system.<br>(F) Hospice medication information specific to each patient.<br>(G) Hospice physician and attending physician (if any) orders specific to each patient.<br>(v) Ensuring that the LTC facility staff provides orientation in the policies and procedures of the facility, including patient rights, appropriate forms, and record keeping requirements, to hospice staff furnishing care to LTC residents. | F 849 | | |

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| F 849 | Continued From page 62<br><br>§483.70(o)(4) Each LTC facility providing hospice care under a written agreement must ensure that each resident's written plan of care includes both the most recent hospice plan of care and a description of the services furnished by the LTC facility to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, as required at §483.24.<br>This REQUIREMENT is not met as evidenced by:<br>Based on staff interview and clinical record review, facility staff failed to ensure the hospice care plan, assessments, and treatment notes were available at the facility for staff review and that the hospice care plan was integrated into the resident's comprehensive care plan for 1 of 38 residents in the survey sample (Resident #163).<br><br>The findings included:<br><br>Resident #163 was admitted to the facility on 5/8/18. Diagnoses included cerebral infarction with hemiplegia and hemiparesis of non-dominant side and other sequelae of cerebral infarction, hypertension, diabetes mellitus, and schizophrenia. On the significant change minimum data set assessment with assessment reference date 11/9/18, the resident scored 4/15 on the brief interview for mental status and was assessed as without symptoms of delirium, psychosis, or behaviors affecting care.<br><br>On 11/27/18 at 11:57 AM, the surveyor observed a hospice aid bathing the resident with the assistance of 2 facility nursing assistants (CNA). The aid said she comes on Tuesday and Thursday for bathing. The resident was complaining of pain, and not wanting to be turned | F 849 | 1. The hospice care plan has been integrated into comprehensive care plan and care documentation is current and accessible for Resident #163.<br>2. Current residents under the care of hospice were reviewed to ensure integration of the hospice care plan and that hospice care notes are accessible to staff. Corrections were made as necessary.<br>3. Members of the interdisciplinary care planning team were educated regarding integration of hospice care plan. Current nursing staff were educated regarding accessibility of hospice care notes. Nursing leadership will review all hospice care plans weekly X 4 to ensure hospice integration and notes available as indicated. Any issues will be addressed immediately at the time of identification.<br>4. Process will be reviewed in QA committee for one quarter.<br>5. Completion 1/1/2019 | |

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| F 849 | Continued From page 63 | F 849 | | |

so new linens could be placed under her.

During clinical record review on 11/27/18, the surveyor was unable to locate evidence of hospice care integration in the resident's record. There was an order to admit to hospice effective 11-1-18 signed by the physician 11-2-18. The only documents pertaining to hospice in the record (a section for Resident #163 in the hospice binder) was the cover sheet with hospice contact numbers and web address, a form titled Hospice/Nursing Facility Plan of Care, and a Summary of Hospice Contact in the Facility.

The Hospice/Nursing Facility Plan of Care listed the names of the registered nurse and social worker assigned to the resident and a pre-printed problem list: Durable Medical Equipment, Primary plan of Care, Resuscitation, Treatment Schedule, Visit Schedule, CNA assignment, Emergency Preparedness Care Plan. Hospice POC (plan of care) was handwritten. No narrative, goals, or interventions were documented for any of the problems.

The surveyor asked the resident's nurse if there was any documentation of hospice care plan or responsibility. She pulled the hospice book and said all the care plans were there. There was no care plan or contract for Resident #163. The surveyor asked how staff knew what the hospice was supposed to do and what had been done. She said that hospice staff left notes when they were there and the nurses talked with facility nurses when they came.

The surveyor asked for hospice records and received, at the end of the day, a contract and care plan and a printout of notes that the hospice

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| F 849 | Continued From page 64<br>faxed to the facility on 11/27/18 at 14:56.<br><br>The resident's facility comprehensive care plan only mentioned hospice on the ADL focus with no interventions attributed to hospice staff and under the terminal prognosis focus with the intervention: work cooperatively with hospice team as ordered to ensure the resident's spiritual, emotional, intellectual, physical and social needs are met. When the surveyor asked the MDS nurse responsible for the care plan how that is accomplished and how staff know what hospice responsibilities are, she said they look in the hospice book.<br><br>The surveyor informed the administrator and director of nursing of the concern on 11/27/18. | F 849 | | |
| F 880 SS=D | Infection Prevention & Control<br>CFR(s): 483.80(a)(1)(2)(4)(e)(f)<br><br>§483.80 Infection Control<br>The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.<br><br>§483.80(a) Infection prevention and control program.<br>The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:<br><br>§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals | F 880 | | 1/1/19 |

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| F 880 | Continued From page 65 | F 880 | | |

providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;

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

§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.

§483.80(e) Linens.

