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	495269	A. BUILDING _____ B. WING _____	02/02/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE JEFFERSON	900 NORTH TAYLOR STREET ARLINGTON, VA 22203

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments	E 000	E035	
E 035 SS=C	LTC and ICF/IID Sharing Plan with Patients CFR(s): 483.73(c)(8)	E 035		

An unannounced Emergency Preparedness survey was conducted 1/30/18 through 2/2/18. Corrections are required for compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities

[(c) The [LTC facility and ICF/IID] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least annually.] The communication plan must include all of the following:

(8) A method for sharing information from the emergency plan, that the facility has determined is appropriate, with residents [or clients] and their families or representatives.
This REQUIREMENT is not met as evidenced by:
Based on staff interview and facility document review it was determined the facility staff failed to have a complete emergency preparedness plan.

The facility staff failed to demonstrate the method the facility had developed for sharing the emergency plan with residents or client and their families or representatives.

The findings include:

On 02/2/18 at 9:23 a.m., a review and interview of the facility's emergency preparedness plan was conducted with ASM (administrative staff member) # 1 the administrator. Review of the facility's emergency preparedness plan failed to

Responses to the cited deficiencies do not constitute an admission or agreement by the facility of the truth of facts alleged or conclusions set forth in the Statement of Deficiencies. The Plan of Correction is prepared solely as a matter of compliance with federal and/or state law.

1. **With respect to the specific observation cited:** The fire safety plan in the admission packet was updated by the Administrator to reflect general emergency procedures and emergency contact information.

2. **With respect to how the facility will identify residents with the potential for the identified concern and take corrective action:** Copies of the updated emergency procedures notice will be distributed to all current residents and mailed to their responsible parties by 2/23/18.

3. **With respect to what systemic measures have been put in place to address the stated concern:** The updated emergency procedures notice will be included as part of new admissions materials and reviewed with residents and families upon signing of the residency agreement. A random sample of 5 new admission agreements will be

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
D. Klune, LNHA	Administrator	2/16/18

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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demonstrate the method the facility had developed for sharing the emergency plan with residents or client and their families or representatives. ASM # 1 stated that they had a fire safety plan in the admission packet but it only addressed fire safety. ASM #1 stated the emergency plan was not available for families and residents.

On 02/2/18 at approximately 9:23 a.m. ASM (administrative staff member) # 1, administrator was made aware of the above findings.
No further information was provided prior to exit.

F 000 INITIAL COMMENTS

An unannounced Medicare/Medicaid standard survey was conducted 1/30/18 through 2/2/18. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements.

The census in this 31 certified bed facility was 23 at the time of the survey. The survey sample consisted of 12 current Resident reviews (Residents #175, #4, #18, #174, #178, #19, #17, #2, #3, #15, #183, and #20) and 3 closed record reviews (Residents #25, #14 and #9).

F 607 SS=D Develop/Implement Abuse/Neglect Policies 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

E 035

audited monthly for the next three months by the Administrator or her designee to verify that the emergency procedures notice was reviewed with and signed by the resident and/or responsible party. If an issue is identified, the resident and/or responsible party will be contacted and the emergency procedures notice will be reviewed with them and documented.

F 000

4. **With respect to how the plan of corrective measures will be monitored:** Over the next three months, the findings from the monthly admission agreement audits will be reviewed at Quality Assurance / Performance Improvement (QAPI) meetings. At the conclusion of the three months, the QAPI committee will re-evaluate and initiate any necessary action or extend the review period. The Executive Director and/or Administrator are responsible for ensuring implementation and ongoing compliance with the components of this Plan of Correction and addressing and resolving variances that may occur. The Executive Director and/or Administrator are responsible for ensuring the status of this Plan of Correction is reviewed and discussed at QAPI meetings and action initiated if required.

F 607

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F 607 Continued From page 2

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 document review, and clinical record review, it was determined the facility staff failed to implement abuse policies to investigate an injury of unknown origin for one of 15 residents in the survey sample, Resident #3.

The facility staff failed to implement the abuse policies to investigate a bruise of unknown origin for Resident #3 to determine if abuse had occurred.

The findings include:

Resident #3 was admitted to the facility on 1/14/17 with diagnoses that included but were not limited to dementia without behavioral disturbance, osteoarthritis, spinal stenosis, high blood pressure, stroke, hypothyroidism and muscle weakness. Resident #3's most recent MDS (minimum data set) assessment was a quarterly assessment with an ARD (assessment reference date) of 11/30/17. Resident #3 was coded as being severely impaired in cognitive function scoring 07 out of 15 on the BIMS (Brief Interview for Mental Status) exam. Resident #3 was coded as requiring extensive assistance from one person/staff member with bed mobility, transfers, locomotion on and off on the unit, dressing, and toileting; and total dependence on staff with bathing.

Review of Resident #3's nursing notes revealed

F 607

5. Areas cited in E035 will be corrected by 3/16/18.

F607

Responses to the cited deficiencies do not constitute an admission or agreement by the facility of the truth of facts alleged or conclusions set forth in the Statement of Deficiencies. The Plan of Correction is prepared solely as a matter of compliance with federal and/or state law.

1. **With respect to the specific resident cited:** The DNS completed a full skin integrity assessment of Resident #3 at the time of the survey. No unusual bruising was identified. A birthmark was noted on the right arm above the elbow and documented. The resident exhibited no signs of distress, agitation or withdrawal that might indicate abuse. The nurse who made the 8/31/17 documentation is no longer employed by the facility.

2. **With respect to how the facility will identify residents with the potential for the identified concern and take corrective action:** The Director of Nursing and Assistant Director of Nursing conducted full skin integrity assessments of all residents in-house at the time of

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the following note dated 8/31/17 at 4:12 a.m., that documented in part, the following, "...No s/s (signs/symptoms) of distress nor discomfort noted. No abnormal behavior noted no skin issue..."

Further review of the nursing notes revealed the following note dated 8/31/17 at 7:53 p.m.,"pt (patient) noted trying to get on elevator, assisted by staff back to floor, pt noted with 2 (two) bruises to R (right) arm above elbow, it is unknown to writer if these are new or existing, pt denies pain and any knowledge of Bruises (sic)."

Review of Resident #3's clinical record failed to evidence an incident report or investigation regarding Resident #3's bruises.

Review of Resident #3's most recently signed POS (physician order sheet) documented the following order: "Plavix [1] tablet 75 mg (milligrams) by mouth in the morning for CVA (stroke)." This order was initiated on 5/15/17.

Review of Resident #3's antiplatelet care plan dated 1/14/17 and revised on 2/21/17 documented the following interventions: "Observe and check skin daily during care and report abnormalities to the nurse i.e. bruising/bleeding."

On 2/1/18 at 3:28 p.m., an interview was conducted with RN (registered nurse) #2, Resident #3's nurse. When asked about the process of identifying a bruise of unknown origin, RN #2 stated nurses should complete an incident report and start an investigation determining the cause of the bruise. RN #2 stated the investigation would entail asking family members, nursing aides, or any other staff that have worked

survey. No previously unidentified skin conditions were noted.

3. **With respect to what systemic measures have been put in place to address the stated concern:** Refresher training will be conducted for nursing staff by the Director of Nursing by 3/2/18 regarding the need to report and investigate any new bruises or discolorations of unknown origin to rule out possible abuse. Weekly skin check records will be audited weekly for the next three months by the Director of Nursing or his designee to verify that any new bruises or areas of discoloration are thoroughly investigated. The Director of Nursing or his designee will conduct skin integrity assessments on a random sample of 3 residents each week to check for bruises or discolorations not previously identified. If an issue is identified, an investigation will be conducted and documented, the responsible party and physician will be notified, and outside agencies will be notified as indicated.

4. **With respect to how the plan of corrective measures will be monitored:** Over the next three months, the findings from the weekly skin check audits and weekly skin integrity assessments will be reviewed at Quality Assurance /

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with the resident about the resident's skin or anything that could have contributed to the bruise. RN #2 stated she would investigate to rule out any abuse. When asked if Resident #3 bruises easily, RN #2 stated, "No, she doesn't bruise a lot." RN #2 stated nurses have to monitor for bruising because Resident #3 is on Plavix but Resident #3 does not experience frequent bruising. RN #2 could not recall the bruises found on 8/31/17. RN #2 stated the nurse who found the bruises no longer works at the facility. The incident report Resident #3's bruises from 8/31/17 was requested.

On 2/01/18 at 4:59 p.m., further interview was conducted with RN #2. RN #2 stated she could not find an incident report or investigation regarding Resident #3's bruises.

On 2/01/18 at 5:16 p.m., an interview was conducted with ASM (administrative staff member) #2, the DNS (director of nursing services). When asked what nursing was expected to do when a bruise of unknown origin was identified, ASM #2 stated he would expect his nurses to do an investigation to determine the cause of the bruise. ASM #2 stated nurses should also notify the family and physician. ASM #2 stated bruises of unknown origin should also be reported to the appropriate state agencies immediately and follow up provided to justify the reason for the bruise. ASM #2 was not aware of the identified bruises on 8/31/17.

On 2/02/18 at approximately 9:00 a.m., further interview was conducted with ASM #2. ASM #2 stated he made a skin sweep on 2/01/18 and noticed a birthmark on Resident #3's right arm that was towards her right elbow. ASM #2 stated

Performance Improvement (QAPI) meetings. At the conclusion of the three months, the QAPI committee will re-evaluate and initiate any necessary action or extend the review period. The Executive Director and/or Administrator are responsible for ensuring implementation and ongoing compliance with the components of this Plan of Correction and addressing and resolving variances that may occur. The Executive Director and/or Administrator are responsible for ensuring the status of this Plan of Correction is reviewed and discussed at QAPI meetings and action initiated if required.

5. Areas cited in F607 will be corrected by 3/16/18.

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the bruises identified in the note on 8/31/17 could have been the birthmark. ASM #2 stated there was no previous documentation regarding a birthmark. When asked if he would have expected nurses to investigate a bruise or skin altercation that was not previously identified, ASM #2 stated he would.

On 2/02/18 at 5:16 p.m., ASM #1, the administrator and ASM #2, the DNS were made aware of the above concerns.

