PRINTED: 04/16/2019
FORM APPROVED

State of Virginia

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING	(X3) DATE SURVEY COMPLETED
	VA0103		04/05/2019

NAME OF PROVIDER OR SUPPLIER: HERITAGE HALL KING GEORGE

STREET ADDRESS, CITY, STATE, ZIP CODE: 10051 FOXES WAY, KING GEORGE, VA 22485

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
F 000	Initial Comments An unannounced biennial State Licensure Inspection was conducted 4/2/19 through 4/5/19. The facility was not in compliance with the Virginia Rules and Regulations for the Licensure of Nursing Facilities. One complaint was investigated during the survey. The census in this 130 licensed bed facility was 102 at the time of the survey. The survey sample consisted of 30 Resident reviews.	F 000		
F 001	Non Compliance The facility was out of compliance with the following state licensure requirements: This RULE: is not met as evidenced by: 12 VAC 5-371-370 (A). Please cross reference to F-584. 12 VAC 5-371-140 (A). Please Cross Reference to F-607. 12 VAC 5-371-250 (A.) Please Cross Reference to F-636. 12 VAC 5-371-250 (A). Please Cross Reference to F-641. 12 VAC 5-371-250 (G). Please cross reference to F-656. 12 VAC 5-371-250 (F). Please Cross Reference to F-657. 12 VAC 5-371-200 (B) (1) (ii). Please cross reference to F-658. 12 VAC 5-371-360 (E)(11). Please cross	F 001	F 001 **12 VAC 5-371-370 (A)** Cross References to F-584 Cross Reference POC for F-584 **12 VAC 5-371-140 (A)** - Cross Reference to F-607 Cross Reference POC for F-607 **12 VAC 5-371-250 (A)** - Cross Reference to F-636 Cross Reference POC for F-636 **12 VAC 5-371-250 (A)** - Cross Reference to F-641 Cross Reference POC for F-641 **12 VAC 5-371-250 (G)** - Cross Reference to F-656 Cross Reference POC for F-656 **12 VAC 371-250 (F)** - Cross Reference to F-657 Cross Reference POC for F-657 **12 VAC 371-200 (B) (1) (ii)** - Cross Reference to F-658 Cross Reference POC for F-658 **12 VAC 371-360 (E) (11)** - Cross Reference to F-661 Cross Reference POC for F-661	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature] TITLE: Administrator (X6) DATE: 4/24/19

State of Virginia

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F 001	Continued From page 1 reference to F-661. 12 VAC 5-371-220 (A). Please cross reference to F-685. 12 VAC 5-371-220 (A). Please cross reference to F-689. 12 VAC 5-371-220 (C) (3). Please cross reference to F-690. 12 VAC 5-371-260 (F). Please cross reference to F-730. 12 VAC 5-371-270 (A). Please cross reference to F-740. 12 VAC 5-371-300 (A). Please cross reference to F-755. 12 VAC 5-371-220 (A). Please cross reference to F-757. 12 VAC 5-371-220 (A). Please cross reference to F-758. 12 VAC 5-371-340 (A). Please cross reference to F-812. 12 VAC 5-371-360 (E). Please cross reference to F-842.	F 001	**12 VAC 371-220 (A)** - Cross Reference to F-685 Cross Reference POC for F-685 **12 VAC 371-220 (A)** - Cross Reference to F-689 Cross Reference POC for F-689 **12 VAC 371-220 (C) (3)** - Cross Reference to F-690 Cross Reference POC for F-690 **12 VAC 371-260 (F)** - Cross Reference to F-730 Cross Reference POC for F-730 **12 VAC 371-270 (A)** - Cross Reference to F-740 Cross Reference POC for F-740 **12 VAC 371-300 (A)** - Cross Reference to F-755 Cross Reference POC for F-755 **12 VAC 371-220 (A)** - Cross Reference to F-757 Cross Reference POC for F-757 **12 VAC 371-220 (A)** - Cross Reference to F-758 Cross Reference POC for F-758 **12 VAC 371-340 (A)** - Cross Reference to F-812 Cross Reference POC for F-812 **12 VAC 371-360 (E)** - Cross Reference to F-842 Cross Reference POC for F-842 **Completion Date: May 20, 2019**	

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

PRINTED: 04/16/2019
FORM APPROVED
OMB NO. 0938-0391

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	495300		C 04/05/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 4/2/19 through 4/5/19. The facility was in substantial compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities. No emergency preparedness complaints were investigated during the survey.	E 000		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 4/2/19 through 4/5/19. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. One complaint was investigated during the survey. The census in this 130 certified bed facility was 102 at the time of the survey. The survey sample consisted of 30 resident.	F 000		
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, resident interviews and clinical record review, the facility staff failed to ensure reasonable accommodation of resident needs and preferences for two Residents (Resident # 49 and # 68) in a survey sample of 30 residents.	F 558	**F558** **Corrective Action(s):** Resident #49 & Resident #68 have had the clocks in their rooms set to the correct time. A facility Incident & Accident form was completed for this incident. **Identification of Deficient Practices & Corrective Action(s):** All other residents may have potentially been affected. The Maintenance Director and/or Maintenance Assistant will perform 100% review of all resident room clocks to identify residents at risk. Any/all resident room clocks will be will corrected at the time of discovery.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature] TITLE: Administrator (X6) DATE: 4/24/19

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 558	Continued From page 1 1. For Resident # 49, the facility staff failed to make sure the clock in his room was correct. 2. For Resident # 68, the facility staff failed to make sure the clock in her room was correct. Findings included: 1. For Resident # 49, the facility staff failed to make sure the clock in his room was correct. Resident # 49, a 91 year old male, was admitted to the facility on 12/1/2017. Diagnoses included but were not limited to: Alzheimer's Disease, Hypertension, Malignant Neoplasm of Prostate, Gastroesophageal Reflux Disease, Dementia, Osteoarthritis, and Anxiety. Resident # 49's most recent Minimum Data Set (MDS) was a quarterly assessment with an Assessment Reference Date (ARD) of 2/1/2019. The MDS coded Resident # 49 with a BIMS (Brief Interview for Mental Status) score of "3" out of 15, indicating severe cognitive impairment. Resident # 49 was coded as requiring limited to extensive assistance of one staff person for Activities of Daily Living except total assistance of one staff person for bathing. Resident # 49 was coded as occasionally incontinent of bowel and bladder. During the initial tour of the facility on 4/2/2019 at 12:17 PM, the white clock located above the closet in Resident # 49's room was observed to have the time "11:15." The second hand was not moving. On 4/2/2019 at 4:13 PM, the clock still had the time of 11:15. Resident # 49 was observed lying	F 558	**Systemic Change(s):** The facility policy and procedure has been reviewed and no changes are warranted at this time. All staff will be inserviced by the Administrator and/or DON on ensuring that resident room clocks are set to the correct time and date (if applicable) for all residents. **Monitoring:** The Unit Managers are responsible for maintaining compliance. DON and/or Unit Managers will complete random daily rounds throughout the day to monitor resident room clocks for correct time. Any negative findings will be corrective at time of discovery and disciplinary action will be taken as required. Aggregate findings will be reported to the QA Committee for review, analysis, and recommendations of change in facility policy, procedure, or practice. **Completion Date: May 20, 2019**	

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F 558	Continued From page 2 in bed. On 4/3/2019 at 8:30 AM, the observed time on the clock was 11:15. On 4/3/2019 at 2:45 PM, the observed time on the clock was 11:15. On 4/4/2019 at 3:15 PM, the observed time on the clock was 11:15. Resident # 49 was observed lying in bed. A review of Resident # 49's clinical record was conducted during the survey. Resident #49's care plan, revised on 02/27/2019, read that Resident # 49 had a diagnosis of Alzheimer's Disease and dementia resulting in confusion at times. One of the interventions listed was "Reorient as needed." On 4/4/2019 during the end of day debriefing, the Director of Nursing was interviewed. The Director of Nursing stated Resident # 49 was confused and that clocks were used to help with orientation to time. The Director of Nursing went with the surveyor to Resident # 49's room to look at the clock. The Director of Nursing stated the clock in Resident # 49's room should have been accurate. 2. For Resident # 68, the facility staff failed to make sure the clock in her room was correct. Resident # 68, a 91 year old female was admitted to the facility on 12/1/2017. Diagnoses included but were not limited to: Alzheimer's Disease, Hypertension, Major Depressive Disorder, Gastroesophageal Reflux Disease, Dementia,	F 558		

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F 558	Continued From page 3 Cardiomegaly, and Anxiety. Resident # 68's most recent Minimum Data Set (MDS) was a quarterly assessment with an Assessment Reference Date (ARD) of 2/21/2019. The MDS coded Resident # 68 with a BIMS (Brief Interview for Mental Status) score of "3" out of 15, indicating severe cognitive impairment. Resident # 68 was coded as requiring extensive assistance of one to two staff persons for Activities of Daily Living except total assistance of one staff person for Bathing. Resident # 68 was coded as frequently incontinent of bowel and bladder. On 4/2/2019 at 4:13 PM, the clock had the time of 11:15. Resident # 68 was observed lying in bed. On 4/3/2019 at 8:30 AM, the observed time on the clock was 11:15. On 4/3/2019 at 1:30 PM, Resident # 68 was observed lying in bed. Resident # 68 told the surveyor she was waiting to get some pain medicine. The surveyor asked when she last had pain medicine. Resident # 68 looked at the clock and stated I don't know but I need some medicine. On 4/3/2019 at 2:45 PM, the observed time on the clock was 11:15. On 4/4/2019 at 3:15 PM, the observed time on the clock was 11:15. Resident # 68 was observed walking in her room. Review of the clinical record was conducted on 4/4/2019. Review of care plan revealed: Page 1 of 8 Resident #68's care plan, revised on	F 558		

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F 558	Continued From page 4 02/27/2019, read that Resident #68 had a cognitive/communication deficit related to Alzheimer's Disease. On page diagnosis of Alzheimer's Disease and dementia resulting in confusion at times. One of the interventions listed was "Reorient as needed." On 4/5/2019 during the end of day debriefing, the facility Administrator and Director of Nursing were informed of the findings. The Director of Nursing stated new batteries had been placed in the clock and that the clock should be accurate. No further information was provided.	F 558		
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives	F 578	**F578** **Corrective Action(s):** Residents #63 has had their code status and DDNR form reviewed by the DON and the attending physician and the comprehensive care plan and the residents closet care plan have been updated to correctly reflect their DNR code status. An Incident and Accident form was completed for this incident. **Identification of Deficient Practice(s) & Corrective Action(s):** All other residents may have been potentially affected. The Social Services Director and/or Activities Director will review all resident's medical records to ensure the Code status and the DDNR are accurate and that the DDNR form is accurately filled out. Any negative findings with result in the Social Services Director and/or Admission Director to contact all responsible parties to verify each resident's code status and advance directives to insure that the proper code status has been explained and that written notification has been placed in the medical record, comprehensive care plan and the residents closet care plan..	

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F 578	Continued From page 5 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 observation, staff interview, clinical record review, and facility documentation, the facility staff failed to accurately convey Advanced Directives preferences to the staff responsible for resident's care for one resident (Resident #63) in a sample size of 30 residents. The findings included: Resident #63, a 68-year old female, was admitted to the facility on 04/02/2015. Diagnoses include but not limited to Non-ST elevation (NSTEMI) myocardial infarction, heart failure, cerebral infarction, hypertension, diabetes, and hemiplegia. Resident #63's most recent Minimum Data Set had an Assessment Reference Date (ARD) of 02/18/2019 and was coded as a quarterly	F 578	**Systemic Change(s);** The Facility policy and procedure was reviewed and no changes are warranted at this time. The Admissions Director and Social Services director have been inserviced on the proper completion of a DDNR and Advance Directives when required. The Admission Director will discuss with each future Admission their advance directors and resuscitation status upon admission to the facility. Any/all concerns expressed will be reported to the Administrator. The Administrator & Director of Nursing will speak to those concerned or with questions about each area & follow through on all concerns to ensure proper resuscitation status is reflected in the medical record. **Monitoring:** The Admission Director and Social Services Director are responsible for maintaining compliance. The Social Services Director and/or Admissions Director will audit all Residents medical records monthly to monitor compliance for having a current resuscitation order and/or advance directive Any/all negative findings will be reported to the Administrator for immediate corrective action to include an investigation. **Completion Date: May 20, 2019**	

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F 578	Continued From page 6 assessment. Resident #63 was coded with a Brief Interview of Mental Status (BIMS) score of 3 out of possible 15 indicative of severe cognitive impairment. Functional status for bed mobility, transfers, dressing, and personal hygiene were all coded as requiring extensive assistance from staff. Functional status for eating was coded as requiring supervision from staff. On 04/02/2019 at 4:15 PM, the current physician's orders in the electronic health record were reviewed. A physician's order dated 11/25/2018 documented, "Resident Hospice care as of 11/16/18 [hospice company name]." A physician's order dated 11/26/2018 documented, "DNR (do not resuscitate)." The care plan in the electronic health record was reviewed. A problem onset dated 04/02/2015 documented, "[Resident #63] has an inability to perform ADLs (Activities of Daily Living) independently secondary to muscle spasms, HTN (hypertension), CVA (cerebral vascular accident), hemiparesis, RAKA (right above-the-knee amputation), depression. Resident refuses meals & supplements at time." (sic) One "approach" documented for this problem documented, "Full code." On 04/02/2019 at 4:40 PM, an interview with CNA C was conducted. When asked where a CNA would find out information about how to care for Resident #63, she stated she looks at "the care plan" that is posted on the inside of Resident #63's closet door. CNA C and this surveyor then entered Resident#63's room and CNA C then opened Resident #63's closet door to show a document entitled, "CNA Care Plan" which included Resident #63's name and room number	F 578		