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| F 880 | Continued From page 66<br>Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.<br><br>§483.80(f) Annual review.<br>The facility will conduct an annual review of its IPCP and update their program, as necessary.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, clinical record review, facility document review, and staff interview the facility staff failed to ensure an effective infection control program for 1 of 38 Residents, Resident #151.<br><br>The findings included:<br><br>For Resident #151, during a wound care observation the facility staff placed a dirty towel on top of a clean surface, failed to complete hand hygiene after cleaning a surface with a bleach wipe, and used a contaminated dressing on the Resident's wound.<br><br>Resident #151 is a 91 year-old-female admitted to the facility on 10/23/2018. Diagnoses included, but were not limited to, atrial fibrillation, hypertension, osteoporosis, muscle weakness and chronic obstructive pulmonary disease.<br><br>The clinical record for Resident # 151 was reviewed on 11/27/18. The most recent MDS (minimum data set) assessment was an admission assessment with an ARD (assessment reference date) of 11/06/18. Section C of the MDS assesses cognitive patterns. In Section C0500, the facility staff documented that Resident #151 had a BIMS (brief interview for mental status) score of 14 out of 15. Section M (skin | F 880 | 1. Resident #151 is currently receiving wound care based on standard infection control procedures.<br>2. Current residents with wound care dressing orders were reviewed. Current nurses performing dressing changes were observed to ensure standard infection control measures were followed while performing dressing change. Corrections were made as necessary.<br>3. Current licensed nurses were educated regarding standard infection control measures when performing a dressing change. Nursing leadership will complete treatment administration observations for 3 nurses weekly X 4 weeks to ensure compliance with infection control measures. Any issues will be addressed immediately at the time of identification.<br>4. Process will be reviewed in QA committee for one quarter.<br>5. Completion 1/1/19 | |

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conditions) had been coded to indicate the Resident was at risk for developing pressure ulcers and has a stage 2 pressure ulcer. The MDS had been coded to indicate the Resident has a pressure reducing device for her chair, a pressure reducing device for her bed, and Resident is receiving pressure ulcer care.

Resident #151's CCP (comprehensive care plan) was reviewed on 11/27/18. The CCP contained a focus area for "The Resident has pressure to sacrum," and included the intervention "Weekly skin assessment; treatments as ordered."

During an interview with Resident #151 on 11/27/18 at 2:03pm Resident #151 voiced a concern to the surveyor regarding her wound. Resident #151 stated "It's been a few days since they have changed the patch (dressing) on my butt. It's sore. It bothers me a lot."

On 11/27/18 at 2:33pm LPN (licensed practical nurse) #1 was asked by surveyor, "How often Resident #151 receives wound care?" LPN #1 voiced he would have to go check Resident #151's order. LPN #1 reported back to the surveyor that Resident #151's pressure ulcer treatment is every three days.

On 11/28/18 at 11:37am, the surveyor observed Resident #151 receiving wound care. When the surveyor entered Resident 151's room the supplies to provide wound care were on top of a towel on a bedside table. Supplies and towel were removed due to a visitor touching the towel when exiting the room. CNA (certified nurse assistant) #1 applied a clean towel to the table top and then removed towel. CNA #1 wiped table top with bleach wipe. The same towel was

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| F 880 | Continued From page 68<br>reapplied by LPN #2 prior to allowing the table top to dry. CNA #1 did not wash hands or change gloves after cleaning the table top. CNA #1 then placed three individual sterile vials of normal saline, package of 4x4 gauze, and a package of Allevyn 3x3 gentle border adhesive foam dressing directly on top of the towel. LPN #2 placed scissors and a sharpie that were contained in tin foil on top of towel. LPN #2 cleansed scissors with alcohol prep and returned them directly back to the tin foil they were previously placed in. CNA #1 assisted the Resident out of her wheelchair and provided the Resident her walker for support. While the Resident was standing LPN #2 cleansed the Residents wound and applied treatment as ordered. LPN #2 then retrieved an Allevyn 3x3 gentle border adhesive foam dressing from package. LPN #2 dropped the Allevyn 3x3 gentle border adhesive foam dressing in Resident #151's wheelchair that was positioned behind her. LPN #2 then picked up the dressing and applied it to the Resident's wound.<br><br>On 11/28/18 at 12:10pm, the surveyor asked infection control nurse "What should CNA#1 and LPN #2 should have done?" The Infection control nurse voiced the CNA and/or LPN should have obtained another towel after picking the one up off the bedside table and cleaning the table. The towel previously on the table should have been discarded and a new one obtained.<br><br>On 11/28/18 at 3:33pm, LPN #2 was asked by surveyor if there was an issue when she the towel on the table and then picked it back up for the CNA#1 to clean? LPN #2 stated, "I should have cleaned the table first and then put a new towel down ..." | F 880 | | |

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The administrative team was made aware of issue during end of day meeting on 11/28/18 on 4:52pm.

On 11/29/18 at 12:55pm the infection control nurse provided the surveyor with a facility document titled "Treatment Observation Non-Sterile Treatment Technique". The infection control nurse voiced that the document provided to the surveyor is a checklist utilized as a quality assurance tool that is used when she observes nurses performing treatment. Under the sectioned entitled "Observation" the following task were listed but were not limited to; "Clean and sanitize surface before placing waterproof barrier on table", and "Perform hand hygiene ..." The infection control nurse voiced that the task listed on the facility document is what she expects the nurses to complete when a treatment is performed.

No further information was provided to the surveyor prior to exit conference on 11/29/18.