The facility policy titled, "Abuse, Neglect and Exploitation" documents in part, the following: "It is the policy of the community that: a) each resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation. Team members most not engage in, nor permit anyone else to engage in, abuse, neglect or exploitation. b) team members of the community are mandated reporters and have a duty to report known or suspected abuse, neglect or exploitation to local, state, and/or federal authorities in accordance with applicable state law and regulation. c) In addition, team members who know of or suspect abuse, neglect or exploitation of any resident must immediately notify the Executive Director/designee, to ensure appropriate action is timely taken for the safety of the resident and those potentially impacted....Investigation: The SNA(skilled nursing administrator) validates that the mandatory report of known or suspected abuse, neglect or exploitation has been made to the applicable authorities in accordance with state/federal requirements. The SNA/designee manages and directs the investigation of all abuse, neglect, and/or exploitation. The SNA/designee implements corrective actions as indicated by the

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F 607	Continued From page 6 results of the investigation..." [1] Plavix- is a platelet aggregation inhibitor used to lessen the chance of a heart attack or stroke. This information was obtained from The National Institutes of Health. https://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0009687/?report=details.	F 607		
F 622 SS=D	Transfer and Discharge Requirements CFR(s): 483.15(c)(1)(i)(ii)(2)(i)-(iii) §483.15(c) Transfer and discharge- §483.15(c)(1) Facility requirements- (i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless- (A) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility; (B) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility; (C) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident; (D) The health of individuals in the facility would otherwise be endangered; (E) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a	F 622	**F622** Responses to the cited deficiencies do not constitute an admission or agreement by the facility of the truth of facts alleged or conclusions set forth in the Statement of Deficiencies. The Plan of Correction is prepared solely as a matter of compliance with federal and/or state law. 1. **With respect to the specific residents cited:** The physician for residents #18 and #19 documented late entries regarding the hospital transfers on 6/8/17, 7/16/17, 1/1/18, and 1/21/18. Resident #174 was discharged from the facility to home on 2/10/18 due to resident's health improving and no longer requiring services of the facility. 2. **With respect to how the facility will identify residents with the potential for the identified concern and take corrective action:** An audit of physician documentation for current guests who have had a hospital transfer during their stay was completed on 2/14/18 by the Assistant Director of Nursing. For those guests found not to have physician documentation of the	

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resident only allowable charges under Medicaid; or
(F) The facility ceases to operate.
(ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose.

§483.15(c)(2) Documentation.
When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider.
(i) Documentation in the resident's medical record must include:
(A) The basis for the transfer per paragraph (c)(1)(i) of this section.
(B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s).
(ii) The documentation required by paragraph (c)(2)(i) of this section must be made by-
(A) The resident's physician when transfer or discharge is necessary under paragraph (c) (1) (A) or (B) of this section; and
(B) A physician when transfer or discharge is

needs that cannot be met, the facility efforts and attempts to meet the needs and the service available at the receiving facility to meet the needs, late entries will be made by the physician.

3. **With respect to what systemic measures have been put in place to address the stated concern:** Refresher training and policy review will be conducted for the Medical Director, attending physicians and nurse practitioners by the Director of Nursing by 3/2/18 regarding the need to document in the resident's record the specific resident need(s) that cannot be met, facility efforts and attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s) each time a resident is transferred to the hospital. Physician notes for any residents transferred to the hospital will be audited weekly for the next three months by the Director of Nursing or his designee to verify that reasons for the transfer are appropriately documented by the physician. If an issue is identified, a late entry will be made by the physician.

4. **With respect to how the plan of corrective measures will be monitored:** Over the next three months, the findings from the weekly

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F 622	Continued From page 8 necessary under paragraph (c)(1)(i)(C) or (D) of this section. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, it was determined the facility staff failed to provide evidence of physician documentation when residents were transferred to the hospital for three of 15 residents in the survey sample, Resident #18, #174 and #19. 1. Resident #18 was transferred to the hospital on three occasions, 6/8/17, 7/16/17 and 1/1/18. There were no physician notes regarding the reason for the transfers in the clinical record. 2. Resident #174 was transferred to the hospital on 1/11/18. There were no physician notes regarding the reason for the transfer in the clinical record. 3. Resident #19 was transferred to the hospital on 1/21/18. There were no physician notes regarding the reason for the transfer in the clinical	F 622	physician notes audits will be reviewed at Quality Assurance / Performance Improvement (QAPI) meetings. At the conclusion of the three months, the QAPI committee will re-evaluate and initiate any necessary action or extend the review period. The Executive Director and/or Administrator are responsible for ensuring implementation and ongoing compliance with the components of this Plan of Correction and addressing and resolving variances that may occur. The Executive Director and/or Administrator are responsible for ensuring the status of this Plan of Correction is reviewed and discussed at QAPI meetings and action initiated if required. **5.** Areas cited in F622 will be corrected by 3/16/18.	

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record.

The findings include;

1. Resident #18 was transferred to the hospital on three occasions, 6/8/17, 7/16/17 and 1/1/18. There were no physician notes regarding the reason for the transfers in the clinical record.

Resident #18 was admitted to the facility on 12/27/16 with a readmission on 10/5/17 with diagnoses that included, but were not limited to; rectal hemorrhage, gastrostomy (placement of a feeding tube directly into the stomach), an irregular heart rate, cerebral palsy [1] (a disorder of movement, muscle tone or posture that is caused by damage that occurs to the immature, developing brain, most often before birth), and aphasia (difficulty with speaking.)

Resident #18's most recent MDS (minimum data set), a significant change assessment with an ARD (assessment reference date) of 1/11/18, coded Resident #18's BIMS (brief interview of mental status) score as 15 out of a possible 15, indicating that Resident #18 is cognitively intact to make decisions regarding daily living.

A review of Resident #18's clinical record revealed, in part, that Resident #18 had been transferred and admitted to an acute hospital on 6/8/17 (for rectal bleeding), 7/16/17 for vomiting bright red blood and on 1/11/18 for bleeding hemorrhoids.

Further review of Resident #18's clinical record failed to reveal any documentation from the physician regarding the reasons for #18's transfers and subsequent admissions to the

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hospital.

A review of Resident #18's nursing progress notes revealed, in part, the following:
- "7/17/17. Clinical/General changes requiring notification - (Family/physician/other): Guest had a change in VS (vital signs). Elevated Temperature irritated as noted (sic). MD (medical doctor) (name of MD) notified and per order to transfer guest to (name of hospital) ER (emergency room). (Name of ambulance service) called and guest transferred."
- "1/1/18. Guest was sent to the (name of hospital) ER d/t (due to) profuse bleeding from the anus. MD and Son (name of son) notified. Called (name of hospital) and he (Resident #18) has been admitted."
The facility did not provide progress notes documenting the transfer that occurred on 6/8/17.

A review of Resident #18's comprehensive care plan dated 10/5/17 did not reveal any documentation regarding hospital admissions.

On 2/1/18 at 5:00 P.M., an interview was conducted with ASM (administrative staff member) #1, the administrator, and ASM #2, the director of clinical services. When asked what documentation should be in the clinical record when a resident is transferred to the hospital, ASM #2 stated, the staff would notify the doctor and family then document those notifications. When asked if the documentation would include why the resident was being discharged, ASM #2 stated the nurse would document why the resident was being transferred and describe the circumstance of the transfer. When asked if the physician would document the reason for transfer in the progress notes, ASM #1 and ASM #2

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stated that they didn't think so, that an H&P (history and physical) would be completed at the time the resident returned back to the facility. ASM #1 and ASM #2 were made aware of the concerns regarding Resident #18's transfers to the hospital and asked to provide any evidence the physician completed a note at the time of transfers which explained the reasons for transfer. A facility policy was requested at this time regarding resident transfers to the hospital.

A review of the facility policy titled "Transfer, Discharge & Bed-Hold Notices" revealed, in part, the following documentation; "Policy Statement. It is the community's policy to abide by all applicable requirements, including provision of adequate notice to the resident/legal representative in the event that transfer or discharge is required and their right to return to the community if eligible. 7. The Resident's Physician/Physician Extender must document in the resident's clinical record when the reason given for the transfer or discharge is either one of the following two reasons: a. The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the community."

No further information was presented prior to the end of the survey process.

[1] This information was obtained from the following website; https://www.mayoclinic.org/diseases-conditions/cerebral-palsy/symptoms-causes/syc-20353999

2. Resident #174 was transferred to the hospital on 1/11/18. There were no physician notes regarding the reason for the transfer in the clinical

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record.

Resident #174 was admitted to the facility on 8/10/15 with a readmission on 1/14/18 with diagnoses that included, but were not limited to; cognitive communication deficit, heart failure, dementia, slow heart rate, altered mental status and Parkinson's disease [1] (a progressive disorder of the nervous system that affects movement),

Resident #174's most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 1/21/18, coded Resident #174 as scoring 11 out of a possible 15 on the BIMS (brief interview for mental status) indicating that Resident #174 is moderately cognitively impaired with decisions of daily living.

A review of Resident #174's clinical record revealed, in part, the following progress note; "1/11/18. Guest was sleeping when writer arrived at 7 p.m. He (Resident #174) was not verbally responsive but could open his eyes when spoken to. Compared to his baseline, guest unresponsiveness was not normal. Vitals were taken and all were normal. MD (medical doctor) (name of MD) was notified and gave order for guest to be sent out to the hospital. 911 (emergency response number) was called and guest was taken out of the facility to (name of hospital)."

Further review of Resident #174's clinical record did not reveal a physician note regarding the purpose of the transfer to the hospital.

A review of Resident #174's comprehensive care plan dated 1/14/18 did not reveal any

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documentation regarding the transfer to the hospital on 1/11/18.

On 2/1/18 at 5:00 P.M., an interview was conducted with ASM (administrative staff member) #1, the administrator, and ASM #2, the director of clinical services. When asked what documentation should be in the clinical record at the time of a resident's transfer to the hospital, ASM #2 stated the staff would notify the doctor and family then document those notifications. When asked if the documentation would include why the resident was being discharged, ASM #2 stated the nurse would document why the resident was being transferred and describe the circumstance of the transfer. When asked if the physician would document the reason for transfer in the progress notes, ASM #1 and ASM #2 stated they didn't think so, that an H&P (history and physical) would be completed at the time the resident returned back to the facility. ASM #1 and ASM #2 were made aware of the concern regarding Resident #174's transfer to the hospital and asked to provide any evidence that the physician completed a note on 1/11/18 that documented the reason for the transfer.

No further information was provided prior to the end of the survey process.

[1] This information was obtained from the following website; https://www.mayoclinic.org/diseases-conditions/parkinsons-disease/symptoms-causes/syc-20376055

3. Resident #19 was transferred to the hospital

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on 1/21/18. There were no physician notes regarding the reason for the transfer in the clinical record.