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F 578	Continued From page 7 (handwritten). It also included Resident #63's needs pertaining to ADLs. On the left hand side of the paper, it was documented, "Information is current as of this date: 10-31-18." On the top left side of the CNA Care Plan, it was documented "Full code." CNA C then closed the closet door. This surveyor then asked CNA C what Resident #63's code status was and she stated, "She's a full code." A copy of the CNA Care Plan was requested and CNA C stated she would have to ask the nurse. On 04/02/2019 at approximately 4:45 PM, this surveyor and CNA C walked to the nurse's station. After speaking with a nurse, CNA C went to Resident #63's room to retrieve the CNA Care Plan on the closet door. The staff nurse got Resident #63's hard chart and displayed the Durable Do Not Resuscitate Order and stated to this surveyor, "Do you realize this resident is on hospice and she's a DNR?" CNA C returned with the CNA Care Plan and handed it to LPN B. LPN B looked at the document and stated, "It (closet care plan) wasn't updated." A copy of the Durable Do Not Resuscitate order and the electronic care plan were requested. On 04/02/2019 at 4:55 PM, a Durable Do Not Resuscitate document was provided. It was dated 11/20/18 and signed by physician, responsible party, and a witness. A paper copy of the electronic care plan was provided. Under the problem entitled, "[Resident #63] has an inability to perform ADLs (Activities of Daily Living) independently secondary to muscle spasms, HTN (hypertension), CVA (cerebral vascular accident), hemiparesis, RAKA (right above-the-knee amputation), depression. Resident refuses meals & supplements at time." ,"Full Code" was crossed	F 578		

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F 578	Continued From page 8	F 578		

out and "DNR" was added (handwritten and not dated or initialed). Employee L stated the most updated version of the care plan is on paper kept on the unit. Employee L stated electronic care plans (what is seen on the computer) are updated quarterly.

On 04/05/19 at 10:10 AM, an interview with Employee H, the MDS, Care Plan Coordinator was conducted. When asked about how to determine when an intervention on a care plan was implemented, Employee H stated, "We don't date interventions." She went on to say the intervention either continues or it would be resolved. When asked about a resolved intervention, Employee H stated, "I would delete it." Employee H stated the paper copy care plans are kept in a book on the unit, updated on the paper, and eventually entered into the computer. When asked about the CNA (closet) care plans, Employee H stated closet care plans are also updated as needed.

The facility policy entitled, "Advanced Directives" was reviewed. Section 7 documented, "Information about whether or not the resident has executed an advanced directive shall be displayed prominently in the medical record." Section 10 documented, "The plan of care for each resident will be consistent with his or her documented treatment preferences and/or advanced directive."

In summary, there was conflicting information regarding Resident #63's Advanced Directives preferences on the electronic care plan, the paper copy care plan, and the CNA closet care plan.

On 04/05/2019 at approximately 2:30 PM, the

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F 578	Continued From page 9 DON and Administrator were notified of findings and they offered no further information or documentation.	F 578		
F 582 SS=D	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section. §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least	F 582	**F582** **Corrective Action(s):** The Business Office Manager and the Social Services Director have been inserviced on the procedure for notifying Medicare recipients on the termination of skilled services and that a beneficiary signature is required to be obtained. A Facility Incident and Accident form was completed for the incident. **Identification of Deficient Practice(s) & Corrective Action(s):** All other residents receiving Medicare Skilled Services may have been potentially affected. The Business Office Manager will review all current residents that have Medicare Skilled Benefits to insure that the termination of benefits process has been explained and that written notification has been or will be sent to the resident and/or Responsible Party and that a signature from the beneficiary has been obtained to acknowledge that they have received the notice of their Medicare benefits will be terminating.	

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	495300		C 04/05/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 582	Continued From page 10 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by: Based on staff interview and facility documentation review, the facility staff failed to notify resident/responsible party of termination of Medicare Part A benefits for one resident (Resident #77) in a sample of 3 residents. The findings included: Resident #77, a 99-year old female, was admitted to the facility on 02/15/2019. Diagnoses included but not limited to diabetes, hypertension, and hyperlipidemia. Resident #77's most recent MDS (Minimum Data Set) assessment with an ARD (assessment reference date) of 02/22/2019 was coded as an annual assessment. The Brief Interview for Mental Status (BIMS) was coded as 9 out of	F 582	**Systemic Change(s);** Facility policy and procedure was reviewed and no changes are warranted at this time. The Business Office Manager and/or Social Services Director will discuss with each future Medicare recipient the termination of benefits notification process upon notification that Medicare skilled services are stopping for resident. Any/all concerns expressed will be reported to the Administrator. The Administrator & Business Office Manager will investigate & follow through on all concerns. **Monitoring:** The Business Office Manager is responsible for maintaining compliance. The Business Office Manager will audit all Medicare recipients monthly to monitor compliance with the notification of termination of Medicare Benefits. Any/all negative findings will be reported to the Administrator for immediate corrective action to include an investigation. **Completion Date: May 20, 2019**	

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F 582	Continued From page 11 possible 15 indicative of moderate cognitive impairment. Resident #77's Notice of Medicare Non-Coverage (NOMNC) and Skilled Nursing Facility Advance Beneficiary Notice of Non-Coverage (SNFABN) were reviewed. Neither form was signed. On 04/03/2019 at 3:00 PM, an interview with Employee N was conducted. When asked why there were no signatures on the forms, Employee N provided a copy of a page from a ledger dated 03/07/2019 . Employee N stated it shows that the documents were mailed to the responsible party on 03/07/2019. When asked how it is verified the recipient received the information, Employee N stated she knows they were received because they are her relatives. Employee N verified they do not have signed forms as evidence the responsible party was notified. On 04/04/2019 at 9:10 AM, Employee L confirmed that Resident #77 was admitted to skilled care on 02/15/2019, received physical therapy, and was discharged to long-term care status effective 03/15/2019. The facility policy entitled Advance Beneficiary Notices was provided by facility staff. Section 5 documented, "A notice of Medicare non-coverage form CMS 10123, shall be issued to the resident/representative when medicare-covered services are ending, no matter if resident is leaving the facility or remaining in the facility. This informs the resident on how to request an appeal or expedited determination from their quality improvement organization." Section 6 documented, "To ensure that the resident, or representative, has enough time to make a	F 582		

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F 582	Continued From page 12 decision whether or not to receive the services in question and assume financial responsibility, the notice shall be provided within two days of the last anticipated covered day." Section 12 entitled "Delivery Requirements" part (b) documented, "The notice shall be hand-delivered as possible (sic) to obtain beneficiary signature. The facility shall retain the original and give a copy to the resident representative." On 04/05/2019 at approximately 2:30 PM, the Administrator and DON were notified of findings and offered no further information or documentation.	F 582		
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly,	F 584	**F584** **Corrective Action(s):** Resident #71's Foot Board on her bed was replaced and the entire bed was inspected to ensure it was in proper working order. **Identification of Deficient Practice(s) and Corrective Action(s):** All other resident beds may have potentially been affected. A complete documented Bed review of all facility beds will be conducted by the Maintenance Director and/or Maintenance Assistant to identify resident beds at risk. All resident beds identified at risk will be repaired or replaced by the Maintenance Department.	

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F 584	Continued From page 13 and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and facility record review the facility staff failed to ensure one hospital bed was in good repair for one resident (Resident #71) in a survey sample of 30 residents. The facility staff failed to maintain a hospital bed in good repair for Resident #71. The findings included: Resident #71, a 79 year old, was admitted to the facility on 5/18/16. Resident #71's diagnoses included but were not limited to: unspecified dementia with behavioral disturbance, hypothyroidism, essential hypertension, major depressive disorder, gastro-esophageal reflux disease without esophagitis, progressive bulbar	F 584	**Systemic Change(s):** The facility's policy & procedure for providing a safe, sanitary, and comfortable environment has been reviewed. No changes are warranted at this time. The Maintenance Director will provide inservices to all staff on facility policy and procedure on the maintenance notification system to use when facility equipment and repairs are noted and needed throughout the facility. **Monitoring:** The Maintenance Director and the administrator are responsible for maintaining compliance. Documented facility rounds will be completed weekly to monitor compliance. The administrator will review the findings of the audits weekly to ensure negative findings are being corrected. Cumulative findings will be reported to the Quality Assurance Committee for review, analysis, and recommendations for change in facility policy, procedure, and/or practice **Completion Date: May 20, 2019**	

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F 584	Continued From page 14 palsy, and pseudobulbar affect. Resident #71's most recent MDS (minimum data set) (an assessment tool) with an ARD (assessment reference date) of 2/25/19, was coded as an Annual assessment. The resident was coded of having a BIMS (Brief Interview for Mental Status) score of 5, which indicated the resident's cognitive functioning was severely impaired. Resident #71 was coded as requiring extensive assistance of one staff member for dressing and eating; required extensive assistance of two staff members for transfers, toilet use and personal hygiene. During initial observation of the facility on 4/2/19 at approximately 2:25pm the foot board of the bed was noted to be broken. Facility rounds on 4/5/19 at 9:25am the footboard was observed to remain broken. On 4/5/19 at 9:35am an interview was conducted with Employee I; he stated, "I didn't know about this footboard. I can't work on the bed while the resident is in it, but as soon as she is up I can put a replacement on." On 4/5/19 at 12:34pm an interview was conducted with Employee M who stated, "all staff have access to enter work orders. Whoever broke that bed and noticed it should have filled out a work order." The Administrator and Director of Nursing were informed of the failure of staff to maintain furniture in good repair during end of day meeting on 4/5/19. No further information was provided.	F 584		
F 607	Develop/Implement Abuse/Neglect Policies	F 607		

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F 607 SS=E	Continued From page 15 CFR(s): 483.12(b)(1)-(3) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, This REQUIREMENT is not met as evidenced by: Based on staff interview, facility documentation review and in the course of a complaint investigation, the facility staff failed to implement their abuse and neglect policy for 5 of 25 employees. (Employee D, Employee E, LPN C, CNA E and CNA F) The facility staff failed to implement their abuse and neglect policy by failing to pre-screen employees prior to hire by failing to obtain reference checks and verifying licenses/certification. The findings included: A review of employee records was conducted on 4/3/19. The facility failed to conduct license verification prior to hire for 2 of 25 employees, (employees LPN C and CNA E). During employee record review, LPN C was hired 3/5/19 and her nursing license was not verified until 3/8/19. This nurse did have findings against her	F 607	F607 **Corrective Action(s):** Employee LPN C has had her license verification completed and the findings on her license have been reviewed by the DON. C.N.A. E has had her Certification verified and printed off by the DON. A facility Incident and Accident for has been completed for this incident. Employee D, employee E and C.N.A. F have all had their reference check forms reviewed by the HR director and all errors and omissions have been corrected. A Facility Incident & Accident form has been completed for this incident. **Identification of Deficient Practices & Corrective Action(s):** All other employees may have been potentially affected. The Human Resources department will audit 100% of all active employee records to identify employees at risk. Any/all negative findings will be corrected at the time of discovery. A Facility Incident and Accident Report will be completed for any/all negative findings.	

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F 607	Continued From page 16 license for a complaint of misconduct, which the facility was not aware of prior to her hire. During an interview with (Employee F), Human Resources Coordinator, on 4/4/19 at 9:37am, when asked if this is something the facility would want to know prior to hire, she replied, "I would assume so, when I saw that I spoke with the DON." Review of CNA E's file revealed no certification verification prior to hire could be found. On 4/4/19, an interview with Employee F was conducted and she stated, "it's not in here, it should have been done." The facility failed to check references prior to hire for 3 of 25 employees. References were not checked prior to hire for employees (Employee D, Employee E, and CNA F). Employee D's reference checks were not dated as to when they were obtained. Employee E's reference checks were incomplete, the form had multiple omissions. CNA F had a reference check that had no date to indicate when it was obtained. On 4/4/19 at 9:37am, an interview was conducted with Employee F, when asked about the process for reference checks she stated, "I call the people on the application, I ask the questions on the paper. I have to have them before the person can enter orientation." Review of the facility policy titled "Guidelines for the prevention of abuse" with a revision date of 7/2016 states the standard as, "The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion." The policy reads, "4. Careful screening of all employees, physicians, and contracted professionals. All information provided by the applicant is verified and at least	F 607	**Systemic Change(s):** The facility policy and procedure has been reviewed and no changes are warranted at this time. Administrative Staff, Department Managers and the HR department will be inserviced on the policy & procedure regarding abuse prevention and pre-employment procedures by the Administrator. Administrative Staff and Department Heads extending employment without meeting the requirements of the facility policy & procedure will receive disciplinary action. Perspective employees will not be allowed to work until all required documentation has been obtained and reviewed by the appropriate department manager. **Monitoring:** The Human Resources Manager is responsible for maintaining compliance. The Human Resources Director and/or designee will conduct monthly audits of all new hire employee files for each month to maintain compliance. The administrator will review all audits and report aggregate findings to the Quality Assurance Committee for review, analysis, and recommendations for changes in policy, procedure, and/or facility practice. **Completion Date: May 20, 2019**	

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F 607	Continued From page 17 two references are contacted with documentation maintained in the personnel file. 6. License verification performed for all licensed staff prior to employment." The Administrator and Director of Nursing were made aware of the findings on 4/4/19 at 5:30pm. No further information was provided.	F 607		
F 623 SS=D	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (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. (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 (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (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. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would	F 623	**F623** **Corrective Action(s):** The state ombudsman office has been notified that the facility failed to provide a discharge/transfer notice for resident #41's discharges to the hospital on 02/19/19 and 02/25/19. A facility Incident and Accident form has been completed for this incident. **Identification of Deficient Practices/Corrective Action(s):** All other residents discharged and/or transferred from the facility may have been affected. The Social Services Director will conduct a 100% audit of all residents who have been discharged and/or transferred in the past 90 days to identify residents at risk. Residents identified at risk will be corrected at time of discovery and the required notifications to the state ombudsman will be made. A facility Incident & Accident Form will be completed for each negative finding.	