Resident #19 was admitted to the facility on 12/28/17 with a readmission on 1/30/18 with diagnoses that include, but are not limited to; acute respiratory failure, sepsis (a severe bacterial infection), acute kidney failure, chronic kidney disease and anxiety.

Resident #19's most recent MDS (minimum data set), a 14 day assessment with an ARD (assessment reference date) of 1/11/18 coded Resident #19 as having a BIMS (brief interview of mental status) score of 13 out of a possible 15, indicating that Resident #19 is cognitively intact for decisions of daily living.

A review of Resident #19's clinical record revealed, in part, the following progress note; "1/21/2018. Reason for Transfer: Alter (sic) mental status. Around 5:45 AM this morning, noticed guest snoring very loud. When called guest name out loud, guest eyes opened but went back to sleep, able to stay awake while snoring loudly. (Name of NP [nurse practitioner]), notified, order to send guest out to ER (emergency room) via 911 (emergency response number, give (sic) report to nurse (name of nurse), confirmed received medications list."

Further review of Resident #19's clinical record did not reveal any physician notes documenting the reason for a transfer to the hospital.

A review of Resident #19's comprehensive care plan dated 1/30/18 did not document the hospitalization.

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F 622	Continued From page 15 On 2/1/18 at 5:00 P.M., an interview was conducted with ASM (administrative staff member) #1, the administrator, and ASM #2, the director of clinical services. When asked what documentation should be in the clinical record at the time of a resident's transfer to the hospital, ASM #2 stated the staff would notify the doctor and family then document those notifications. When asked if the documentation should include why the resident was being transferred ASM #2 stated the nurse would document why and the circumstance of the transfer. When asked if the physician would document the reason for transfer in the progress notes, ASM #1 and ASM #2 stated they did not think so, that an H&P (history and physical) would be completed at the time the resident returned to the facility. ASM #1 and ASM #2 were made aware of the above concerns and asked to provide any evidence that the physician completed a note at the time of Resident #19's transfer to the hospital on 1/21/18. A facility policy was requested at this time regarding resident transfers to the hospital. No further information was provided prior to the end of the survey process.	F 622		
F 623 SS=E	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	F 623	**F623** Responses to the cited deficiencies do not constitute an admission or agreement by the facility of the truth of facts alleged or conclusions set forth in the Statement of Deficiencies. The Plan of Correction is prepared solely as a matter of compliance with federal and/or state law.	

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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 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

1. **With respect to the specific residents cited:** The State Office of the Long-Term Care Ombudsman was notified on 2/16/18 of hospital transfers for resident #18 on 6/8/17, 7/22/17 and 1/1/18; for resident #174 on 1/11/18; for resident #19 on 1/21/18; and for resident #183 on 1/19/18. Residents #18, #19, and #183 and their responsible parties were provided with written notifications regarding the above-mentioned transfers on 2/16/18. Resident #174 was discharged from the facility to home on 2/10/18 due to resident's health improving and no longer requiring services of the facility.

2. **With respect to how the facility will identify residents with the potential for the identified concern and take corrective action:** An audit of transfer documentation for current residents who have had a hospital transfer from this facility within the past 60 days was completed on 2/16/18 by the Social Services Coordinator. For those guests found not to have documentation that the State Office of the Long-Term Care Ombudsman, resident and responsible party were notified of the transfer in writing, notifications were made and documented in the resident's medical record.

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transferred or discharged;
(iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;
(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;
(vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and
(vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act.

§483.15(c)(6) Changes to the notice.
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

3. **With respect to what systemic measures have been put in place to address the stated concern:** Refresher training and policy review will be conducted for nursing staff by the Social Services Coordinator by 3/2/18 regarding the need to provide written notification of hospital transfers to the State Office of the Long-Term Care Ombudsman, resident and responsible party. Transfer notes for any residents transferred to the hospital will be audited weekly for the next three months by the Social Services Coordinator or his designee to verify that written notification of hospital transfers was provided to the State Office of the Long-Term Care Ombudsman, resident and responsible party. If an issue is identified, written notice will be provided and documented.

4. **With respect to how the plan of corrective measures will be monitored:** Over the next three months, the findings from the weekly transfer notes audits will be reviewed at Quality Assurance / Performance Improvement (QAPI) meetings. At the conclusion of the three months, the QAPI committee will re-evaluate and initiate any necessary action or extend the review period. The Executive Director and/or Administrator are responsible for

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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 document review and clinical record review, it was determined the facility staff failed to provide the required written notifications at the time of a facility initiated transfer for four of 15 residents in the survey sample, Resident #18, #174, #19 and #183.

1. The facility staff failed to provide a written notification to the resident/ RP (responsible party) and the long-term care ombudsman when Resident #18 was transferred to the hospital on 6/8/17, 7/22/17 and 1/1/18.

2. The facility staff failed to provide a written notification to the resident/RP (responsible party) and the long-term care ombudsman when Resident #174 was transferred to the hospital on 1/11/18.

3. The facility staff failed to provide a written notification to the resident/RP (responsible party) and the long-term care ombudsman when Resident #19 was transferred to the hospital on 1/21/18.

4. The facility staff failed to provide written notification to the resident and long-term care ombudsman when Resident #183 was transferred to the hospital on 1/19/18.

ensuring implementation and ongoing compliance with the components of this Plan of Correction and addressing and resolving variances that may occur. The Executive Director and/or Administrator are responsible for ensuring the status of this Plan of Correction is reviewed and discussed at QAPI meetings and action initiated if required.

5. Areas cited in F623 will be corrected by 3/16/18.

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The findings include:

1. The facility staff failed to provide a written notification to the resident/ RP (responsible party) and the long-term care ombudsman when Resident #18 was transferred to the hospital on 6/8/17, 7/22/17 and 1/1/18.

Resident #18 was admitted to the facility on 12/27/16 with a readmission on 10/5/17 with diagnoses that included, but were not limited to; rectal hemorrhage, gastrostomy (placement of a feeding tube directly into the stomach), an irregular heart rate, cerebral palsy [1] (a disorder of movement, muscle tone or posture that is caused by damage that occurs to the immature, developing brain, most often before birth), and aphasia (difficulty with speaking.)

Resident #18's most recent MDS (minimum data set), a significant change assessment with an ARD (assessment reference date) of 1/11/18, coded Resident #18's BIMS (brief interview of mental status) score as 15 out of a possible 15, indicating that Resident #18 is cognitively intact to make decisions regarding daily living.

A review of Resident #18's clinical record revealed, in part, that Resident #18 had been transferred and admitted to an acute hospital on 6/8/17 (for rectal bleeding), 7/16/17 for vomiting bright red blood and on 1/11/18 for bleeding hemorrhoids.

Further review of Resident #18's clinical record did not reveal any documented evidence the facility had provided written notification describing the circumstances of the facility initiated transfers to the resident/RP or the ombudsman.

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A review of Resident #18's nursing progress notes revealed, in part, the following:

- "7/17/17. Clinical/General changes requiring notification - (Family/physician/other): Guest had a change in VS (vital signs). Elevated Temperature irritated as noted (sic). MD (medical doctor) (name of MD) notified and per order to transfer guest to (name of hospital) ER (emergency room). (Name of ambulance service) called and guest transferred."

- "1/1/18. Guest was sent to the (name of hospital) ER d/t (due to) profuse bleeding from the anus. MD and Son (name of son) notified. Called (name of hospital) and he (Resident #18) has been admitted."
The facility did not provide progress notes documenting the transfer that occurred on 6/8/17.

A review of Resident #18's comprehensive care plan dated 10/5/17 did not reveal any documentation regarding hospital admissions.

On 2/1/18 at 2:52 P.M., an interview was conducted with RN (registered nurse) #2, a floor nurse. RN #2 was asked to describe the process followed when resident has a change in condition and needs to go to the hospital. RN #2 stated she would notify the doctor of the situation, receive the order to transfer the resident and notify the family. When asked what she would document in the progress note, RN #2 stated, "We have to explain to the patient what is going on and we have to notify the family, document the notification and resident status prior to transfer."

On 2/1/18 at 3:15 P.M., an interview was

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conducted with OSM (other staff member) #2, the social worker. OSM #2 was asked his responsibility when a resident is transferred to the hospital. OSM #2 stated, "From a social work perspective, either myself or the admissions coordinator call the hospital if we do not know yet if they are admitted or not and we reach out to the family because we need to remind them of the bed hold, if they want or not." When asked if he, as the social worker, notified the ombudsman of a facility initiated transfer, OSM #2 stated, "We do not notify the ombudsman, I am not aware we are required to do so. I think we only have to do that if we discharge someone home." OSM #2 was asked if he would notify the resident or RP in writing to document the reasons for the transfer. OSM #2 stated, "No we do not do that type of notification." OSM #2 was asked if he had any documentation that evidenced conversations with Resident #18 or his RP when he was transferred on the three occasions to the hospital. OSM #2 stated he did not have any documentation relative to those hospital transfers.

On 2/1/18 at approximately 3:40 P.M., an interview was conducted with OSM #1, the admissions coordinator. OSM #1 was asked to describe her role at the facility. OSM #1 stated, "I am responsible for admissions, when someone is in the hospital and the hospital is ready to discharge and needs a skilled bed I am in charge of bringing them in. An admissions package is provided to the resident and/or family." OSM #1 was asked if she was responsible for any part of the facility initiated discharge process when a resident was transferred to the hospital. OSM #1 stated, "The resident and family has enough to worry about, the next day I will communicate with the family and ask them whether or not they want

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to do a bed hold. If they go out on a weekend it will normally wait until Monday." When asked if she would send out written notifications to the resident/RP and ombudsman regarding the circumstances of transfer, OSM #1 stated she would not do that.

On 2/1/18 at 5:00 P.M., an interview was conducted with ASM (administrative staff member) #1, the administrator, and ASM #2, the director of clinical services. When asked who was responsible for sending out written notification to the resident/RP and ombudsman regarding a facility initiated transfer, ASM #1 and ASM #2 stated they were not aware that they were supposed to do that. ASM #1 and ASM #2 were made aware of the concerns regarding Resident #18's transfers to the hospital and asked to provide any evidence of written notifications to the resident/RP and ombudsman. Both ASM #1 and ASM #2 stated they had not been doing written notifications. A facility policy was requested at this time regarding resident transfers to the hospital.