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F 623	Continued From page 18 be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (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 (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	F 623	**Systemic Change(s):** Facility policy and procedures have been reviewed. No revisions are warranted at this time. The Administrator and/or Regional Nurse Consultant will inservice the facility's social worker on the requirement that the state ombudsman be notified of resident discharges/transfers. **Monitoring:** The Social Services Director will be responsible for maintaining compliance. The Social Services Director will review all residents who have been discharged and/or transferred from the facility weekly to monitor for compliance. Any/all negative findings and or errors will be corrected at time of discovery and disciplinary action will be taken as needed. Aggregate findings of these audits will be reported to the Quality Assurance Committee quarterly for review, analysis, and recommendations for change in facility policy, procedure, and/or practice. **Completion Date: May 20, 2019**	

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F 623	Continued From page 19 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. 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. §483.15(c)(8) Notice in advance of facility closure 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). This REQUIREMENT is not met as evidenced by: Based on staff interview, facility documentation review, and clinical record review, the facility staff failed to notify the Ombudsman of a transfer to the hospital on 2 separate occasions for 1 resident (Resident #41) in a sample size of 30 residents. For Resident #41, the facility staff failed to notify the Ombudsman upon transfer to the hospital on 02/19/2019 and 02/25/2019.	F 623		

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F 623	Continued From page 20 The Findings included: Resident #41, a 60 year old male who was admitted to the facility on 06/19/2018 with diagnoses to include but not limited to diabetes, heart failure, kidney failure requiring dialysis, and depression. Resident #41's most recent Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 03/13/2019 was coded as re-entry from an acute hospital. Resident #41 was coded with a Brief Interview of Mental Status (BIMS) score of "11" out of possible 15 indicating moderately impaired cognition. On 04/04/2019 at approximately 9:15 AM, Resident #41 was observed awake and resting quietly in bed. Resident #41 stated that he had several recent hospitalizations in February 2019 but declined further interview. On 04/04/2019, the nurse's notes for February 2019 were reviewed and confirmed 2 hospital admissions on 02/19/2019 and 02/25/2019. On 04/04/2019, a copy of the Ombudsman Notification for both February hospital admissions was requested. The Social Worker (Employee G) stated "I send the notifications to the Ombudsman at the end of each month, however I cannot explain why (Resident #41) is missing from my list and I cannot find the forms, he must have been overlooked". A copy of the facility policy regarding resident transfers was requested and provided by the Social Worker (Employee G). Line item #4 of the facility's policy entitled "Transfer or Discharge Notice" (revised	F 623		

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F 623	Continued From page 21 December 2016) states that "a copy of the notice will be sent to the Office of the State Long-Term Care Ombudsman". On 04/04/2019 at approximately 5:30 PM, the Administrator (Employee A) and Director of Nursing (DON, Employee B) were notified of the findings. No further information was received.	F 623		
F 625 SS=D	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy	F 625	**F625** **Corrective Action(s):** Resident #41's and their RP has been notified that the facility failed to provide them with the facility Bed-Hold policy when resident #41 was transferred to the hospital. Resident #41 and their RP has had the facility bed-hold policy reviewed with them by the Social Services Director. An Incident and Accident form has been completed for each resident identified in the review. **Identification of Deficient Practice(s) and Corrective Action(s):** All other residents could potentially be affected. The Bed-Hold policy and forms are now kept at the nursing station for after hour's transfers to the hospital to be completed by the charge nurse. The Social Services director/Admissions director will be responsible for normal business hour transfer notification of all bed-holds to residents and/or Responsible parties.	

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F 625	Continued From page 22 described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility documentation review, and clinical record review, the facility staff failed to provide notice of the facility Bed Hold Policy on 2 separate occasions for 1 resident (Resident #41) in a sample size of 30 residents. For Resident #41, the facility staff failed to provide notice of the facility Bed Hold Policy upon transfer to the hospital on 02/19/2019 and 02/25/2019. The Findings included: Resident #41, a 60 year old male who was admitted to the facility on 06/19/2018 with diagnoses to include but not limited to diabetes, heart failure, kidney failure requiring dialysis, and depression. Resident #41's most recent Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 03/13/2019 was coded as re-entry from an acute hospital. Resident #41 was coded with a Brief Interview of Mental Status (BIMS) score of "11" out of possible 15 indicating moderately impaired cognition. On 04/04/2019 at approximately 9:15 AM, Resident #41 was observed awake and resting quietly in bed. Resident #41 stated that he had several recent hospitalizations in February 2019 but declined further interview. On 04/04/2019, the nurse's notes for February 2019 were reviewed and confirmed 2 hospital admissions on 02/19/2019 and 02/25/2019.	F 625	**Systemic Change(s):** The facility Policy and Procedure has been reviewed and no changes are warranted at this time. The Social Services Director, Admissions Director and licensed nursing staff have been inserviced by the administrator on the bed-hold requirement and the proper use and notification of Bed-Hold policy. **Monitoring:** The Admissions Director and Social Service Director are responsible for compliance. All transfers/discharges from the facility will be audited the by the Social service director and/or Admissions Director to ensure proper bed-hold notification was completed at the time of transfer or therapeutic leave. Any/all negative findings will be corrected at time of discovery. The results of these audits will be forwarded to the Quality Assurance Committee quarterly for review, analysis, and recommendations for change in facility policy, procedure, and/or practice. **Completion Date: May 20, 2019**	

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F 625	Continued From page 23 On 04/04/2019, a copy of the Bed Hold Notification for both February hospital admissions was requested. The Social Worker (Employee G) stated "I cannot find any forms, they must not have been done". A copy of the facility policy regarding bed holds was requested and provided by the Director of Nursing (DON, Employee B). The facility's policy entitled "Bed-Holds and Returns" (revised 3/17, updated 1/19) states that "prior to transfers and therapeutic leaves, residents or resident representatives will be informed in writing of the bed-hold and return policy". On 04/04/2019 at approximately 5:30 PM, the Administrator (Employee A) and DON (Employee B) were notified of the findings. No further information was received.	F 625		
F 636 SS=D	Comprehensive Assessments & Timing CFR(s): 483.20(b)(1)(2)(i)(iii) §483.20 Resident Assessment The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. §483.20(b) Comprehensive Assessments §483.20(b)(1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following: (i) Identification and demographic information (ii) Customary routine.	F 636	**F636** **Corrective Action(s):** Resident #35 has had a modification done to her most recent MDS to accurately code section B 1000 – Vision to reflect her current vision status. **Identification of Deficient Practices & Corrective Action(s):** All other residents may have potentially been affected. A 100% review of section B 1000 – Vision of all residents most current MDS will be completed by the RCC to identify residents at risk. All residents identified will have their current MDS assessments modified at the time of discover and their comprehensive care plans updated to accurately reflect their vision status.	

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F 636	Continued From page 24 (iii) Cognitive patterns. (iv) Communication. (v) Vision. (vi) Mood and behavior patterns. (vii) Psychological well-being. (viii) Physical functioning and structural problems. (ix) Continence. (x) Disease diagnosis and health conditions. (xi) Dental and nutritional status. (xii) Skin Conditions. (xiii) Activity pursuit. (xiv) Medications. (xv) Special treatments and procedures. (xvi) Discharge planning. (xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS). (xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts. §483.20(b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs. (i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility	F 636	**Systemic Change(s):** The facility policy and procedure was reviewed and no changes are warranted at this time. The regional nurse consultant will inservice the Resident Care Coordinator's and the interdisciplinary Care Plan Team on accurately coding all sections of the MDS. This will include accurate coding of section B Vision. **Monitoring:** The RCC is responsible for maintaining compliance. The RCC will complete MDS audit tool weekly coinciding with the MDS calendar to monitor for compliance. Any/all negative findings will be reported to the RCC and the DON at the time of discovery for immediate correction. Aggregate findings will be reported to the Quality Assurance Committee for review, analysis, and recommendations for changes in policy, procedure, and/or facility practice. **Completion Date: May 20, 2019**	

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F 636	Continued From page 25 following a temporary absence for hospitalization or therapeutic leave.) (iii)Not less than once every 12 months. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, clinical record review, and facility documentation review, the facility staff failed to conduct accurate assessment of resident's functional capacity for one resident (Resident #35) in a sample size of 30 residents. For Resident #35, the facility staff failed to accurately assess her visual functional capacity The findings included: Resident #35, 70-year female, was admitted to the facility on 10/22/2011. Diagnoses include but not limited to heart failure, hypertension, morbid obesity, and muscle weakness. Resident #35's most recent Minimum Data Set had an Assessment Reference Date (ARD) of 01/02/2019 and was coded as a significant change in status assessment. Resident #35 was coded with a Brief Interview of Mental Status (BIMS) score of 15 out of possible 15 indicative of intact cognition. Functional status for bed mobility, dressing, and personal hygiene were all coded as requiring extensive assistance from staff. Vision was coded as adequate - sees fine detail, including regular print in newspapers/books. On 04/02/2019 at 12:51 PM, an interview with Resident #35 was conducted. When asked if she had any concerns, Resident #35 stated she had an eye exam last year but never received glasses. Resident #35 stated she spoke with LPN	F 636		

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F 636	Continued From page 26 B about it. Resident #35 also stated she loves to read but is unable to do so without her reading glasses. Resident #35 was not wearing glasses at the time of the interview. On 04/03/2019 at 9:10 AM, Resident #35 was observed in her bed sleeping with the head of the bed elevated approximately 30 degrees. On 04/04/2019 at 9:00 AM, Resident #35 was observed in bed, awake, with the head of her bed elevated approximately 45 degrees. The TV was on. Resident #35 was not wearing glasses. Resident #35 stated, "my left eye is my good eye." She went on to say that if she closes her left eye, everything is blurry. On 04/04/2019 at 4:05 PM, LPN B was asked if she was aware Resident #35 needed glasses and LPN B stated, "Yes." When asked about the process of getting glasses for Resident #35, LPN B stated, "The social worker takes care of that." On 04/04/2019 at approximately 4:40 PM, Employee G, a social worker, was asked about the process for vision services and Employee G stated she visits with residents and asks them if they want to see the eye doctor and if so, their name is put on a list. Employee G then provided a list to show that Resident #35 was scheduled for vision services on 04/17/2019. On 04/05/2019 at 9:25 AM, Resident #35 was observed in her room, in bed, awake. When asked if a social worker had talked with her about getting glasses and she stated, "No." She went on to say "I miss being able to read." On 04/05/2019 at approximately 10:05 AM,	F 636		

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F 636	Continued From page 27 Employee G was interviewed. When asked about the process if a resident has concerns pertaining to their glasses, she stated if the glasses are broken, she will try to fix them herself and used the example of applying superglue to the hinge. She also stated that if a resident needs reading glasses, she has a whole box of them in her office and will give them to the residents that need them. When asked if she knew why Resident #35 wanted to see the eye doctor, she stated she didn't know. On 04/05/2019 at approximately 10:15 AM, the MDS coordinator, Employee H, confirmed that Social Services completes Part B of the MDS assessment and then it is signed off by the nurse. Vision was coded as "Adequate - sees fine detail, such as regular print in newspapers/books." The social service notes ranging from 06/15/2018 through 03/18/2019. Of the 15 social services entries by Employee G, there were no entries addressing vision services. The facility provided "Summary Ocular Progress Notes" dated 07/13/2018 for Resident #35. An optometrist documented the chief complaint, "Blurred vision, hard to see at distance and near." Under "Diagnosis and Treatments", it was documented, "Age-related nuclear cataract, bilateral - cataracts - OU-Mild/stable - not visually significant - monitor 6 mos (months)." The progress notes also included a glasses prescription that expires 7/13/19. The prescription documented, "OD (right eye) -2.75 sph x ...add +2.50 OS (left eye) -1.25 sph x ...Add +2.50." In summary, Resident #35 was examined by an optometrist in July 2018 which included a	F 636		

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F 636	Continued From page 28 prescription for glasses. Resident #35 loves to read but is unable to do so because she did not have glasses and did not receive glasses following the exam by the optometrist nearly 9 months ago. The most recent MDS assessment documented Resident #35's vision was adequate. On 04/05/2019 at approximately 2:30 PM, the DON and Administrator were notified of findings and they offered no further information or documentation.	F 636		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview, facility documentation review and clinical record review, the facility staff failed to ensure the assessment of the resident accurately reflected the resident's status for one resident (Resident #55) in a survey sample of 30 residents. For Resident #55, the facility staff failed to accurately code the MDS (Minimum Data Set) (an assessment tool). The findings included: Resident #55, a 55 year old, was admitted to the facility on 2/1/19. The resident's diagnoses included, but were not limited to: hypertension, Type 2 diabetes, and neuromuscular dysfunction of bladder.	F 641	**F641** **Corrective Action(s):** Resident #55 has had their most recent MDS modified to accurately code section H0100 A for the presence of a Foley Catheter. Resident #55's comprehensive care plan has been reviewed and revised to include the use of a Foley catheter and the Foley catheter care to be completed each shift. A facility Incident & Accident form was completed for this incident. **Identification of Deficient Practice(s) and Corrective Action(s):** All other residents with a Foley Catheter may have potentially been affected. A 100% audit of all residents current MDS assessments will be completed by the RCC and/or designee to ensure that sections H0100 A of the MDS are coded correctly. All negative findings will be reported to the MDS department for immediate correction. A Modification will be completed for each discrepancy identifiedon the most current MDS.	