A review of the facility policy titled "Transfer, Discharge & Bed-Hold Notices" revealed, in part, the following documentation; "Policy Statement. It is the community's policy to abide by all applicable requirements, including provision of adequate notice to the resident/legal representative in the event that transfer or discharge is required and their right to return to the community if eligible. 11. The SSC (social services coordinator)/designee will ensure that the emergency notice of transfer and bed hold information are provided to resident, family or legally responsible party within 24 hours of the transfer.

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No further information was presented prior to the end of the survey process.

[1] This information was obtained from the following website;
https://www.mayoclinic.org/diseases-conditions/cerebral-palsy/symptoms-causes/syc-20353999

2. The facility staff failed to provide a written notification to the resident/RP (responsible party) and the long-term care ombudsman when Resident #174 was transferred to the hospital on 1/11/18.

Resident #174 was admitted to the facility on 8/10/15 with a readmission on 1/14/18 with diagnoses that included, but were not limited to; cognitive communication deficit, heart failure, dementia, slow heart rate, altered mental status and Parkinson's disease [1] (a progressive disorder of the nervous system that affects movement),

Resident #174's most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 1/21/18, coded Resident #174 as scoring 11 out of a possible 15 on the BIMS (brief interview for mental status) indicating that Resident #174 is moderately cognitively impaired with decisions of daily living.

A review of Resident #174's clinical record revealed, in part, the following progress note; "1/11/18. Guest was sleeping when writer arrived at 7 p.m. He (Resident #174) was not verbally responsive but could open his eyes when spoken to. Compared to his baseline, guest unresponsiveness was not normal. Vitals were

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taken and all were normal. MD (medical doctor) (name of MD) was notified and gave order for guest to be sent out to the hospital. 911 (emergency response number) was called and guest was taken out of the facility to (name of hospital)."

Further review of Resident #174's clinical record did not reveal any documented evidence the facility had provided written notification describing the circumstances of the facility initiated transfers to the resident/RP or the ombudsman.

A review of Resident #174's comprehensive care plan dated 1/14/18 did not reveal any documentation regarding the transfer to the hospital on 1/11/18.

On 2/1/18 at 2:52 P.M. an interview was conducted with RN (registered nurse) #2, a floor nurse. RN #2 was asked to describe the process followed when resident has a change in condition and needs to go to the hospital. RN #2 stated she would notify the doctor of the situation, receive the order to transfer the resident and notify the family. When asked what she would document in the progress note, RN #2 stated, "We have to explain to the patient what is going on and we have to notify the family, document the notification and resident status prior to transfer."

On 2/1/18 at 3:15 P.M., an interview was conducted with OSM (other staff member) #2, the social worker. OSM #2 was asked his responsibility when a resident is transferred to the hospital. OSM #2 stated, "From a social work perspective, either myself or the admissions coordinator call the hospital if we do not know yet if they are admitted or not and we reach out to the

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family because we need to remind them of the bed hold, if they want or not." When asked if he, as the social worker, notified the ombudsman of a facility initiated transfer, OSM #2 stated, "We do not notify the ombudsman, I am not aware we are required to do so. I think we only have to do that if we discharge someone home." OSM #2 was asked if he would notify the resident or RP in writing to document the reasons for the transfer. OSM #2 stated, "No we do not do that type of notification." OSM #2 was asked if he had any documentation that evidenced conversations with Resident #174 or his RP when he was transferred to the hospital. OSM #2 stated that he did not have any documentation relative to any hospital transfers.

On 2/1/18 at approximately 3:40 P.M., an interview was conducted with OSM #1, the admissions coordinator. OSM #1 was asked to describe her role at the facility. OSM #1 stated, "I am responsible for admissions, when someone is in the hospital and the hospital is ready to discharge and needs a skilled bed I am in charge of bringing them in. An admissions package is provided to the resident and/or family." OSM #1 was asked if she was responsible for any part of the facility initiated discharge process when a resident was transferred to the hospital. OSM #1 stated, "The resident and family has enough to worry about, the next day I will communicate with the family and ask them whether or not they want to do a bed hold. If they go out on a weekend it will normally wait until Monday." When asked if she would send out written notifications to the resident/RP and ombudsman regarding the circumstances of transfer, OSM #1 stated she would not do that.

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On 2/1/18 at 5:00 P.M., an interview was conducted with ASM (administrative staff member) #1, the administrator, and ASM #2, the director of clinical services. When asked who was responsible for sending out written notification to the resident/RP and ombudsman regarding a facility initiated transfer, ASM #1 and ASM #2 stated they were not aware they were supposed to do that. ASM #1 and ASM #2 were made aware of the concerns regarding Resident #174's transfer to the hospital and asked to provide any evidence of written notifications to the resident/RP and ombudsman. Both ASM #1 and ASM #2 stated they had not been doing written notifications. A facility policy was requested at this time regarding resident transfers to the hospital.

No further information was provided prior to the end of the survey process.

3. The facility staff failed to provide a written notification to the resident/RP (responsible party) and the long-term care ombudsman when Resident #19 was transferred to the hospital on 1/21/18.

Resident #19 was admitted to the facility on 12/28/17 with a readmission on 1/30/18 with diagnoses that include, but are not limited to; acute respiratory failure, sepsis (a severe bacterial infection), acute kidney failure, chronic kidney disease and anxiety.

Resident #19's most recent MDS (minimum data set), a 14 day assessment with an ARD (assessment reference date) of 1/11/18 coded Resident #19 as having a BIMS (brief interview of mental status) score of 13 out of a possible 15, indicating that Resident #19 is cognitively intact

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for decisions of daily living.

A review of Resident #19's clinical record revealed, in part, the following progress note; "1/21/2018. Reason for Transfer: Alter (sic) mental status. Around 5:45 AM this morning, noticed guest snoring very loud. When called guest name out loud, guest eyes opened but went back to sleep, able to stay awake while snoring loudly. (Name of NP [nurse practitioner]), notified, order to send guest out to ER (emergency room) via 911 (emergency response number, give (sic) report to nurse (name of nurse), confirmed received medications list."

Further review of Resident #19's clinical record did not reveal any documented evidence that the facility had provided written notification describing the circumstances of the facility initiated transfers to the resident/RP or the ombudsman

A review of Resident #19's comprehensive care plan dated 1/30/18 did not document the hospitalization.

On 2/1/18 at 2:52 P.M., an interview was conducted with RN (registered nurse) #2, a floor nurse. RN #2 was asked to describe the process followed when resident has a change in condition and needs to go to the hospital. RN #2 stated that she would notify the doctor of the situation, receive the order to transfer the resident and notify the family. When asked what she would document in the progress note, RN #2 stated, "We have to explain to the patient what is going on and we have to notify the family, document the notification and resident status prior to transfer."

On 2/1/18 at 3:15 P.M., an interview was

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conducted with OSM (other staff member) #2, the social worker. OSM #2 was asked his responsibility when a resident is transferred to the hospital. OSM #2 stated, "From a social work perspective, either myself or the admissions coordinator call the hospital if we do not know yet if they are admitted or not and we reach out to the family because we need to remind them of the bed hold, if they want or not." When asked if he, as the social worker, notified the ombudsman of a facility initiated transfer, OSM #2 stated, "We do not notify the ombudsman, I am not aware we are required to do so. I think we only have to do that if we discharge someone home." OSM #2 was asked if he would notify the resident or RP in writing to document the reasons for the transfer. OSM #2 stated, "No we do not do that type of notification." OSM #2 was asked if he had any documentation that evidenced conversations with Resident #19 or her RP when she was transferred to the hospital. OSM #2 stated he did not have any documentation relative to any hospital transfers.

On 2/1/18 at approximately 3:40 P.M., an interview was conducted with OSM #1, the admissions coordinator. OSM #1 was asked to describe her role at the facility. OSM #1 stated, "I am responsible for admissions, when someone is in the hospital and the hospital is ready to discharge and needs a skilled bed I am in charge of bringing them in. An admissions package is provided to the resident and/or family." OSM #1 was asked if she was responsible for any part of the facility initiated discharge process when a resident was transferred to the hospital. OSM #1 stated, "The resident and family has enough to worry about, the next day I will communicate with the family and ask them whether or not they want

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to do a bed hold. If they go out on a weekend it will normally wait until Monday." When asked if she would send out written notifications to the resident/RP and ombudsman regarding the circumstances of transfer, OSM #1 stated she would not do that.

On 2/1/18 at 5:00 P.M., an interview was conducted with ASM (administrative staff member) #1, the administrator, and ASM #2, the director of clinical services. When asked who was responsible for sending out written notification to the resident/RP and ombudsman regarding a facility initiated transfer, ASM #1 and ASM #2 stated that they were not aware they were supposed to do that. ASM #1 and ASM #2 were made aware of the concerns regarding Resident #19's transfer to the hospital and asked to provide any evidence of written notifications to the resident/RP and ombudsman. Both ASM #1 and ASM #2 stated they had not been doing written notifications. A facility policy was requested at this time regarding resident transfers to the hospital.

No further information was provided prior to the end of the survey process
4. The facility staff failed to provide written notification to the resident and long-term care ombudsman when Resident #183 was transferred to the hospital on 1/19/18.

Resident #183 was admitted to the facility on 1/15/18 and readmitted on 1/20/18 with diagnoses that included but were not limited to muscle weakness, osteomyelitis of the right shoulder, type two diabetes, GI (gastrointestinal bleed), pneumonia, and panic disorder. Resident #183 had not yet had a completed MDS

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(minimum data set) assessment. Resident #183 was documented in her clinical record as being alert and oriented x 4 (to person, place, time and situation).

Review of Resident #183's clinical record revealed she was transferred to the hospital on 1/19/18 at 4:15 p.m. The following note was documented, "Reason for transfer or discharge: presumed acute GI blood loss, anemia as evidenced by positive occult blood in stool Hgb (hemoglobin) [1] 6.8, Hct (hematocrit) [2] 21.2. Resident status including V/S (vital signs), general appearance, orientation, mood, s/s (signs/symptoms) of pain and discomfort: Alert and Oriented x4. 131/61 (blood pressure), 99.18 (sic) F (Fahrenheit), 84 bpm (beats per minute) (pulse), 20 (respirations), 02 sat (saturation) 95 percent via NC (nasal cannula) 1 L (liter)/min, no SOB (shortness of breath)/distress...notified guest, Dr. (name of physician), daughter (Name of daughter) notified...sent nursing home to hospital form, face sheet, order summary, recent lab results for 1/19/18."

Resident #183's clinical record revealed she arrived back to the facility on 1/20/18 at 6:15 p.m.