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F 641	Continued From page 29 Resident #55's most recent MDS with an ARD (assessment reference date) of 2/8/19 was coded as an admission assessment. The resident was coded as having a BIMS (Brief Interview for Memory Status) score of 15, indicating the resident was cognitively intact. Functional status for transfers, dressing, toilet use and personal hygiene, was coded as Resident #55 required extensive assistance. Review of the Nursing Admission Assessment, dated 2/1/19 revealed the resident had an indwelling catheter on admission. The hospital discharge summary dated 1/31/19 indicated the resident had an indwelling catheter at the time of discharge from the hospital. A history and physical completed by a physician on 2/5/19 read that the resident had a foley catheter. Review of the Treatment Administration Record indicated Resident #55 received foley cath (catheter) care every shift from 2/3/19-4/3/19. Review of Resident #55's most recent MDS with an ARD of 4/3/19 was coded on section H0100 A. Indwelling catheter, as a catheter not being present. An interview was conducted with Resident #55 on 4/4/19 and when questioned about the catheter he stated, "I've had that thing since I was in the hospital." The MDS, with an ARD of 2/8/19 was coded indicating the resident was incontinent of bowel. Review of the Nursing Admission Assessment dated 2/1/19 is coded that the resident is continent of bowel movements. Review of Fall Risk Assessments with dates of 2/1/19, 2/7/19, 2/15/19, and 2/22/19 stated that Resident #55	F 641	**Systemic Change(s):** The Resident Interdisciplinary Care Team has been inserviced by the Regional Nurse consultant on the proper assessment and coding of all sections of the MDS. All comprehensive MDS's and quarterly MDS's will now be reviewed each week according to the MDS schedule by the RCC and/or DON to ensure the accuracy and integrity of resident data. **Monitoring:** The DON and RCC are responsible for monitoring compliance. The MDS assessment audit will be completed weekly coinciding with the MDS calendar to monitor for compliance. All negative findings from the audits will be reported to the DON and RCC at the time of discovery for immediate correction. Aggregate findings will be reported to the Quality Assurance Committee monthly for review, analysis, andrecommendations for change in facility policy, procedure, and/or practice. **Completion Date: May 20, 2019**	

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F 641	Continued From page 30 was, "ambulatory and continent." In an Interview with Resident #55 on 4/5/19 at 9:34am the resident stated, "I know when I need to go but it makes it easier for everyone if I use this diaper and let them know when it needs changing. I can get in my chair and go to the bathroom." Surveyor A conducted an interview with CNA M on 4/3/19 at approximately 2pm. During the interview, CNA M stated, "[Resident #55's name] is continent, he has a foley, he will let me know when he needs changed, he just uses his brief." The Administrator and Director of Nursing were notified of the findings of facility staff failing to accurately code an assessment, on 4/4/19 at 5:30pm. No further information was provided.	F 641		
F 645 SS=E	PASARR Screening for MD & ID CFR(s): 483.20(k)(1)-(3) §483.20(k) Preadmission Screening for individuals with a mental disorder and individuals with intellectual disability. §483.20(k)(1) A nursing facility must not admit, on or after January 1, 1989, any new residents with: (i) Mental disorder as defined in paragraph (k)(3)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission, (A) That, because of the physical and mental condition of the individual, the individual requires	F 645	**F645** **Corrective Action(s)** Resident #7's attending physician and responsible party have been notified that the facility failed to obtain a PASARR for the resident prior to their admission. A facility Incident & Accident form has been completed for this incident. Resident #28's attending physician and responsible party have been notified that the facility failed to obtain a PASARR for the resident prior to their admission. A facility Incident & Accident form has been completed for this incident.	

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F 645	Continued From page 31 the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services; or (ii) Intellectual disability, as defined in paragraph (k)(3)(ii) of this section, unless the State intellectual disability or developmental disability authority has determined prior to admission- (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services for intellectual disability. §483.20(k)(2) Exceptions. For purposes of this section- (i)The preadmission screening program under paragraph(k)(1) of this section need not provide for determinations in the case of the readmission to a nursing facility of an individual who, after being admitted to the nursing facility, was transferred for care in a hospital. (ii) The State may choose not to apply the preadmission screening program under paragraph (k)(1) of this section to the admission to a nursing facility of an individual- (A) Who is admitted to the facility directly from a hospital after receiving acute inpatient care at the hospital, (B) Who requires nursing facility services for the condition for which the individual received care in the hospital, and (C) Whose attending physician has certified, before admission to the facility that the individual is likely to require less than 30 days of nursing	F 645	Resident #97's attending physician and responsible party have been notified that the facility failed to obtain a PASARR for the resident prior to their admission.. A facility Incident & Accident form has been completed for this incident. Resident #49's attending physician and responsible party have been notified that the facility failed to obtain a PASARR for the resident prior to their admission. A facility Incident & Accident form has been completed for this incident. Resident #68's attending physician and responsible party have been notified that the facility failed to obtain a PASARR for the resident prior to their admission. A facility Incident & Accident form has been completed for this incident. **Identification of Deficient Practices & Corrective Action(s):** All other residents who were required to have a PASARR prior to admission may have been affected. The social services director and/or Admissions director will complete a 100% review of all residents to identify residents who needed a PASARR completed prior to admission but did not have one. All negative findings will be corrected at the time of discovery by notifying the attending physician and responsible party. A facility Incident & Accident form has been completed for each incident.	

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F 645	Continued From page 32 facility services. §483.20(k)(3) Definition. For purposes of this section- (i) An individual is considered to have a mental disorder if the individual has a serious mental disorder defined in 483.102(b)(1). (ii) An individual is considered to have an intellectual disability if the individual has an intellectual disability as defined in §483.102(b)(3) or is a person with a related condition as described in 435.1010 of this chapter. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility documentation and clinical record review the facility failed ensure Residents had (Pre Admission Screening And Resident Review) PASARR screening prior to admission for five residents, Residents (#7, #28, #97, #49, and #68) in a survey sample of 30 residents. 1. For Resident # 7 the facility staff failed to obtain a PASARR prior to admission to the facility. 2. For Resident # 28 the facility staff failed to obtain a PASARR prior to admission to the facility. 3. For Resident # 97 the facility staff failed to obtain a PASARR prior to admission to the facility. 4. For Resident # 49, the facility staff failed to obtain a PASARR screening prior to admission to the facility. 5. For Resident # 68, the facility staff failed to	F 645	**Systemic Change(s):** The facility policy and procedure has been reviewed and no changes are warranted at this time. The admission director, social worker, DON, and administrator have been inserviced by the regional nurse consultant on the requirement that residents with a mental disorder have a PASARR be completed prior to admission **Monitoring:** The social worker and admissions director will be responsible for maintaining compliance. Potential new residents will be reviewed prior to their admission to ensure that a PASARR has been completed if indicated. Negative findings will be corrected at the time of discovery. Aggregate findings will be reported to the QA Committee for review, analysis and recommendation for changes in facility policy, procedure and/or practice. **Completion Date: May 20, 2019**	

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F 645	Continued From page 33 obtain a PASARR screening prior to admission to the facility. The findings include: 1. For Resident # 7 the facility staff failed to obtain a PASARR prior to admission to the facility. Resident # 7 is a 78 year old woman admitted to the facility on 5/2/13 with diagnoses of but not limited to Bipolar Disorder, Acute Kidney Failure, Repeated Falls, Pacemaker implant, Major Depressive Disorder, and Seizure Disorder. On 4/2/19 a clinical record review was done and no PASARR Level 1 was found in hard copy of chart or electronic medical record. A request then made for PASARR Level I and or II depending on what the Resident's diagnoses required. On 4/3/19 at 11:30 AM, an interview was conducted with the Social Worker who stated that the usual process for obtaining a PASARR is that the Resident comes in and is admitted and the PASARR is a part of the admissions process. During end of day conference on 4/3/19 the Administrator was made aware of the issue of obtaining a PASARR prior to admission no further information was provided. 2. For Resident # 28 the facility staff failed to obtain a PASARR prior to admission to the facility. Resident # 28 a 65 year old man, admitted to the	F 645		

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F 645	Continued From page 34 facility on 1/23/18 with diagnoses of but not limited to Unspecified Psychosis, Altered Mental Status, Cerebral Infarction (stroke), Hemiplegia and Hemiparesis following cerebral infarction, Major Depressive Disorder and Diabetes Type II. On 4/2/19 a clinical record review was done and no PASARR Level 1 was found in hard copy of chart or electronic medical record. A request then made for PASARR Level I and or II depending on what the Resident's diagnoses required. On 4/3/19 facility staff submitted PASARR LEVEL I screening signed by facility Social Worker and dated 5/11/18. The PASARR was completed after admission. On 4/3/19 at 11:30 AM, an interview was conducted with the Social Worker who stated that the usual process for obtaining a PASARR is that the Resident comes in and is admitted and the PASARR is a part of the admissions process. During end of day conference on 4/3/19 the Administrator was made aware of the issue of obtaining a PASARR prior to admission no further information was provided. 3. For Resident # 97 the facility staff failed to obtain a PASARR prior to admission to the facility. Resident #97 is an 84 year old woman admitted to the facility on 6/22/17 with diagnoses of but not limited to Anemia, Hypertension, Dementia (Alzheimer's Type) History of Stroke, Anxiety and Depression.	F 645		

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F 645	Continued From page 35 On 4/2/19 a clinical record review was done and no PASARR Level 1 was found in hard copy of chart or electronic medical record. A request then made for PASARR Level I and or II depending on what the Resident's diagnoses required. On 4/3/19 facility staff submitted PASARR LEVEL I screening signed by facility Social Worker and dated 6/8/18. The PASARR was completed after admission. On 4/3/19 at 11:30 AM an interview was conducted with the Social Worker who stated that the usual process for obtaining a PASARR is that the Resident comes in and is admitted and the PASARR is a part of the admissions process. During end of day conference on 4/3/19 the Administrator was made aware of the issue of obtaining a PASARR prior to admission no further information was provided. 4. For Resident # 49, the facility staff failed to obtain a PASARR (Preadmission Screening and Resident Review) prior to admission to the facility. Resident # 49, a 91 year old male, was admitted to the facility on 12/1/2017. Diagnoses included but were not limited to: Alzheimer's Disease, Hypertension, Malignant Neoplasm of Prostate, Gastroesophageal Reflux Disease, Dementia, Osteoarthritis, and Anxiety. Resident # 49's most recent Minimum Data Set (MDS) was a quarterly assessment with an Assessment Reference Date (ARD) of 2/1/2019. The MDS coded Resident # 49 with a BIMS (Brief Interview for Mental Status) score of "3" out of 15, indicating severe cognitive impairment. Resident	F 645		

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F 645	Continued From page 36 # 49 was coded as requiring limited to extensive assistance of one staff person for Activities of Daily Living except total assistance of one staff person for bathing. Resident # 49 was coded as occasionally incontinent of bowel and bladder. On 04/04/2019 at 2:30 PM, review of the clinical record was conducted. Review of the clinical record revealed there was no PASARR Level 1 Screening in the electronic or paper clinical record. On 04/4/2019 at 11:08 AM, an interview was conducted with the Social Worker who stated the facility process was for the PASARR to be completed by the Social Worker on the day of admission. The Social Worker stated she did not see a PASARR screening in the clinical Record for Resident # 49. The Social Worker stated she was aware that the PASARR should be done prior to admission but stated "I am not a part of the admission team. I don't see them (residents) until they get here." The Social Worker stated the Admissions Committee at the facility was responsible for seeing residents prior to admission and the Social Worker was responsible for the PASARR on the day of admission. On 4/4/2019 at 11:55 AM, the Social Worker stated that she reviewed the record and talked with the Admissions staff. The Social Worker stated she was told a PASARR screening was not done for Resident # 49 because he had been admitted to the facility as a private pay resident and a PASARR screening was not required for him. The Social Worker was advised that residents must have a Level 1 PASARR	F 645		

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F 645	Continued From page 37 screening done prior to admission. On 04/04/2019, during the end of day debriefing, the Administrator and the Director of Nursing were informed of the findings of no PASARR for Resident # 49. The Administrator and the Director of Nursing were advised that residents admitted to nursing facilities must have a Level 1 screening prior to admission. The Administrator stated the facility staff would ensure all future admissions had a PASARR prior to admission. No further information was provided. 5. For Resident # 68, the facility staff failed to obtain a PASARR (Preadmission Screening and Resident Review) prior to admission to the facility. Resident # 68, a 91 year old female was admitted to the facility on 12/1/2017. Diagnoses included but were not limited to: Alzheimer's Disease, Hypertension, Major Depressive Disorder, Gastroesophageal Reflux Disease, Dementia, Cardiomegaly, and Anxiety. Resident # 68's most recent Minimum Data Set (MDS) was a quarterly assessment with an Assessment Reference Date (ARD) of 2/21/2019. The MDS coded Resident # 68 with a BIMS (Brief Interview for Mental Status) score of "3" out of 15, indicating severe cognitive impairment. Resident # 68 was coded as requiring extensive assistance of one to two staff persons for Activities of Daily Living except total assistance of one staff person for Bathing. Resident # 68 was coded as frequently incontinent of bowel and bladder. Review of the clinical record was conducted on	F 645		