Further review of Resident #183's clinical record failed to evidence her or the responsible party were notified of the reason for her transfer in writing, and that the ombudsman received a copy of this written notification.

On 2/1/18 at 3:28 p.m., an interview was conducted with RN (registered nurse) #2, Resident #183's nurse. RN #2 was asked about the process followed when a resident is transferred to the hospital. RN #2 stated she

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would explain to resident the reason for the transfer, notify family, obtain vital signs, and document the resident's condition prior to the transfer. RN #2 stated she usually documents the status of the resident in a nursing note prior to a transfer. RN #2 stated \she does not document her conversation with the resident or resident's representative regarding the transfer. RN #2 stated she does not provide written notification to the resident or representative regarding the transfer.

On 2/1/18 at 3:33 p.m., an interview was conducted with OSM (other staff member) #2, the social worker. OSM #2 stated he only notifies the ombudsman with resident discharges. OSM #2 stated he does not provide written notification of resident transfers to the hospital in writing to the long-term care ombudsman. OSM #2 also stated he does not provide the resident or resident representative written notification explaining the reason for transfer.

On 2/1/18 at 5:00 p.m., an interview was conducted with ASM (administrative staff member) #2, the DNS (Director of Nursing Services). When asked about the process followed when a resident is transferred to the hospital, ASM #2 stated he would expect his nurses to notify the family, medical doctor and document the reason for transfer to the emergency room. ASM #2 stated they would also give report to the hospital and send documentation such as a history and physical, lab results, physician's orders and progress notes with the resident to go to the hospital staff. ASM #2 stated he was not aware of the new regulation that he had to provide notification in writing to the resident and/or representative explaining the

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F 623	Continued From page 32 reason for hospital discharge, and that a copy had to be sent to the ombudsman. On 2/1/18 at 5:16 p.m., ASM (administrative staff member) #1, the administrator and ASM #2, the DNS (Director of Nursing Services) were made aware of the above concerns. No further information was presented prior to exit. [1] HGB (Hemoglobin) "a protein inside red blood cells that carry oxygen from the lungs to the tissues and organs of the body and carries back C02 (carbon dioxide) to the lungs. A low hemoglobin count could indicate anemia, blood loss, dehydration, and malnutrition." This information was obtained from The National Institutes of Health. https://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0022015/ [2] HCT (Hematocrit) "Hematocrit measures the volume of red blood cells compared to the total blood volume (red blood cells and plasma). The normal hematocrit for men is 40 to 54%; for women it is 36 to 48%. Helps to detect blood loss." This information was obtained from The National Institutes of Health. https://www.ncbi.nlm.nih.gov/books/NBK259/	F 623		
F 624 SS=D	Preparation for Safe/Orderly Transfer/Dschrg CFR(s): 483.15(c)(7) §483.15(c)(7) Orientation for transfer or discharge. A facility must provide and document sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility. This orientation must be provided in a	F 624	**F624** Responses to the cited deficiencies do not constitute an admission or agreement by the facility of the truth of facts alleged or conclusions set forth in the Statement of Deficiencies. The Plan of Correction is prepared solely as a matter of compliance with federal and/or state law.	

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form and manner that the resident can understand.
This REQUIREMENT is not met as evidenced by:
Based on staff interview, facility document review and clinical record review, it was determined the facility staff failed to ensure preparation and orientation of the resident / RP (responsibility party) prior to transfer to the hospital for three of 15 residents in the survey sample, Resident #18, #174, and #19.

1. The facility staff failed to ensure Resident #18 was properly prepared and oriented for a hospital transfer on three occasions 6/8/17, 7/22/17 and 1/1/18.

2. The facility staff failed to ensure Resident #174 was properly prepared and oriented for a hospital transfer that occurred on 1/11/18.

3. The facility staff failed to ensure Resident #19 was properly prepared and oriented for a hospital transfer that occurred on 1/21/18.

The findings include:

1. Resident #18 was admitted to the facility on 12/27/16 with a readmission on 10/5/17 with diagnoses that included, but were not limited to; rectal hemorrhage, gastrostomy (placement of a feeding tube directly into the stomach), an irregular heart rate, cerebral palsy [1] (a disorder of movement, muscle tone or posture that is caused by damage that occurs to the immature, developing brain, most often before birth), and aphasia (difficulty with speaking.)

Resident #18's most recent MDS (minimum data

1. **With respect to the specific residents cited:** Residents #18 and #19 exhibited no signs of distress, agitation or concern regarding the hospital transfers on 6/8/17, 7/16/17, 1/1/18, and 1/21/18. Resident #174 was discharged from the facility to home on 2/10/18 due to resident's health improving and no longer requiring services of the facility.

2. **With respect to how the facility will identify residents with the potential for the identified concern and take corrective action:** The Social Services Coordinator met individually with current guests who have had a hospital transfer from this facility within the past 60 days to verify that they had no signs of distress, agitation or concern regarding the hospital transfers. No issues were identified.

3. **With respect to what systemic measures have been put in place to address the stated concern:** Refresher training and policy review will be conducted for the nursing staff by the Social Services Coordinator by 3/2/18 regarding the need to document in the resident's record that the resident was prepared and oriented for the transfer each time a resident is transferred to the hospital. Transfer notes for any residents transferred to the hospital will be

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set), a significant change assessment with an ARD (assessment reference date) of 1/11/18, coded Resident #18's BIMS (brief interview of mental status) score as 15 out of a possible 15, indicating that Resident #18 is cognitively intact to make decisions regarding daily living.

A review of Resident #18's clinical record revealed, in part, that Resident #18 had been transferred and admitted to an acute hospital on 6/8/17 (for rectal bleeding), 7/16/17 for vomiting bright red blood and on 1/11/18 for bleeding hemorrhoids.

Further review of Resident #18's clinical record did not reveal any documentation evidencing the facility had provided written notification describing the circumstances of the facility initiated transfers to the resident/RP or the ombudsman.

A review of Resident #18's nursing progress notes revealed, in part, the following:

- "7/17/17. Clinical/General changes requiring notification - (Family/physician/other): Guest had a change in VS (vital signs). Elevated Temperature irritated as noted (sic). MD (medical doctor) (name of MD) notified and per order to transfer guest to (name of hospital) ER (emergency room). (Name of ambulance service) called and guest transferred."

- "1/1/18. Guest was sent to the (name of hospital) ER d/t (due to) profuse bleeding from the anus. MD and Son (name of son) notified. Called (name of hospital) and he (Resident #18) has been admitted."

The facility did not provide progress notes documenting the transfer that occurred on 6/8/17.

audited weekly for the next three months by the Social Services Coordinator or his designee to verify that preparation of the resident for transfer is documented. If an issue is identified, a late entry will be made.

4. **With respect to how the plan of corrective measures will be monitored:** Over the next three months, the findings from the weekly transfer notes audits will be reviewed at Quality Assurance / Performance Improvement (QAPI) meetings. At the conclusion of the three months, the QAPI committee will re-evaluate and initiate any necessary action or extend the review period. The Executive Director and/or Administrator are responsible for ensuring implementation and ongoing compliance with the components of this Plan of Correction and addressing and resolving variances that may occur. The Executive Director and/or Administrator are responsible for ensuring the status of this Plan of Correction is reviewed and discussed at QAPI meetings and action initiated if required.

5. Areas cited in F624 will be corrected by 3/16/18.

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A review of Resident #18's comprehensive care plan dated 10/5/17 did not reveal any documentation regarding hospital admissions.

On 2/1/18 at 2:52 P.M., an interview was conducted with RN (registered nurse) #2, a floor nurse. RN #2 was asked to describe the process followed when resident has a change in condition and needs to go to the hospital. RN #2 stated she would notify the doctor of the situation, receive the order to transfer the resident and notify the family. When asked what she would document in the progress note, RN #2 stated, "We have to explain to the patient what is going on and we have to notify the family, document the notification and resident status prior to transfer." RN #2 was asked how she prepared and oriented the resident in regards to the transfer to the hospital. RN #2 stated, "We have to explain to the resident what is going on and explain why." RN #2 was asked if she documented how she prepared and oriented the resident. RN #2 stated, "I don't document that."

On 2/1/18 at 5:00 P.M., an interview was conducted with ASM (administrative staff member) #1, the administrator, and ASM #2, the director of clinical services. When asked who was responsible for ensuring and documenting how the resident/RP was prepared and oriented to the facility initiated transfer. ASM #1 and ASM #2 stated they would assume the nurse but they were unaware they were supposed to do that. ASM #1 and ASM #2 were made aware of the concerns regarding Resident #18's transfers to the hospital and asked to provide any documented evidence Resident #18 and / or his RP had been prepared and oriented to the

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transfer.

A review of the facility policy titled "Transfer, Discharge & Bed-Hold Notices" did not contain documentation that addressed the preparation and orientation of the resident / RP for transfer to the hospital.

No further information was presented prior to the end of the survey process.

[1] This information was obtained from the following website; https://www.mayoclinic.org/diseases-conditions/cerebral-palsy/symptoms-causes/syc-20353999

2. The facility staff failed to provide a written notification to the resident/RP (responsible party) and the long-term care ombudsman when Resident #174 was transferred to the hospital on 1/11/18.

Resident #174 was admitted to the facility on 8/10/15 with a readmission on 1/14/18 with diagnoses that included, but were not limited to; cognitive communication deficit, heart failure, dementia, slow heart rate, altered mental status and Parkinson's disease [1] (a progressive disorder of the nervous system that affects movement),

Resident #174's most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 1/21/18, coded Resident #174 as scoring 11 out of a possible 15 on the BIMS (brief interview for mental status) indicating that Resident #174 is moderately cognitively impaired with decisions of daily living.

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A review of Resident #174's clinical record revealed, in part, the following progress note; "1/11/18. Guest was sleeping when writer arrived at 7 p.m. He (Resident #174) was not verbally responsive but could open his eyes when spoken to. Compared to his baseline, guest unresponsiveness was not normal. Vitals were taken and all were normal. MD (medical doctor) (name of MD) was notified and gave order for guest to be sent out to the hospital. 911 (emergency response number) was called and guest was taken out of the facility to (name of hospital)."

Further review of Resident #174's clinical record did not reveal any documented evidence the facility had provided written notification describing the circumstances of the facility initiated transfers to the resident/RP or the ombudsman

A review of Resident #174's comprehensive care plan dated 1/14/18 did not reveal any documentation regarding the transfer to the hospital on 1/11/18.