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F 645	Continued From page 38 4/4/2019. Review of the Screening for Mental Illness, Mental Retardation/Intellectual Disability, or Related Conditions, PASARR (Preadmission Screening and Resident Review) form revealed a signature and a date of 5/11/2018. The spaces for "Screening Committee, Telephone number, and Street Address" were left blank. On 04/4/2019 at 11:08 AM, an interview was conducted with the Social Worker who stated the facility process was for the PASARR to be completed by the Social Worker on the day of admission. The Social Worker stated there was a PASARR screening in the clinical Record for Resident # 68 that was dated on 5/11/2018. The Social Worker stated the signature on the form was hers and she had completed the PASARR on 5/11/2018 because she noticed one was not in the record. The Social Worker stated she was aware that the PASARR should be done prior to admission but stated "I am not a part of the admission team. I don't see them (residents) until they get here." The Social Worker stated the Admissions Committee at the facility was responsible for seeing residents prior to admission and the Social Worker was responsible for the PASARR on the day of admission. On 04/04/2019, during the end of day debriefing, the Administrator and Director of Nursing were informed of the findings of no PASARR for Resident # 49. The Administrator and Director of Nursing were advised that residents admitted to nursing facilities must have a Level 1 screening prior to admission. The Administrator stated the	F 645		

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F 645	Continued From page 39 facility staff would ensure all future admissions had a PASARR prior to admission. No further information was provided.	F 645		
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §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- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (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	F 655	**F655** **Corrective Action(s):** Resident #6's Attending physician and RP have been notified that the facility did not address the residents Behavioral Health Needs on the Base line care plan. Resident #6's medical record and Comprehensive care plan has been reviewed and revised to reflect her behavioral health needs and her current diagnosis of Depression and Anxiety. **Identification of Deficient Practices & Corrective Action(s):** All residents may have potentially been affected. A 100% review of all new admissions in the last 30 days will be conducted by the DON, RCC and/or designee to identify residents who did not have an accurate baseline care plan completed to address any behavior health needs identified. All residents identified will have their comprehensive care plan reviewed and updated to reflect their current Behavior health needs and the Resident and RP's will be notified of any/all changes to the current comprehensive care plan. A Facility Incident & Accident Form will be completed for each incident identified.	

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F 655	Continued From page 40 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 observation, resident interview, staff interview, clinical record review, and facility document review, the facility staff failed to complete a baseline care plan to provide behavioral health services for 1 resident (Resident #6) of the 30 residents in the survey sample. For Resident 6, the facility staff failed to develop a base line care plan for behavioral health services. The findings included: Resident #6, was admitted to the facility on 12-18-18. Diagnoses included; depression, anxiety, heart disease, diabetes, high blood pressure, and chronic obstructive pulmonary disease (COPD). The most recent Minimum Data Set assessment was a quarterly assessment with an assessment reference date (ARD) of 3-26-19. Resident #6 was coded with a Brief Interview of Mental Status (BIMS) score of 13 indicating little to no cognitive impairment and requiring assistance with physical activities of daily living. The full admission MDS	F 655	**Systemic Changes:** The facility Policy and Procedure has been reviewed and no changes are warranted at this time. The nursing assessment process as evidenced by the 24 Hours Report and documentation in the medical record and physician orders will be used to develop and revise base line care plans within 48 hours of admission to the facility and a written summary will be given to the Resident and RP. The RCC, IDT and the DON will be inserviced by the regional nurse consultant on the development, implementation of the baseline as well as ensuring that the baseline care plan is accurate prior to providing the base line care plan summary to the residents and RP's. **Monitoring:** The RCC and DON are responsible for maintaining compliance. The DON and/or RCC will perform care plan audits on all new admissions 48 hours after admission to ensure a base line care plan has been completed accurately and timely and that a written summary has been completed and reviewed with the resident and/or RP. Any/all negative findings will be reported to the RCC for immediate correction. Detailed findings of the Care Plan audit will be reported to the Quality Assurance Committee for review, analysis, and recommendations for change in facility policy, procedure, and/or practice. **Completion Date: May 20, 2019**	

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F 655	Continued From page 41 assessment was also reviewed with an ARD date of 12-25-18 which revealed a BIMS score of 13, and both documents did not code depression nor anxiety as diagnoses to be treated or care planned for this Resident. An interview was conducted with Resident #6 on 4-2-19, at 1:00 p.m., and on 4-3-19 at 12:00 p.m. During the interviews, Resident #6 was tearful. The Resident stated that she did not get to see her family often, and had just moved to Virginia from another state, and had no friends here other than family. The Resident went on to say the family members lived quite a distance from the facility, and were busy raising children, and working. The Resident was asked if she had ever talked with the social worker about her feelings, and she stated "no, I only saw her twice the first week I came here, and the day I had to move out of my room because my room mate was so disruptive." "I haven't seen her since." When asked if she was interested in talking with the social worker, Resident #6 stated "no, I would rather see a doctor." When asked if she meant a psychologist, or a psychiatrist, she stated "yes". Resident #6's clinical record was reviewed. The social services notes indicated that the social services director (SSD) did visit the Resident on 12-19-18, and ten days later on 12-29-18 for routine admission, and "14 day" follow up. The SSD did not document seeing the Resident again until 3-18-19 to prepare for the quarterly MDS submission. The SSD documented the following entry on 3-18-19; "There has been no change to the resident during	F 655		

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F 655	Continued From page 42 this quarter in behaviors or mood. The resident appears anxious, nervous in conversation but is very pleasant and nice. Residents son visits often, but tends to complain about "little things" or things of unimportance in regards to residents overall care and treatment. The resident tends to stay in room and is socially withdrawn by nature." On 3-19-19, the Resident was moved to another room. A review of all discipline notes in the clinical record did not reveal any documentation of the reason for the move, or how the Resident responded to the move. All behavior documents were reviewed, to include social work notes, physician notes, nursing notes, medication administration notes, and MDS documents, which revealed that the Resident had no aberrant behaviors. All physician notes were reviewed from admission to the dates of survey. There were 4 visits, and the documents revealed the first visit as a "medical history", which was a 3 page form dated 12-20-18. This first visit document described the Resident as negative for psychiatric problems, and went on to document, alert and oriented to person/place/time. Depression and anxiety were not included in the diagnoses written on the form. On 2-7-19, 2-21-19, and 3-26-19 the doctor saw the Resident and documented the first 2 visits as "recert" visits for skilled care. The final visit on 3-26-19 was a sick visit, as the Resident had been diagnosed with pneumonia. None of these visits have any documentation under the "psyche" heading on the document, and they were left blank, as no assessment in this area was conducted. All other headings were assessed and documented as such. No psychiatric	F 655		

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F 655	Continued From page 43 physician evaluation was ever conducted. Review of all nursing notes since admission, and to the time of survey revealed no assessment or interventions for depression or anxiety. Physician's orders, and Medication Administration Records (MAR's) were reviewed and revealed the following (4) psychoactive medications were ordered and administered during Resident #6's stay; 1. Zoloft 125 milligrams (mg) every day at 9:00 a.m. for depression. Ordered 12-19-18, and continued through survey. 2. Buspar 15 mg three times per day at 10:00 a.m., 2:00 p.m., and 9:00 p.m. for anxiety. Ordered 12-19-18, and continued through survey. 3. Xanax 0.5 mg every 6 hours as needed for anxiety. Ordered 12-19-18, discontinued 12-23-18, reordered 12-25-18 to stop 2-15-19. 4. Xanax 0.5 mg every day at 9:00 a.m. for anxiety. ordered 2-16-19, and continued through survey. The Residents care plan in the computer, and the paper copy with revisions from the care plan book on the nursing unit were reviewed. The 2 care plans revealed, no baseline initial care plan, nor comprehensive care plan was ever devised for the Resident's depression, anxiety, and behavioral health care needs. On 04/05/19 at 10:10 AM, an interview with Employee H, the MDS/ Care Plan Coordinator was conducted. When asked about how to	F 655		

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	495300		C 04/05/2019

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F 655	Continued From page 44 determine when an intervention on the care was implemented, Employee H stated, "We don't date interventions." She went on to say the intervention either continues or it would be resolved. When asked about a resolved intervention, Employee H stated, "I would delete it." Employee H stated the paper copy care plans are kept in a book on the unit, updated on the paper, and eventually entered into the computer. At the end of day meeting on 4-3-19, the Director of Nursing (DON) and Administrator were notified that it did not appear that the facility staff were providing for Resident #6's behavioral health needs. It was reviewed that it did not appear that Resident #6's depression and anxiety were ever care planned, nor was there any formal psychiatric assessment, nor social work interventions. The administrative staff were asked to provide clarification in this matter, and they stated they would get back to the surveyors with any information found. The Administrator and DON were notified of the concern again on 4-4-19 at 11:00 a.m. regarding Resident #6, and the DON stated "you have everything we have." No further information was able to be provided.	F 655		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's	F 656	**F656** **Corrective Action(s):** Resident #63's comprehensive care plan has been reviewed and revised to reflect appropriate goals with measurable time frames and interventions and approaches with dates they were initiated and/or discontinued or changed. A Facility Incident & Accident Form was completed for this incident.	

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F 656	Continued From page 45 medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to develop a comprehensive resident-centered care plan for 3 residents (Resident #63, #35, #6) in a sample	F 656	Resident #35's comprehensive care plan has been reviewed and revised to reflect appropriate measurable goals and interventions and approaches to address the resident's specific medical and treatment needs to include her vision deficits and the need for glasses. A Facility Incident & Accident Form was completed for this incident. Resident #6's comprehensive care plan has been reviewed and revised to reflect appropriate goals, interventions and approaches to address the resident's specific medical and treatment needs to include the care and treatment needed to manage the Resident #6's behavioral health needs and her current diagnosis of Depression and Anxiety. **Identification of Deficient Practices & Corrective Action(s):** All residents may have potentially been affected. A 100% review of all comprehensive care plans will be conducted by the DON, ADON, RCC and/or designee to identify residents with inaccurate or incomplete comprehensive care plans. Resident identified with inaccurate or incomplete care plans will have their care plan reviewed and updated to reflect their current interventions and appropriate approaches to address their medical and treatment needs. A Facility Incident & Accident Form will be completed for each incident identified.	

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F 656	Continued From page 46 size of 30 residents. The findings included: 1. For Resident #63, the facility staff failed to date interventions and goals on the care plan in order to establish time frames and measurable objectives. 2. For Resident #35, the facility staff failed to include vision services/needs on the care plan. 3. For Resident #6, the facility staff failed to develop a comprehensive care plan for the behavioral health services needs of depression and anxiety. The findings include: 1. For Resident #63, the facility staff failed to date interventions and goals on the care plan in order to establish time frames and measurable objectives. Resident #63, a 68-year old female, was admitted to the facility on 04/02/2015. Diagnoses include but not limited to Non-ST elevation (NSTEMI) myocardial infarction, heart failure, cerebral infarction, hypertension, diabetes, and hemiplegia. Resident #63's most recent Minimum Data Set had an Assessment Reference Date (ARD) of 02/18/2019 and was coded as a quarterly assessment. Resident #63 was coded with a Brief Interview of Mental Status (BIMS) score of 3 out of possible 15 indicative of severe cognitive impairment. Functional status for bed mobility,	F 656	**Systemic Changes:** The facility Policy and Procedure has been reviewed and no changes are warranted at this time. The nursing assessment process as evidenced by the 24 Hours Report and documentation in the medical record and physician orders will be used to develop and revise comprehensive plans of care. The RCC, IDT and the DON will be inserviced by the regional nurse consultant on the development, revision and implementation process of individualized care plans. **Monitoring:** The RCC and DON are responsible for maintaining compliance. The DON and/or RCC will perform care plan audits weekly coinciding with the care plan calendar to monitor for compliance. Any/all negative findings will be reported to the DON / RCC for immediate correction. Detailed findings of the interdisciplinary team's audit will be reported to the Quality Assurance Committee for review, analysis, and recommendations for change in facility policy, procedure, and/or practice. **Completion Date: May 20, 2019**	

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F 656	Continued From page 47 transfers, dressing, and personal hygiene were all coded as requiring extensive assistance from staff. Functional status for eating was coded as requiring supervision from staff. The care plan in the electronic health record was reviewed. There were 12 problem areas. The interventions associated with each problem did not include dates of initiation and revision. Under "Goal and Target Date", each goal would end with " ...through next review." There were no measurable timeframes, initiation, or target dates included. On 04/02/2019 at 4:55 PM, the facility provided a paper copy of the care plan. Employee L stated the most updated version of the care plan is on paper copy kept on the unit. Employee L stated electronic care plans (what is seen on the computer) are updated quarterly. Both the electronic and paper versions of the care plan did not have dates associated with interventions with the exception of one which documented (handwritten), "Hospice as of 11/16/18" and an intervention that was crossed out and documented, "D/C (discontinued) 1/15/19." On 04/05/19 at 10:10 AM, an interview with Employee H, the MDS/Care Plan Coordinator was conducted. When asked about how to determine when an intervention on a care plan was implemented, Employee H stated, "We don't date interventions." She went on to say the intervention either continues or it would be resolved. When asked about a resolved intervention, Employee H stated, "I would delete it." Employee H stated the paper copy care plans are kept in a book on the unit, updated on the paper, and eventually entered into the computer.	F 656		