On 2/1/18 at 2:52 P.M., an interview was conducted with RN (registered nurse) #2, a floor nurse. RN #2 was asked to describe the process followed when resident has a change in condition and needs to go to the hospital. RN #2 stated she would notify the doctor of the situation, receive the order to transfer the resident and notify the family. When asked what she would document in the progress note, RN #2 stated, "We have to explain to the patient what is going on and we have to notify the family, document the notification and resident status prior to transfer." RN #2 was asked how she prepared and oriented the resident in regards to the transfer to the

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hospital. RN #2 stated, "We have to explain to the resident what is going on and explain why." RN #2 was asked if she documented how she prepared and oriented the resident. RN #2 stated, "I don't document that."

On 2/1/18 at 5:00 P.M., an interview was conducted with ASM (administrative staff member) #1, the administrator, and ASM #2, the director of clinical services. When asked who was responsible for documenting how the resident/RP was prepared and oriented to the facility initiated transfer. ASM #1 and ASM #2 stated that they would assume the nurse but that they were unaware that they were supposed to do that. ASM #1 and ASM #2 were made aware of the concerns regarding Resident #18's transfers to the hospital and asked to provide any documented evidence that Resident #18 and / or his RP had been prepared and oriented to the transfer.

No further information was provided prior to the end of the survey process.

3. The facility staff failed to provide a written notification to the resident/RP (responsible party) and the long-term care ombudsman when Resident #19 was transferred to the hospital on 1/21/18.

Resident #19 was admitted to the facility on 12/28/17 with a readmission on 1/30/18 with diagnoses that include, but are not limited to; acute respiratory failure, sepsis (a severe bacterial infection), acute kidney failure, chronic kidney disease and anxiety.

Resident #19's most recent MDS (minimum data

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set), a 14 day assessment with an ARD (assessment reference date) of 1/11/18 coded Resident #19 as having a BIMS (brief interview of mental status) score of 13 out of a possible 15, indicating that Resident #19 is cognitively intact for decisions of daily living.

A review of Resident #19's clinical record revealed, in part, the following progress note; "1/21/2018. Reason for Transfer: Alter (sic) mental status. Around 5:45 AM this morning, noticed guest snoring very loud. When called guest name out loud, guest eyes opened but went back to sleep, able to stay awake while snoring loudly. (Name of NP [nurse practitioner]), notified, order to send guest out to ER (emergency room) via 911 (emergency response number, give (sic) report to nurse (name of nurse), confirmed received medications list."

Further review of Resident #19's clinical record did not reveal any documented evidence that the facility had provided written notification describing the circumstances of the facility initiated transfers to the resident/RP or the ombudsman

A review of Resident #19's comprehensive care plan dated 1/30/18 did not document the hospitalization.

On 2/1/18 at 2:52 P.M., an interview was conducted with RN (registered nurse) #2, a floor nurse. RN #2 was asked to describe the process followed when a resident has a change in condition and needs to go to the hospital. RN #2 stated she would notify the doctor of the situation, receive the order to transfer the resident and notify the family. When asked what she would document in the progress note, RN #2 stated,

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F 624	Continued From page 40 "We have to explain to the patient what is going on and we have to notify the family, document the notification and resident status prior to transfer." RN #2 was asked how she prepared and oriented the resident in regards to the transfer to the hospital. RN #2 stated, "We have to explain to the resident what is going on and explain why." RN #2 was asked if she documented how she prepared and oriented the resident. RN #2 stated, "I don't document that." On 2/1/18 at 5:00 P.M., an interview was conducted with ASM (administrative staff member) #1, the administrator, and ASM #2, the director of clinical services. When asked who was responsible for documenting how the resident/RP were prepared and oriented to the facility initiated transfer. ASM #1 and ASM #2 stated they would assume the nurse but that they were unaware that they were supposed to do that. ASM #1 and ASM #2 were made aware of the concerns regarding Resident #18's transfers to the hospital and asked to provide any documented evidence that Resident #18 and / or his RP had been prepared and oriented to the transfer. No further information was provided prior to the end of the survey process	F 624		
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	F 625	**F625** Responses to the cited deficiencies do not constitute an admission or agreement by the facility of the truth of facts alleged or conclusions set forth in the Statement of Deficiencies. The Plan of Correction is prepared solely as a matter of compliance with federal and/or state law.	

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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 described in paragraph (d)(1) of this section.
This REQUIREMENT is not met as evidenced by:
Based on staff interview, family interview, facility document review and clinical record review, it was determined the facility staff failed to provide a notice of bed hold policy prior to transferring one of 15 residents in the survey sample to the hospital, Resident #19.

The facility staff failed to provide Resident #19 or the RP (responsible party) a bed hold notification when Resident #19 was transferred emergently to the hospital on 1/21/18.

The findings include:

Resident #19 was admitted to the facility on

1. **With respect to the specific resident cited:** Resident #19 has had no further hospital transfers since her re-admission on 1/30/18 and was not billed for any bed hold days during her absence from the facility.

2. **With respect to how the facility will identify residents with the potential for the identified concern and take corrective action:** An audit of billing records for current guests who have had a hospital transfer from this facility within the last 60 days was completed on 2/12/18 by the Administrator. Only one resident was charged bed hold days during his absence from the facility. This resident is a long-term resident with multiple signed Bed Hold Agreement's on file indicating his desire to hold the bed at any time he is out of the facility. The resident and family are in agreement with the bed hold days charged during the resident's hospital stays.

3. **With respect to what systemic measures have been put in place to address the stated concern:** Refresher training will be conducted for nursing staff by the Social Services Coordinator by 3/2/18 regarding the need to provide written bed hold notices to the resident and responsible party prior to transfer.

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12/28/17 with a readmission on 1/30/18 with diagnoses that include, but are not limited to; acute respiratory failure, sepsis (a severe bacterial infection), acute kidney failure, chronic kidney disease and anxiety.

Resident #19's most recent MDS (minimum data set), a 14 day assessment with an ARD (assessment reference date) of 1/11/18 coded Resident #19 as having a BIMS (brief interview of mental status) score of 13 out of a possible 15, indicating that Resident #19 is cognitively intact for decisions of daily living.

On 1/30/18 during the facility tour, this writer spoke with Resident #19's daughter who was sitting in the room with her mother. Resident #19's daughter stated she was her mother's RP and her mother had just returned to the facility on that date following a hospitalization. Resident #19's daughter was asked whether the facility had provided her with the bed hold policy when her mother was transferred to the hospital. Resident #19's daughter stated the facility had not done that, she simply assumed there would be a bed available to her for readmission. Resident #19's daughter was asked if she was aware if there were any charges for her room while her mother was admitted in the hospital. Resident #19's daughter stated that she did not know.

A review of Resident #19's clinical record revealed, in part, the following progress note; "1/21/2018. Reason for Transfer: Alter (sic) mental status. Around 5:45 AM this morning, noticed guest snoring very loud. When called guest name out loud, guest eyes opened but went back to sleep, able to stay awake while snoring loudly. (Name of NP [nurse practitioner]),

Transfer notes for any residents transferred to the hospital will be audited weekly for the next three months by the Social Services Coordinator or his designee to verify that written notification of the bed hold policy was provided to resident and responsible party. If an issue is identified, written notice will be provided and documented.

4. **With respect to how the plan of corrective measures will be monitored:** Over the next three months, the findings from the weekly transfer notes audits will be reviewed at Quality Assurance / Performance Improvement (QAPI) meetings. At the conclusion of the three months, the QAPI Improvement committee will re-evaluate and initiate any necessary action or extend the review period. The Executive Director and/or Administrator are responsible for ensuring implementation and ongoing compliance with the components of this Plan of Correction and addressing and resolving variances that may occur. The Executive Director and/or Administrator are responsible for ensuring the status of this Plan of Correction is reviewed and discussed at QAPI meetings and action initiated if required.

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notified, order to send guest out to ER (emergency room) via 911 (emergency response number, give (sic) report to nurse (name of nurse), confirmed received medications list."

Further review of Resident #19's clinical record did not reveal any documented evidence the facility had provided a written bed hold notice to Resident #19 or her RP when she was transferred to the hospital.

A review of Resident #19's comprehensive care plan dated 1/30/18 did not document the hospitalization.

On 2/1/18 at 2:52 P.M., an interview was conducted with RN (registered nurse) #2, a floor nurse. RN #2 was asked to describe the process followed when resident has a change in condition and needs to go to the hospital. RN #2 stated she would notify the doctor of the situation, receive the order to transfer the resident and notify the family. When asked what she would document in the progress note, RN #2 stated, "We have to explain to the patient what is going on and we have to notify the family, document the notification and resident status prior to transfer." When asked who was responsible for notifying the resident about a bed hold RN #2 stated she thought it was the social worker.

On 2/1/18 at 3:15 P.M., an interview was conducted with OSM (other staff member) #2, the social worker. When asked about his responsibility when a resident is transferred to the hospital, OSM #2 stated, "From a social work perspective, either myself or the admissions coordinator call the hospital if we do not know yet if they are admitted or not and we reach out to the

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family because we need to remind them of the bed hold, if they want or not." OSM #2 was asked if he had notified Resident #19 or her RP about the bed hold policy when she was transferred to the hospital on 1/21/18, OSM #2 stated he did not know. If he had, he would have written it in a note. OSM #2 further stated that either he or (name of OSM #1) would talk to the family about a bed hold. OSM #2 was asked to provide documented evidence that Resident #19 or her RP had been provided bed hold information.

On 2/1/18 at approximately 3:40 P.M., an interview was conducted with OSM #1, the admissions coordinator. OSM #1 was asked to describe her role at the facility. OSM #1 stated, "I am responsible for admissions, when someone is in the hospital and the hospital is ready to discharge and needs a skilled bed I am in charge of bringing them in. An admissions package is provided to the resident and/or family." OSM #1 was asked about the bed hold policy. OSM #1 stated that residents / family members were asked to sign a bed hold form at the time of admission but that the residents/family members were asked if they did or did not want a bed hold when they were transferred. When asked if Resident #19 / family had been provided the bed hold policy at the time of Resident #19's transfer to the hospital, OSM #1 stated that she had not. When asked why the facility had not provided the bed hold notice, OSM #1 stated that she was not concerned as they had beds available and the family was dealing with a lot already.

On 2/1/18 at 5:00 P.M., an interview was conducted with ASM (administrative staff member) #1, the administrator, and ASM #2, the

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director of clinical services. When asked their policy on bed hold notification, ASM #2 stated the resident / family were to be notified within 24 hours of transfer to the hospital. ASM #1 and ASM #2 were asked if they were aware this was not done for Resident #19, ASM and ASM #2 stated that they were not and that it should have been done.

A review of the facility policy titled "Transfer, Discharge & Bed-Hold Notices" revealed in part the following documentation; "8. The SSC (social services coordinator) / designee will provide written information to the resident, family member or legal representative before transfer of a resident to a hospital or for therapeutic leave, consisting of Discharge, Transfer & Bed Hold Notices Policy that includes: a. The duration of the bed-hold policy under the State plan, if any, during which the resident is permitted to return and resume residence in the community. b. The reserve bed payment policy in the state plan, if any; c. The community's policies on the duration of the bed-hold. 10. In case of an emergency transfer, the Licensed Nurse will send the Bed Hold Agreement form to the hospital with the resident. Note: In cases of emergency transfer, notice "at the time of transfer" means that the resident, family, or legally responsible party are provided with written notification within 24 hours of the transfer. The requirement is met if the resident's copy of the notice is sent with other papers accompanying the resident to the hospital. 11. The SSC/designee will ensure that the emergency notice of transfer and bed hold information are provided to resident, family or legally responsible party within 24 hours of the transfer."

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No further information was provided prior to the end of the survey process.

F 641 Accuracy of Assessments
SS=D 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 staff interview, facility document review and clinical record review, it was determined the facility staff failed to ensure an accurate MDS (minimum data set) assessment for one of 15 residents in the survey sample, Resident #18.

The facility staff failed to capture Resident #18's fall that occurred on 11/14/17 on the next MDS assessment completed on 1/1/18.

The findings include:

Resident #18 was admitted to the facility on 12/27/16 with a readmission on 10/5/17 with diagnoses that included, but were not limited to; rectal hemorrhage, gastrostomy (placement of a feeding tube directly into the stomach), an irregular heart rate, cerebral palsy [1] (a disorder of movement, muscle tone or posture that is caused by damage that occurs to the immature, developing brain, most often before birth), and aphasia (difficulty with speaking.)

Resident #18's most recent MDS (minimum data set), a significant change assessment with an ARD (assessment reference date) of 1/11/18, coded Resident #18's BIMS (brief interview of mental status) score as 15 out of a possible 15,

F 625

F641

F 641

Responses to the cited deficiencies do not constitute an admission or agreement by the facility of the truth of facts alleged or conclusions set forth in the Statement of Deficiencies. The Plan of Correction is prepared solely as a matter of compliance with federal and/or state law.

1. **With respect to the specific resident cited:** A modification to Resident #18's 1/11/18 MDS was completed to reflect the second fall that occurred during the assessment reference period and transmitted at the time of survey.

2. **With respect to how the facility will identify residents with the potential for the identified concern and take corrective action:** An audit of MDS assessments completed for current guests who had falls within the past 30 days was completed by the Resident Assessment Coordinator on 2/16/18. No issues were identified.

3. **With respect to what systemic measures have been put in place to address the stated concern:** MDS assessments completed for residents who sustain falls will be audited weekly for the next three

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indicating that Resident #18 is cognitively intact to make decisions regarding daily living.

Further review of Resident #18's MDS assessments revealed a discharge assessment with an ARD of 1/1/18 that coded Resident #18 as having one fall since the last assessment.

A review of Resident #18's clinical record revealed Resident #18 had fallen on two occasions since the last assessment, a quarterly assessment with an ARD of 10/19/17. The falls occurred on 11/14/17 and 12/25/17.

On 2/1/18 at approximately 4.00 P.M., an interview was conducted with RN (registered nurse) #1, the MDS coordinator. RN #1 was asked to describe her role. RN #1 stated, "I make sure that I follow the regulations/guidelines in the RAI (resident assessment instrument) when completing the MDS assessments. I meet with the residents, and schedule MDS assessments." RN #1 was asked how she was made aware of information that needed to be captured on the MDS assessments. RN #1 stated she obtained the 24-hour reports and attended the daily clinical meetings. RN #1 was asked specifically about falls. RN #1 stated she kept a "little book" with falls and then she could put them in Section J of the MDS as appropriate. RN #1 was asked to review Resident #18's falls and to provide the evidence the 11/14/17 and 12/25/17 falls had both been captured on Resident #18's discharge assessment with an ARD of 1/1/18. RN #1 reviewed the MDS assessment and stated the fall on 11/14/17 was not captured and should have been.

On 2/1/18 at 5:00 P.M. ASM (administrative staff

months by the two Resident Assessment Coordinators to verify that falls occurring during the assessment reference period are properly coded. If an issue is identified, a modification will be completed and transmitted.

4. **With respect to how the plan of corrective measures will be monitored:** Over the next three months, the findings from the weekly MDS assessment audits will be reviewed at Quality Assurance / Performance Improvement (QAPI) meetings. At the conclusion of the three months, the QAPI committee will re-evaluate and initiate any necessary action or extend the review period. The Executive Director and/or Administrator are responsible for ensuring implementation and ongoing compliance with the components of this Plan of Correction and addressing and resolving variances that may occur. The Executive Director and/or Administrator are responsible for ensuring the status of this Plan of Correction is reviewed and discussed at QAPI meetings and action initiated if required.

5. Areas cited in F641 will be corrected by 3/16/18.

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member) #1, the administrator, and ASM #2, the director of nursing, were made aware of the above findings.

No further information was made available prior to the end of the survey process.

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 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

F 641

F656

F 656 Responses to the cited deficiencies do not constitute an admission or agreement by the facility of the truth of facts alleged or conclusions set forth in the Statement of Deficiencies. The Plan of Correction is prepared solely as a matter of compliance with federal and/or state law.

1. **With respect to the specific resident cited:** The oxygen saturation for resident #183 was checked at 4:26 p.m. on 1/30/18 and found to be 97%. The oxygen tank was refilled and the resident was placed back on oxygen at a flow rate of 2L per minute. The resident experienced no adverse outcomes as a result of the status of the oxygen tank.

2. **With respect to how the facility will identify residents with the potential for the identified concern and take corrective action:** Residents with care plans for oxygen administration were checked at the time of survey. All were found to be receiving oxygen according to their orders.

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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, facility document review and clinical record review, it was determined the facility staff failed to implement the comprehensive care plan for one of 15 residents in the survey sample, Resident #183.

The facility staff failed to administer oxygen to Resident #183 per the comprehensive plan of care.

The findings Include:

Resident #183 was admitted to the facility on 1/15/18 and readmitted on 1/20/18 with diagnoses that included but were not limited to muscle weakness, osteomyelitis of the right shoulder, type two diabetes, GI (gastrointestinal bleed), pneumonia, and panic disorder. Resident #183 had not yet had a completed MDS (minimum data set) assessment. Resident #183 was documented in her clinical record as being alert and oriented x 4 (to person, place, time and situation).

On 1/30/18 at 12:37 p.m., an observation was made of Resident #183. Resident #183 was

3. **With respect to what systemic measures have been put in place to address the stated concern:** Refresher training will be conducted for nursing staff by the Director of Nursing by 3/2/18 regarding checking and filling oxygen tanks, and when to use portable tanks versus concentrators. Periodic rounds will be conducted weekly for the next three months by the Director of Nursing or his designee to verify that residents with orders for oxygen are receiving oxygen according to their orders. If an issue is identified, the resident will be assessed and the oxygen will be adjusted to follow the order.

4. **With respect to how the plan of corrective measures will be monitored:** Over the next three months, the findings from the periodic rounds will be reviewed at Quality Assurance / Performance Improvement (QAPI) meetings. At the conclusion of the three months, the QAPI committee will re-evaluate and initiate any necessary action or extend the review period. The Executive Director and/or Administrator are responsible for ensuring implementation and ongoing compliance with the components of this Plan of Correction and addressing and resolving variances that may occur.

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F 656	Continued From page 50	F 656	The Executive Director and/or Administrator are responsible for ensuring the status of this Plan of Correction is reviewed and discussed at QAPI meetings and action initiated if required. **5.** Areas cited in F656 will be corrected by 3/16/18.	

observed wearing a nasal cannula. The oxygen tubing was connected to an oxygen tank behind her wheelchair. The gage to the oxygen tank was in the red, indicating the oxygen tank was out of oxygen.

On 1/30/18 at 4:16 p.m., an on an observation was made of Resident #183. Resident #183 was observed wearing a nasal cannula. The oxygen tubing was connected to an oxygen tank behind her wheelchair. The gage to the oxygen tank was in the red, indicating the oxygen tank was out of oxygen.

On 01/30/18 at 4:16 p.m., an interview was conducted with LPN (licensed practical nurse) #3, Resident #183's nurse that shift. When asked who was responsible for checking oxygen tanks to ensure residents are receiving oxygen, LPN #3 stated the nurses and the nursing aides are responsible. LPN #3 was when asked when she had last checked Resident #183's oxygen tank. LPN #3 stated she wasn't sure; she had been sitting at the desk. When asked if she knew how much oxygen Resident #183 had left in her tank, LPN #3 stated that she had to check. This writer accompanied LPN #3 to Resident #183's room. LPN #3 looked at the tank and stated, It's finished, I'm going to fill it up." LPN #3 stated she did not know how long the oxygen tank had been empty.

Review of Resident #183's most recent physician order sheet documented the following order: "Oxygen in use continuous at SPECIFY RATE 2 L (liters)/min (minute) via nasal cannula due to SOB (shortness of breath) every shift for SOB."

Review of Resident #183's comprehensive care

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plan dated 1/16/18 documented the following: "The resident has altered respiratory status/difficulty breathing...The resident will maintain normal breathing pattern as evidenced by normal respirations, normal skin color, and regular respiratory rate/pattern through the review date. Interventions: Administer medication/puffers as ordered. Monitor for effectiveness and side effects."

On 2/1/18 at 3:12 p.m., an interview was conducted with RN (registered nurse) #2, Resident #183's nurse that shift. When asked the purpose of the comprehensive care plan, RN #2 stated the purpose of the care plan was to serve as a guide for nurses and the family for the resident's care. RN #2 stated the care plan should reflect the resident. This writer informed RN #2 of the observations made on 1/30/18 and showed RN #2 the above respiratory intervention documented on the care plan. RN #2 stated if the oxygen tank was empty then the care plan was not followed because oxygen is considered a medication.

On 2/1/18 at 5:16 p.m., ASM (administrative staff member) #1, the administrator and ASM #2, the DNS (Director of Nursing Services) were made aware of the above concerns. ASM #2 stated the facility used Potter and Perry as a professional standard of practice.