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F 656	Continued From page 48 When asked about the CNA (closet) care plans, Employee H stated closet care plans are also updated as needed. On 04/05/2019 at approximately 2:30 PM, the DON and Administrator were notified of findings and they offered no further information or documentation. 2. For Resident #35, the facility staff failed to include vision services/needs on the care plan. Resident #35, 70-year female, was admitted to the facility on 10/22/2011. Diagnoses include but not limited to heart failure, hypertension, morbid obesity, and muscle weakness. Resident #35's most recent Minimum Data Set had an Assessment Reference Date (ARD) of 01/02/2019 and was coded as a significant change in status assessment. Resident #35 was coded with a Brief Interview of Mental Status (BIMS) score of 15 out of possible 15 indicative of intact cognition. Functional status for bed mobility, dressing, and personal hygiene were all coded as requiring extensive assistance from staff. Vision was coded as adequate - sees fine detail, including regular print in newspapers/books. On 04/02/2019 at 12:51 PM, an interview with Resident #35 was conducted. When asked if she had any concerns, Resident #35 stated she had an eye exam last year but never received glasses. Resident #35 stated she spoke with LPN B about it. Resident #35 also stated she loves to read but is unable to do so without her reading glasses. Resident #35 was not wearing glasses	F 656		

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F 656	Continued From page 49 at the time of the interview. On 04/03/2019 at 9:10 AM, Resident #35 was observed in her bed sleeping with the head of the bed elevated approximately 30 degrees. On 04/04/2019 at 9:00 AM, Resident #35 was observed in bed, awake, with the head of her bed elevated approximately 45 degrees. The TV was on. Resident #35 was not wearing glasses. Resident #35 stated, "my left eye is my good eye." She went on to say that if she closes her left eye, everything is blurry. On 04/04/2019 at 4:05 PM, LPN B was asked if she was aware Resident #35 needed glasses and LPN B stated, "Yes." When asked about the process of getting glasses for Resident #35, LPN B stated, "The social worker takes care of that." On 04/04/2019 at approximately 4:40 PM, Employee G, a social worker, was asked about the process for vision services and Employee G stated she visits with residents and asks them if they want to see the eye doctor and if so, their name is put on a list. Employee G then provided a list to show that Resident #35 was scheduled for vision services on 04/17/2019. On 04/05/2019 at 9:25 AM, Resident #35 was observed in her room, in bed, awake. When asked if a social worker had talked with her about getting glasses and she stated, "No." She went on to say "I miss being able to read." The facility provided "Summary Ocular Progress Notes" dated 07/13/2018 for Resident #35. An optometrist documented the chief complaint, "Blurred vision, hard to see at distance and near."	F 656		

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F 656	Continued From page 50 Under "Diagnosis and Treatments", it was documented, "Age-related nuclear cataract, bilateral - cataracts - OU-Mild/stable - not visually significant - monitor 6 mos (months)." The progress notes also included a glasses prescription that expires 7/13/19. The prescription documented, "OD (right eye) -2.75 sph x ...add +2.50 OS (left eye) -1.25 sph x ...Add +2.50." The care plan was reviewed. A problem/need onset dated 04/11/2016 documented, "[Resident #35] prefers to structure her own day, and stays in bed per her choice, enjoys reading Bible, listening to gospel music, keeping up with news, and participating with religious programs in her room. Enjoys reading and writing and getting to know new people. In past, loved to sing. Has dx (diagnosis) of DM2 (type 2 diabetes) and severe morbid obesity." Approaches associated with this focus included but not limited to "offer and provide writing materials and other materials to promote continued independence; provide Bible for resident to use as requested." Resident #35's vision deficit and her need for glasses was not addressed on the care plan. In summary, Resident #35 was examined by an optometrist in July 2018 which included a prescription for glasses. Resident #35 loves to read but is unable to do so because she did not have glasses and did not receive glasses following the exam by the optometrist nearly 9 months ago. Vision needs are not included in the care plan. On 04/05/2019 at approximately 2:30 PM, the DON and Administrator were notified of findings and they offered no further information or documentation.	F 656		

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F 656	Continued From page 51	F 656		

3. For Resident #6, the facility staff failed to develop a comprehensive care plan for the behavioral health services needs of depression and anxiety.

Resident #6, was admitted to the facility on 12-18-18. Diagnoses included; depression, anxiety, heart disease, diabetes, high blood pressure, and chronic obstructive pulmonary disease (COPD).

The most recent Minimum Data Set assessment was a quarterly assessment with an assessment reference date (ARD) of 3-26-19. Resident #6 was coded with a Brief Interview of Mental Status (BIMS) score of 13 indicating little to no cognitive impairment and requiring assistance with physical activities of daily living. The full admission MDS assessment was also reviewed with an ARD date of 12-25-18 which revealed a BIMS score of 13, and both documents did not code depression nor anxiety as diagnoses to be treated or care planned for this Resident.

An interview was conducted with Resident #6 on 4-2-19, at 1:00 p.m., and on 4-3-19 at 12:00 p.m. During the interviews, Resident #6 was tearful. The Resident stated that she did not get to see her family often, and had just moved to Virginia from another state, and had no friends here other than family. The Resident went on to say the family members lived quite a distance from the facility, and were busy raising children, and working. The Resident was asked if she had ever talked with the social worker about her feelings, and she stated "no, I only saw her twice

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F 656	Continued From page 52 the first week I came here, and the day I had to move out of my room because my room mate was so disruptive." "I haven't seen her since." When asked if she was interested in talking with the social worker, Resident #6 stated "no, I would rather see a doctor." When asked if she meant a psychologist, or a psychiatrist, she stated "yes". Resident #6's clinical record was reviewed. The social services notes indicated that the social services director (SSD) did visit the Resident on 12-19-18, and ten days later on 12-29-18 for routine admission, and "14 day" follow up. The SSD did not document seeing the Resident again until 3-18-19 to prepare for the quarterly MDS submission. The SSD documented the following entry on 3-18-19; "There has been no change to the resident during this quarter in behaviors or mood. The resident appears anxious, nervous in conversation but is very pleasant and nice. Residents son visits often, but tends to complain about "little things" or things of unimportance in regards to residents overall care and treatment. The resident tends to stay in room and is socially withdrawn by nature." The SSD stated no change, yet describes anxiety and nervousness (which had not been documented before) without assessing for a reason. She also describes the family complaints as unimportant, and, without any psychological assessment, or physicians evaluation, describes the Resident as "socially withdrawn by nature." On 3-19-19, the Resident was moved to another room. A review of all discipline notes in the	F 656		

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F 656	Continued From page 53 clinical record did not reveal any documentation of the reason for the move, or how the Resident responded to the move. All behavior documents were reviewed, to include social work notes, physician notes, nursing notes, medication administration notes, and MDS documents, which revealed that the Resident had no aberrant behaviors. All physician notes were reviewed from admission to the dates of survey. There were 4 visits, and the documents revealed the first visit as a "medical history", which was a 3 page form dated 12-20-18. This first visit document described the Resident as negative for psychiatric problems, and went on to document, alert and oriented to person/place/time. Depression and anxiety were not included in the diagnoses written on the form. On 2-7-19, 2-21-19, and 3-26-19 the doctor saw the Resident and documented the first 2 visits as "recert" visits for skilled care. The final visit on 3-26-19 was a sick visit, as the Resident had been diagnosed with pneumonia. None of these visits have any documentation under the "psyche" heading on the document, and they were left blank, as no assessment in this area was conducted. All other headings were assessed and documented as such. No psychiatric physician evaluation was ever conducted. Review of all nursing notes since admission, and to the time of survey revealed no assessment or interventions for depression or anxiety. Physician's orders, and Medication Administration Records (MAR's) were reviewed and revealed the following (4) psychoactive medications were ordered and administered during Resident #6's	F 656		

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F 656	Continued From page 54 stay; 1. Zoloft 125 milligrams (mg) every day at 9:00 a.m. for depression. Ordered 12-19-18, and continued through survey. 2. Buspar 15 mg three times per day at 10:00 a.m., 2:00 p.m., and 9:00 p.m. for anxiety. Ordered 12-19-18, and continued through survey. 3. Xanax 0.5 mg every 6 hours as needed for anxiety. Ordered 12-19-18, discontinued 12-23-18, reordered 12-25-18 to stop 2-15-19. 4. Xanax 0.5 mg every day at 9:00 a.m. for anxiety. ordered 2-16-19, and continued through survey. The Residents care plan in the computer, and the paper copy with revisions from the care plan book on the nursing unit were reviewed. The 2 care plans revealed no comprehensive care plan was ever devised for the Resident's depression, anxiety, and behavioral health care needs. On 04/05/19 at 10:10 AM, an interview with Employee H, the MDS/ Care Plan Coordinator was conducted. When asked about how to determine when an intervention on the care was implemented, Employee H stated, "We don't date interventions." She went on to say the intervention either continues or it would be resolved. When asked about a resolved intervention, Employee H stated, "I would delete it." Employee H stated the paper copy care plans are kept in a book on the unit, updated on the paper, and eventually entered into the computer. At the end of day meeting on 4-3-19, the Director	F 656		

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F 656	Continued From page 55 of Nursing (DON) and Administrator were notified that it did not appear that the facility staff were providing for Resident #6's behavioral health needs. It was reviewed that it did not appear that Resident #6's depression and anxiety were ever care planned, nor was there any formal psychiatric assessment, nor social work interventions. The administrative staff were asked to provide clarification in this matter, and they stated they would get back to the surveyors with any information found. The Administrator and DON were notified of the concern again on 4-4-19 at 11:00 a.m. regarding Resident #6, and the DON stated "you have everything we have." No further information was able to be provided.	F 656		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (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	F 657	F657 **Corrective Action(s):** Resident #63's comprehensive care plan and C.N.A. closet care plan has been reviewed and revised to reflect Resident 63's current Code status. A Facility Incident & Accident Form was completed for this incident. Resident #49's comprehensive care plan has been reviewed and revised to reflect appropriate goals with measurable time frames and interventions and approaches with dates they were initiated and/or discontinued or changed. A Facility Incident & Accident Form was completed for this incident. Resident #68's comprehensive care plan has been reviewed and revised to reflect appropriate goals with measurable time frames and interventions and approaches with dates they were initiated and/or discontinued or changed. A Facility Incident & Accident Form was completed for this incident.	

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	495300		C 04/05/2019

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F 657	Continued From page 56 not practicable for the development of the resident's care plan. (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 observation, staff interviews, clinical record reviews, and facility documentation, the facility staff failed to revise resident-centered care plans for 3 residents (Resident #63, Resident #49, Resident #68) in a sample size of 30 residents. 1. For Resident #63, the facility staff failed to revise the care plan to reflect current code status from "Full Code" to "DNR" 2. For Resident # 49, the facility staff failed to document the dates of problems and interventions listed on the careplan when revised. 3. For Resident # 68, the facility staff failed to document the dates of problems and interventions listed on the careplan when revised. The findings included: Resident #63, a 68-year old female, was admitted to the facility on 04/02/2015. Diagnoses include but not limited to Non-ST elevation (NSTEMI) myocardial infarction, heart failure, cerebral infarction, hypertension, diabetes, and hemiplegia.	F 657	**Identification of Deficient Practices & Corrective Action(s):** Any/all residents may have potentially been affected. A 100% review of all resident comprehensive care plans will be conducted by the RCC and/or designee to identify residents at risk. Residents identified at risk as having an inaccurate comprehensive care plan with no measurable goals or dated interventions will be corrected at time of discovery and a Risk Management Incident & Accident Form will be completed for each incident identified. **Systemic Changes:** The assessment process will continue to be utilized as the primary tool for developing comprehensive plans of care. The RCC is responsible for implementing the RAI Process. The nursing assessment process as evidenced by the 24 Hours Report and documentation in the medical record/physician orders will be used to develop and revise comprehensive plans of care. The Regional Nurse Consultant will provide in-service training to the interdisciplinary care plan team on the mandate to develop individualized care plans within 7 days of the completion of the comprehensive assessment and/or revisions to the comprehensive care plan as indicated with any changes in resident condition.	

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F 657	Continued From page 57 Resident #63's most recent Minimum Data Set had an Assessment Reference Date (ARD) of 02/18/2019 and was coded as a quarterly assessment. Resident #63 was coded with a Brief Interview of Mental Status (BIMS) score of 3 out of possible 15 indicative of severe cognitive impairment. Functional status for bed mobility, transfers, dressing, and personal hygiene were all coded as requiring extensive assistance from staff. Functional status for eating was coded as requiring supervision from staff. On 04/02/2019 at 4:15 PM, the current physician's orders in the electronic health record were reviewed. A physician's order dated 11/25/2018 documented, "Resident Hospice care as of 11/16/18 [hospice company name]." A physician's order dated 11/26/2018 documented, "DNR (do not resuscitate)." The care plan in the electronic health record was reviewed. A problem onset dated 04/02/2015 documented, "[Resident #63] has an inability to perform ADLs (Activities of Daily Living) independently secondary to muscle spasms, HTN (hypertension), CVA (cerebral vascular accident), hemiparesis, RAKA (right above-the-knee amputation), depression. Resident refuses meals & supplements at time." (sic) One "approach" documented for this problem documented, "Full code." On 04/02/2019 at 4:40 PM, an interview with CNA C was conducted. When asked where a CNA would find out information about how to care for Resident #63, she stated she looks at "the care plan" that is posted on the inside of Resident #63's closet door. CNA C and this surveyor then	F 657	**Monitoring:** The RCC and DON are responsible for maintaining compliance. The interdisciplinary team will audit all comprehensive care plans prior to finalization coinciding with the care plan calendar to monitor for compliance. Any/all negative findings will be reported to the DON and RCC for immediate correction. Detailed findings of the interdisciplinary team's audit will be reported to the Quality Assurance Committee for review, analysis, and recommendations for change in facility policy, procedure, and/or practice. **Completion Date: May 20, 2019**	

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F 657	Continued From page 58 entered Resident#63's room and CNA C then opened Resident #63's closet door to show a document entitled, "CNA Care Plan" which included Resident #63's name and room number (handwritten). It also included Resident #63's needs pertaining to ADLs. On the left hand side of the paper, it was documented, "Information is current as of this date: 10-31-18." On the top left side of the CNA Care Plan, it was documented "Full code." CNA C then closed the closet door. This surveyor then asked CNA C what Resident #63's code status was and she stated, "She's a full code." A copy of the CNA Care Plan was requested and CNA C stated she would have to ask the nurse. On 04/02/2019 at approximately 4:45 PM, this surveyor and CNA C walked to the nurse's station. After speaking with a nurse, CNA C went to Resident #63's room to retrieve the CNA Care Plan on the closet door. The staff nurse got Resident #63's hard chart and displayed the Durable Do Not Resuscitate Order and stated to this surveyor, "Do you realize this resident is on hospice and she's a DNR?" CNA C returned with the CNA Care Plan and handed it to LPN B. LPN B looked at the document and stated, "It (closet care plan) wasn't updated." A copy of the Durable Do Not Resuscitate order and the electronic care plan were requested. On 04/02/2019 at 4:55 PM, a Durable Do Not Resuscitate document was provided. It was dated 11/20/18 and signed by physician, responsible party, and a witness. A paper copy of the electronic care plan was provided. Under the problem entitled, "Resident #63] has an inability to perform ADLs (Activities of Daily Living) independently secondary to muscle spasms, HTN	F 657		

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F 657	Continued From page 59 (hypertension), CVA (cerebral vascular accident), hemiparesis, RAKA (right above-the-knee amputation), depression. Resident refuses meals & supplements at time." ,"Full Code" was crossed out and "DNR" was added (handwritten and not dated or initialed). Employee L stated the most updated version of the care plan is on paper kept on the unit. Employee L stated electronic care plans (what is seen on the computer) are updated quarterly. On 04/05/19 at 10:10 AM, an interview with Employee H, the MDS, Care Plan Coordinator was conducted. When asked about how to determine when an intervention on a care plan was implemented, Employee H stated, "We don't date interventions." She went on to say the intervention either continues or it would be resolved. When asked about a resolved intervention, Employee H stated, "I would delete it." Employee H stated the paper copy care plans are kept in a book on the unit, updated on the paper, and eventually entered into the computer. When asked about the CNA (closet) care plans, Employee H stated closet care plans are also updated as needed. The facility policy entitled, "Advanced Directives" was reviewed. Section 7 documented, "Information about whether or not the resident has executed an advanced directive shall be displayed prominently in the medical record." Section 10 documented, "The plan of care for each resident will be consistent with his or her documented treatment preferences and/or advanced directive." In summary, there was conflicting information regarding Advanced Directives on the electronic	F 657		

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F 657	Continued From page 60 care plan, the paper copy care plan, and the CNA closet care plan for Resident #63. On 04/05/2019 at approximately 2:30 PM, the DON and Administrator were notified of findings and they offered no further information or documentation. 2. For Resident # 49, the facility staff failed to document the dates of problems and interventions listed on the careplan when revised. Resident # 49, a 91 year old male, was admitted to the facility on 12/1/2017. Diagnoses included but were not limited to: Alzheimer's Disease, Hypertension, Malignant Neoplasm of Prostate, Gastroesophageal Reflux Disease, Dementia, Osteoarthritis, and Anxiety. Resident # 49's most recent Minimum Data Set (MDS) was a quarterly assessment with an Assessment Reference Date (ARD) of 2/1/2019. The MDS coded Resident # 49 with a BIMS (Brief Interview for Mental Status) score of "3" out of 15, indicating severe cognitive impairment. Resident # 49 was coded as requiring limited to extensive assistance of one staff person for Activities of Daily Living except total assistance of one staff person for bathing. Resident # 49 was coded as occasionally incontinent of bowel and bladder. On 04/04/2019 at 2:30 PM, review of the clinical record was conducted. Resident #49 was admitted to the facility on 12/1/2017. A review of Resident # 49's clinical record was conducted during the survey. Resident #49's care plan, revised on 02/27/2019,	F 657		

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F 657	Continued From page 61 read that Resident # 49 had a diagnosis of Alzheimer's Disease and dementia resulting in confusion at times. One of the interventions listed was "Reorient as needed." Under the problem: "Has inability to perform ADLS (Activities of Daily Living) independently secondary to Alzheimer's disease, dementia... , there was a problem added by handwriting: "occasionally refuses scheduled shower, become agitated and at times aggressive. There was no date of when that handwritten note was added. There were interventions that were handwritten: "Encourage res (resident) to take showers. Approach Res (Resident) in a calm manner." There were other interventions handwritten on the care plan under other problems. There were no dates of when the problems or interventions were added. On 04/05/19 at 10:10 AM, an interview with Employee H, the MDS/ Care Plan Coordinator was conducted. When asked about how to determine when an intervention on the care was implemented, Employee H stated, "We don't date interventions." Employee H state the intervention would either continue or it would be resolved. When asked about a resolved intervention, Employee H stated, "I would delete it." Employee H stated the paper copy care plans were kept in a book on the unit, updated on the paper, and eventually entered into the computer. There was no way to determine when interventions were added to the care plan or if the care plan needed to be revised.	F 657		

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F 657	Continued From page 62 On 4/5/2019 during the end of day debriefing, the facility Administrator and the Director of Nursing were informed of the findings. The Director of Nursing stated the interventions and revisions should be dated. No further information was provided. 3. For Resident #68, the facility staff failed to document the dates of problems and interventions listed on the careplan when revised. Resident # 68, a 91 year old female was admitted to the facility on 12/1/2017. Diagnoses included but were not limited to: Alzheimer's Disease, Hypertension, Major Depressive Disorder, Gastroesophageal Reflux Disease, Dementia, Cardiomegaly, and Anxiety. Resident # 68's most recent Minimum Data Set (MDS) was a quarterly assessment with an Assessment Reference Date (ARD) of 2/21/2019. The MDS coded Resident # 68 with a BIMS (Brief Interview for Mental Status) score of "3" out of 15, indicating severe cognitive impairment. Resident # 68 was coded as requiring extensive assistance of one to two staff persons for Activities of Daily Living except total assistance of one staff person for Bathing. Resident # 68 was coded as frequently incontinent of bowel and bladder. Review of the clinical record was conducted on 4/4/2019. A review of Resident # 68's clinical record was conducted during the survey. Resident #68's care plan, revised on 02/27/2019, read that Resident # 68 had a diagnosis of Alzheimer's	F 657		

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F 657	Continued From page 63 Disease and dementia resulting in confusion at times. One of the interventions listed was "Reorient as needed." Another problem listed was: "Bunion to right inner foot" and " (L) (left) foot skin integrity" "Treat as ordered to bunion on right inner foot. Ted hose per order, treat as ordered to left foot to maintain skin integrity, weekly weights, Aquaphor to BLE (Bilateral Lower Extremities) every other day." There was no documentation of when the problems or interventions were added to the careplan. There were other interventions handwritten on the care plan under other problems. There were no dates of when the problems or interventions were added. On 04/05/19 at 10:10 AM, an interview with Employee H, the MDS/ Care Plan Coordinator ,was conducted. When asked about how to determine when an intervention on the care was implemented, Employee H stated, "We don't date interventions." Employee H state the intervention would either continue or it would be resolved. When asked about a resolved intervention, Employee H stated, "I would delete it." Employee H stated the paper copy care plans were kept in a book on the unit, updated on the paper, and eventually entered into the computer. There was no way to determine when interventions were added to the care plan or if the care plan needed to be revised. On 4/5/2019 during the end of day debriefing, the facility Administrator and Director of Nursing were	F 657		

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F 657	Continued From page 64 informed of the findings. The Director of Nursing stated the interventions and revisions should be dated. The facility provided no further information.	F 657		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and clinical record review the facility staff failed to maintain professional standards when administering medications for 1 Resident (#97) in a survey sample of 30 Residents. For Resident #97 the facility staff failed to administer Heparin (an anti-coagulant) ,Daily, as ordered by the Physician. The findings include: Resident #97 is an 84 year old woman admitted to the facility on 6/22/17 with diagnoses of but not limited to Anemia, Hypertension, Dementia (Alzheimer's Type) History of Stroke, Anxiety and Depression. The most recent Minimum Data Set assessment was a PPI 5 Day assessment with an assessment reference date (ARD) of 3/12/19 Resident #97 was coded as having a (Brief Interview of Mental Status) BIMS score of 3, indicating severe	F 658	**F658** **Corrective Action(s):** Resident #97's Heparin and Saline midline flush orders have been reviewed by the Nurse Practitioner and clarified. A Facility Incident & Accident Form was completed for these incidents. **Identification of Deficient Practices/Corrective Action(s):** All other residents with Heparin and Saline flush orders may have potentially been affected. The DON, ADON and/or designee will conduct a 100% review of all resident's medication orders to identify any residents at risk for inaccurate heparin and saline flush orders. All residents identified at risk will be corrected at time of discovery and the attending physician will be notified of each error. An Incident & Accident form will be completed for each negative finding.	

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F 658	Continued From page 65 cognitive impairment. Resident # 97 was coded as requiring 1 person physical assistance for all aspects of ADL's and a physical assist of 2 staff for transfers. On 4/5/19 during clinical record review it was noted that Resident #97 had orders for Flushing Midline Catheter (Intravenous Line for medication administration.). The orders began on 3/17/18 at 2:30 PM. The orders read: Heparin flush 10 Units/ML [10 Units per Milliliter] Flush midline with Heparin [an Anti-Coagulant] & Normal Saline QD [Every Day] The order appears on the (Medication Administration Record) MAR signed off and timed for 6:30 AM, 2:30 PM and 10:30 PM (3 times daily) The first dose was signed off at 2:30 PM on 3/17/19 and continued to be signed off as administered three (3) times a day for the duration of the month of March. A second order was initiated on 3/17/19 in addition to the original Heparin Flush order. The order stated: Normal Saline Flush Syringe Flush Midline with saline & Heparin QD [Every Day] Discontinue Date 3/18/19 - That order was timed for 2:00 PM (daily) and signed off on 3/17/19 and 3/18/19 at 2:00 PM	F 658	**Systemic Change(s):** The facility policy and procedure has been reviewed and no revisions are warranted at this time. The nursing assessment process as evidenced by the 24 Hours Report, documentation in the medical record and physician orders remains the source document for the development and monitoring of care which includes, obtaining, transcribing and administering physician ordered medications per physician order. Licensed staff will be inserviced by the DON and/or regional nurse consultant on the policy & procedure for medication administration to include administering Heparin and Saline Flush orders as ordered. **Monitoring:** The DON is responsible for maintaining compliance. The DON and/or ADON will review medication orders weekly coinciding with the care plan calendar in order to maintain compliance. Any/all negative findings will be corrected at time of discovery and disciplinary action will be taken as needed. Aggregate findings of these audits will be reported to the Quality Assurance Committee quarterly for review, analysis, and recommendations for change in facility policy, procedure, and/or practice. **Completion Date: May 20, 2019**	

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F 658	Continued From page 66 then it was discontinued. A third order was initiated on 3/18/19 in addition to the Heparin Flush order. That order stated: Clarification order: Normal Saline Flush Syringe 10 ML Flush Midline with 10 ML NS [normal saline] Q 12 hours [Every 12 hours] This order was written on the 18th but not imitated until the 19th and timed for 9:00 AM and 9:00 PM. This order was signed off as administered twice daily for the duration of the month of March. The Physicians order sheet for April read: Heparin flush 10 Units/ML Flush midline with Heparin [an Anti-Coagulant] & Normal Saline QD [Every Day] [Once again the Heparin order was timed and signed off at 6:30 AM 2:30 PM and 10:30 PM for April 1st-5th] Also on April Physicians Orders was: Clarification order: Normal Saline Flush Syringe 10 ML Flush Midline with 10 ML NS [normal saline] Q 12 hours [Every 12 hours] The Normal Saline order was signed off at 9:00 AM and 9:00 PM.	F 658		

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F 658	Continued From page 67 On 4/5/19 at 1:45 PM LPN E was asked how many times a day does the Residents Midline get flushed and stated that it was done every shift. She then elaborated that "Night shift does it at 6:30 AM, Day shift at 2:30 PM and Evening shift does it at 10:30 PM." The facility cited Lippincott as the resource used for professional nursing standards. Guidance was given from Lippincott, Fundamentals of Nursing, which reads: To prevent medication errors, follow the six rights of medication administration consistently every time you administer medications. Many medication errors can be linked, in some way, to an inconsistency in adhering to these rights: 1. The right medication 2. The right dose 3. The right patient 4. The right route 5. The right time 6. The right documentation No further information was provided.	F 658		
F 661 SS=D	Discharge Summary CFR(s): 483.21(c)(2)(i)-(iv) §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. (ii) A final summary of the resident's status to	F 661	**F661** **Corrective Action(s):** Resident #104's attending physician has been notified that the facility staff failed to accurately complete a discharge summary and recapitulation of Resident #104 stay at the facility. Facility Incident & Accident Form was completed for this incident.	

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	495300		C 04/05/2019

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F 661	Continued From page 68 include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative. (iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter). (iv) A post-discharge plan of care that is developed with the participation of the resident and, with the resident's consent, the resident representative(s), which will assist the resident to adjust to his or her new living environment. The post-discharge plan of care must indicate where the individual plans to reside, any arrangements that have been made for the resident's follow up care and any post-discharge medical and non-medical services. This REQUIREMENT is not met as evidenced by: Based on facility documentation review and clinical record review, the facility failed to complete a discharge summary that included a recapitulation of the resident's stay. For Resident #104, the facility staff failed to complete a discharge summary that accurately described the clinical status of the resident and a recapitulation of the resident's stay. The findings included: Resident #104, 59 year old, admitted to the facility on 11/1/18 and discharged on 1/10/19. The resident's diagnoses included but were not limited to, legal blindness, muscle weakness, encephalopathy, dysphagia, cognitive	F 661	**Identification of Deficient Practices/Corrective Action(s):** All other discharged residents may have been potentially affected. The DON, ADON and/or Medical Records Clerk will review the last 30 days of discharge residents to identify residents at risk. All residents identified at risk will be corrected at time of discovery and an Incident & Accident form will be completed for each negative finding. The attending physician will be notified of each inaccurate discharge summary. **Systemic Change(s):** The facility policy and procedure has been reviewed and no revisions are warranted at this time. All Department managers and Medical Records will be inserviced on the Policy and Procedure for completion of Discharge Summaries and the need for an accurate recapitulation of the residents stay. **Monitoring:** The DON is responsible for maintaining compliance. The DON, ADON and/or Medical Records will perform discharge chart audits weekly of discharge summaries and recapitulation of the residents stay. Any/all negative findings from these audits will be corrected at time of discovery and disciplinary action will be taken as needed. Aggregate findings of these audits will be reported to the Quality Assurance Committee quarterly for review, analysis, and recommendations for change in facility policy, procedure, and/or practice. **Completion Date: May 20, 2019**	

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F 661	Continued From page 69 communication deficit and athscl [sic] heart disease. Resident #104's most recent MDS (Minimum Data Set) (an assessment tool) with an ARD (assessment reference date) of 1/1/19 was coded as a 60 day assessment. Resident #104 was coded as having a BIMS (brief interview for memory status) score of 4, indicating severe cognitive impairment. Functional status for Resident #104 was coded as being totally dependent on staff for transfers, locomotion, eating, toilet use and personal hygiene. Review of the Recapitulation of resident stay dated 1/10/19 by various members of the interdisciplinary team to include, social services director, director of nursing and certified dietary manager was incomplete. The following items had no response written: 1. the reason for admission 2. treatment provided 3. progress 4. reason for discharge/discharge diagnosis 5. mental and psychosocial status 6. cognitive status 7. clinical lab values or diagnostic tests 8. weight trend 9. eating habits/preferences Drug therapy required had "P.O.S." (physician's order sheet) noted on the line. Review of the discharge summary signed by the physician on 1/15/19 and signed by the director of nursing on 1/10/19 revealed the following: 1. functional status: "alert to self" 2. dental condition: blank 3. cognitive status: "limited" with no explanation	F 661		

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F 661	Continued From page 70 4. activities potential: "limited" with no explanation 5. drug therapy : "P.O.S." [sic] (physician's order sheet) 6. Condition at the time of discharge: blank Review of the facility policy titled, "Discharge Summary and Plan" revised December 2016 read: "The discharge summary will include a recapitulation of the resident's stay at this facility and a final summary of the resident's status at the time of discharge in accordance with established regulations governing release of resident information and as permitted by the resident. The discharge summary shall include a description of the resident's: a. current diagnosis, b. medical history, c. course of illness, treatment and/or therapy since entered the facility, d. current laboratory, radiology, consultation, and diagnostic test results; e. physical and mental functional status, f. ability to perform activities of daily living, g. sensory and physical impairments, h. nutritional status and requirements, i. special treatments or procedures, j. mental and psychosocial status (ability to deal with life, interpersonal relationships and goals, make healthcare decisions, and indicators of resident behavior and mood); k. discharge potential, l. dental condition, m. activities potential (the ability and desire to take part in activity pursuits which maintain or improve physical, mental, and psychosocial well-being); n. rehabilitation potential (the ability to improve independence in functional status through restorative care programs); o. cognitive status (the ability to problem solve, decide, remember, and be aware of and respond to safety hazards) and p. medication therapy (all prescription and over-the-counter medications taken by the	F 661		

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F 661	Continued From page 71 resident including dosage, frequency of administration, and recognition of significant side effects that would be most likely to occur in the resident)." The Administrator and Director of Nursing were informed of the facility staff to complete a discharge summary that accurately describes the current clinical status of the resident and a recapitulation of the resident's stay on 4/4/19 at 5:30pm. No further information was provided.	F 661		
F 676 SS=D	Activities Daily Living (ADLs)/Mntn Abilities CFR(s): 483.24(a)(1)(b)(1)-(5)(i)-(iii) §483.24(a) Based on the comprehensive assessment of a resident and consistent with the resident's needs and choices, the facility must provide the necessary care and services to ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that such diminution was unavoidable. This includes the facility ensuring that: §483.24(a)(1) A resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living, including those specified in paragraph (b) of this section ... §483.24(b) Activities of daily living. The facility must provide care and services in accordance with paragraph (a) for the following activities of daily living: §483.24(b)(1) Hygiene -bathing, dressing,	F 676	**F676** **Corrective Action(s):** Resident #55's Bowel and Bladder status has been reassessed by the nursing department. A restorative bowel program has been established to reestablish bowel continence and the use of the commode for all bowel movements. His comprehensive care plan has been revised to reflect his current bowel program. **Identification of Deficient Practices & Corrective Action(s):** All other residents requiring toileting assistance may have potentially been affected. The DON, ADON and/or Unit Managers will review each resident's current bowel and Bladder status to include appropriate interventions to meet their resident specific needs. The residents comprehensive care plans will be revised to reflect their current needs to promote or maintain their current bowel and bladder function to promote continence of bowel and bladder.	

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F 676	Continued From page 72 grooming, and oral care, §483.24(b)(2) Mobility-transfer and ambulation, including walking, §483.24(b)(3) Elimination-toileting, §483.24(b)(4) Dining-eating, including meals and snacks, §483.24(b)(5) Communication, including (i) Speech, (ii) Language, (iii) Other functional communication systems. This REQUIREMENT is not met as evidenced by: Based on resident interview and clinical record review, the facility staff failed to provide necessary care and services to ensure that a resident's abilities in activities of daily living do not diminish for one resident (Resident #55) in a survey sample of 30 residents. The facility staff failed to provide care and assistance in ADL's (Activities of daily living) to maintain a resident's continence for Resident #55. The findings included: Resident #55, a 55 year old, was admitted to the facility on 2/1/19. The resident's diagnoses included, but were not limited to: hypertension, Type 2 diabetes, and neuromuscular dysfunction of bladder. Resident #55's most recent MDS with an ARD (assessment reference date) of 2/8/19 was coded	F 676	**Systemic Change(s):** The facility policy and procedure has been reviewed and no changes are warranted at this time. The DON and/or designee will provide ongoing inservice training to the licensed staff and CNA staff to address the importance of providing assistance to residents during bowel and bladder care and accurately following and maintaining a Bowel and Bladder continence program. **Monitoring:** The DON is responsible for maintaining compliance. The DON and/or designee will perform weekly audits to ensure that their bowel and bladder needs are being addressed. Any/all negative findings will be reported to the DON for immediate correction. Detail findings of these audits will be reported to the Quality Assurance Committee for review, analysis, and recommendations for changes in facility policy, procedure, and/or practice. **Completion Date: May 20, 2019**	

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F 676	Continued From page 73 as an admission assessment. The resident was coded as having a BIMS (Brief Interview for Memory Status) score of 15, indicating the resident was cognitively intact. Functional status for transfers, dressing, toilet use and personal hygiene, was coded as Resident #55 required extensive assistance of staff. Review of the Nursing Admission Assessment dated 2/1/19 is coded that the resident is continent of bowel movements. In an interview with Resident #55 on 4/5/19 at 9:34am the resident stated, "I know when I need to go but it makes it easier for everyone if I use this diaper and let them know when it needs changing. I can get in my chair and go to the bathroom." The baseline careplan indicates resident requires assistance of one staff person for transfers and toileting and is continent of bowel. The CNA careplan dated 2/1/19 indicates resident needs "assisted toileting." Review of the "Bowel & Bladder Report" from 2/2/19-4/4/19 showed Resident #55 had a bowel movement on 70 of those days. Of the 70 occurrences 66 of those were incontinent, using an adult brief. Surveyor A conducted an interview with CNA M on 4/3/19 at approximately 2pm. During the interview, CNA M stated, "[Resident #55's name] is continent, he has a foley, he will let me know when he needs changed, he just uses his brief." The Administrator and Director of Nursing were made aware of the findings of staff failing to provide ADL assistance to maintain bowel continence for Resident #55 during end of the day meeting on 4/4/19.	F 676		

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F 676	Continued From page 74 No further information was provided.	F 676		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, clinical record review, and facility documentation review, and in the course of a complaint investigation, the facility staff failed to provide needed care and services for one resident (Resident #45) in a sample size of 30 residents. 1. For Resident #45, the facility failed to identify, assess, and notify provider for a potential change in condition. It was documented in the clinical record Resident #45 weighed 226.4 pounds on 03/25/2019 and 199.6 pounds on 04/01/2019 (11.84% weight loss in 6 days). The findings include: Resident #45, a 76-year old male, was admitted to the facility on 05/21/2018. Diagnoses included but not limited to atherosclerotic heart disease, diabetes, cerebral infarction, hypertension, atrial	F 684	**F684** **Corrective Action(s):** Residents #45's attending physician was notified that the facility failed to identify a potentially significant weight loss that was transcribed incorrectly on the weekly weight sheet. Resident #45 was reweighed and there was no significant weight loss noted. A facility Incident & Accident form was completed for this incident. **Identification of Deficient Practices/Corrective Action(s):** All other residents with physician ordered weekly weights may have potentially been affected. The DON, QA nurse and/or Unit Manager will conduct a 100% audit of all resident's physician ordered weekly weights to identify resident at risk. Residents identified at risk will be corrected at time of discovery and their attending physicians will be notified of each negative finding and a facility Incident & Accident Form will be completed for each negative finding.	

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F 684	Continued From page 75 fibrillation, and dementia. Resident #45's most recent MDS (minimum data set) with an ARD (assessment reference date) of 01/25/2019 was coded as a quarterly review. The Brief Interview for Mental Status was coded as 9 out of possible 15 indicative of moderate cognitive impairment. Weight gain or weight loss of more than 10% in the past 6 months was coded as "No or unknown." On 04/03/2019 at 9:10 AM, Resident #45 was observed in his room seated in his wheelchair watching TV in no apparent distress. On 04/03/2019 at 11:43 AM, the electronic clinical record was reviewed for weight status. An entry dated 03/25/2019 at 1:49 PM documented the value 226.4 pounds. An entry dated 04/01/2019 at 11:32 AM documented the value 199.6 pounds indicative of an 11.84% weight loss in 6 days. The nurse's notes for 04/01/2019 were reviewed. There was no documentation addressing or assessing the weight loss. The active physician's orders were reviewed. An entry dated 03/18/2019 documented, "Weight monitor weekly." An entry dated 03/14/2019 documented, "Lasix 40 mg by mouth BID (twice a day)." A provider's visit dated 03/14/2019 under the section "Subjective" documented, "Left axillary 3x3 cm mass with pain; bilateral leg edema." On the bottom of the form under the section "Diagnosis part (2) documented, "Bilateral leg edema." Under the section "Plan" part (2) documented, "Lasix 40 mg po BID (by mouth	F 684	**Systemic Change(s):** The facility policy and procedures have been reviewed and no revisions are warranted at this time. The nursing assessment process as evidenced by the 24 Hour Report and documentation in the medical record /physician orders remains the source document for the development and monitoring of the provision of care, which includes, obtaining accurate weights per MD order. The DON and/or Regional nurse consultant will inservice all licensed nursing staff and C.N.A. staff on the procedure for obtaining physician ordered weights and the review process by the QA nurse for physician notification weight changes. **Monitoring:** The DON will be responsible for maintaining compliance. The DON and/or QA nurse will perform weekly review of all weekly weights to monitor for compliance. Any/all negative findings and or errors will be corrected at time of discovery and disciplinary action will be taken as needed. Aggregate findings of these audits will be reported to the Quality Assurance Committee quarterly for review, analysis, and recommendations for change in facility policy, procedure, and/or practice. **Completion Date: May 20, 2019**	