The facility policy titled, "Individualized Care Plan," documents in part, the following: "The IDT (interdisciplinary) team educates the resident/responsible party to the care plan and implements the care plan."

Basic Nursing, Essentials for Practice, 6th edition,

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F 656	Continued From page 52 (Potter and Perry, 2007, pages 119-127), documents the following: "A nursing care plan is a written guideline for coordinating nursing care, promoting continuity of care and listing outcome criteria to be used in the evaluation of nursing care. The written care plan communicates nursing care priorities to other health care professionals. The care plan also identifies and coordinates resources used to deliver nursing care. A correctly formulated care plan makes it easy to continue care from one nurse to another. If the patient's status has changed and the nursing diagnosis and related interventions are no longer appropriate, modify the nursing care plan. An out of date or incorrect care plan compromises the quality of nursing care." [1] This information was obtained from the following website; https://www.mayoclinic.org/diseases-conditions/cerebral-palsy/symptoms-causes/syc-20353999	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.	F 657	**F657** Responses to the cited deficiencies do not constitute an admission or agreement by the facility of the truth of facts alleged or conclusions set forth in the Statement of Deficiencies. The Plan of Correction is prepared solely as a matter of compliance with federal and/or state law. 1. **With respect to the specific resident cited:** The care plan for resident #18 was corrected to reflect	

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(E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan.
(F) 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 interview, facility document review and clinical record review, it was determined that facility staff failed to review and revise the comprehensive care plan for one of 15 residents in the survey sample, Resident #183.

The facility staff failed to revise Resident #183's comprehensive care plan after an order for oxygen rate was changed from one to two liters.

The findings include:

On 1/30/18 through 2/2/18, several observations were made of Resident #183. Resident #183's oxygen concentrator was set to 2 liters per minute.

Review of Resident #183's most recent physician order sheet documented the following order: "Oxygen in use continuous at SPECIFY RATE 2 L (liters)/min (minute) via nasal cannula due to SOB (shortness of breath) every shift for SOB." This

F 657

the current oxygen order at the time of survey.

2. **With respect to how the facility will identify residents with the potential for the identified concern and take corrective action:** An audit of care plans for residents with orders for oxygen was completed on 2/14/18 by the Assistant Director of Nursing. No discrepancies were identified between orders and care plans.

3. **With respect to what systemic measures have been put in place to address the stated concern:** Refresher training will be conducted for nursing staff by the Director of Nursing by 3/2/18 regarding timely updating of care plans when changes are made to oxygen orders. Care plans for residents with orders for oxygen will be audited weekly for the next three months by the Director of Nursing or his designee to verify that care plans reflect the current oxygen orders. If an issue is identified, the care plan will be updated to reflect the current order.

4. **With respect to how the plan of corrective measures will be monitored:** Over the next three months, the findings from the periodic rounds will be reviewed at Quality Assurance / Performance

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order was initiated on 1/21/18.

Review of Resident #183's respiratory care plan dated 1/16/18, documented the following current intervention: "OXYGEN SETTINGS: Oxygen in use via NC at 1 L/min via NC (nasal cannula) due to SOB (Shortness of breath)."

Further review of Resident #183's physician orders revealed a discontinued order that was initiated on 1/15/18: "Oxygen in use via N/C at 1 L (liter)/min via N/C due to SOB."

On 2/01/18 at 3:12 p.m., an interview was conducted with RN (registered nurse) #2, Resident #183's nurse. When asked the purpose of the care plan, RN #2 stated the purpose of the care plan was to serve as a guide for nurses and the family for the resident's care. RN #2 stated the care plan should reflect the resident. When asked if it was important for the care plan to be accurate, RN #2 stated it was. RN #2 stated the care plan was revised with new medications or any change in the resident's care. RN #2 stated any staff member of the IDT (interdisciplinary) team could revise the care plan. When asked how many liters of oxygen Resident #183 was on, RN #2 stated Resident #183 should be on 2 liters of oxygen. When asked if she could read the intervention for the 1 liter of oxygen, RN #2 stated the care plan was not accurate the intervention should have been taken off the care plan.

On 2/1/18 at 5:16 p.m., ASM #1, the administrator and ASM #2, the DNS (Director of Nursing Services) were made aware of the above concerns. ASM #2 stated that the facility used Potter and Perry as a professional reference.

Improvement (QAPI) meetings. At the conclusion of the three months, the QAPI committee will re-evaluate and initiate any necessary action or extend the review period. The Executive Director and/or Administrator are responsible for ensuring implementation and ongoing compliance with the components of this Plan of Correction and addressing and resolving variances that may occur. The Executive Director and/or Administrator are responsible for ensuring the status of this Plan of Correction is reviewed and discussed at QAPI meetings and action initiated if required.

5. Areas cited in F657 will be corrected by 3/16/18.

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F 657	Continued From page 55 Basic Nursing, Essentials for Practice, 6th edition, (Potter and Perry, 2007, pages 119-127), was a reference for care plans. A nursing care plan is a written guideline for coordinating nursing care, promoting continuity of care and listing outcome criteria to be used in the evaluation of nursing care. The written care plan communicates nursing care priorities to other health care professionals. The care plan also identifies and coordinates resources used to deliver nursing care. A correctly formulated care plan makes it easy to continue care from one nurse to another. If the patient's status has changed and the nursing diagnosis and related interventions are no longer appropriate, modify the nursing care plan. An out of date or incorrect care plan compromises the quality of nursing care.	F 657		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review and clinical record review, it was determined that facility staff failed to provide respiratory services in a manner consistent with professional standards of care for one of 15 residents in the survey sample, Resident #183.	F 695	**F695** Responses to the cited deficiencies do not constitute an admission or agreement by the facility of the truth of facts alleged or conclusions set forth in the Statement of Deficiencies. The Plan of Correction is prepared solely as a matter of compliance with federal and/or state law. 1. **With respect to the specific resident cited:** The oxygen saturation for resident #183 was checked at 4:26 p.m. on 1/30/18 and found to be 97%. The oxygen tank was refilled and the resident was placed back on oxygen at a flow rate of 2L per minute. The resident	

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The facility staff failed to provide respiratory treatment and services to Resident #183 per physician's order.

The findings include:

Resident #183 was admitted to the facility on 1/15/18 and readmitted on 1/20/18 with diagnoses that included but were not limited to muscle weakness, osteomyelitis of the right shoulder, type two diabetes, GI (gastrointestinal bleed), pneumonia, and panic disorder. Resident #183 had not yet had a completed MDS (minimum data set) assessment. Resident #183 was documented in her clinical record as being alert and oriented x 4 (to person, place, time and situation).

On 1/30/18 at 12:37 p.m., an observation was made of Resident #183. Resident #183 was observed wearing a nasal cannula. The oxygen tubing was connected to an oxygen tank behind her wheelchair. The gage to the oxygen tank was in the red, indicating the oxygen tank was out of oxygen.

On 1/30/18 at 4:16 p.m., an on an observation was made of Resident #183. Resident #183 was observed wearing a nasal cannula. The oxygen tubing was connected to an oxygen tank behind her wheelchair. The gage to the oxygen tank was in the red, indicating the oxygen tank was out of oxygen.

On 01/30/18 at 4:16 p.m., an interview was conducted with LPN (licensed practical nurse) #3, Resident #183's nurse that shift. When asked who was responsible for checking oxygen tanks to ensure residents are receiving oxygen, LPN

experienced no adverse outcomes as a result of the status of the oxygen tank.

2. **With respect to how the facility will identify residents with the potential for the identified concern and take corrective action:** Residents with orders for oxygen were checked at the time of survey. All were found to be receiving oxygen according to their orders.

3. **With respect to what systemic measures have been put in place to address the stated concern:** Refresher training will be conducted for nursing staff by the Director of Nursing by 3/2/18 regarding checking and filling oxygen tanks, and when to use portable tanks versus concentrators. Periodic rounds will be conducted weekly for the next three months by the Director of Nursing or his designee to verify that residents with orders for oxygen are receiving oxygen according to their orders. If an issue is identified, the resident will be assessed and the oxygen will be adjusted to follow the order.

4. **With respect to how the plan of corrective measures will be monitored:** Over the next three months, the findings from the periodic rounds will be reviewed at

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

F 695 Continued From page 57

#3 stated the nurses and the nursing aides are responsible. LPN #3 was asked when she had last checked Resident #183's oxygen tank. LPN #3 stated she wasn't sure; she had been sitting at the desk. When asked if she knew how much oxygen Resident #183 had left in her tank; LPN #3 stated that she had to check. This writer accompanied LPN #3 to Resident #183's room. LPN #3 looked at the tank and stated, It's finished, I'm going to fill it up." LPN #3 stated she did not know how long the oxygen tank had been empty.

Review of Resident #183's most recent physician order sheet documented the following order: "Oxygen in use continuous at SPECIFY RATE 2 L (liters)/min (minute) via nasal cannula due to SOB (shortness of breath) every shift for SOB."

Review of Resident #183's comprehensive care plan dated 1/16/18 documented the following: "The resident has altered respiratory status/difficulty breathing...The resident will maintain normal breathing pattern as evidenced by normal respirations, normal skin color, and regular respiratory rate/pattern through the review date. Interventions: Administer medication/puffers as ordered. Monitor for effectiveness and side effects."

On 2/1/18 at 5:16 p.m., ASM (administrative staff member) #1, the administrator and ASM #2, the DNS (Director of Nursing Services) were made aware of the above concerns. ASM #2 stated that the facility used Potter and Perry as a professional standard of practice.

Facility policy titled, "Oxygen Therapy" did not address the above concerns.

F 695

Quality Assurance / Performance Improvement (QAPI) meetings. At the conclusion of the three months, the QAPI committee will re-evaluate and initiate any necessary action or extend the review period. The Executive Director and/or Administrator are responsible for ensuring implementation and ongoing compliance with the components of this Plan of Correction and addressing and resolving variances that may occur. The Executive Director and/or Administrator are responsible for ensuring the status of this Plan of Correction is reviewed and discussed at QAPI meetings and action initiated if required.

5. Areas cited in F695 will be corrected by 3/16/18.

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F 695	Continued From page 58 In "Fundamentals of Nursing" 6th edition, 2005; Patricia A. Potter and Anne Griffin Perry; Mosby, Inc; Page 419. "The physician is responsible for directing medical treatment. Nurses are obligated to follow physician's orders unless they believe the orders are in error or would harm clients. Therefore all orders must be assessed if one is found to be erroneous or harmful further clarification from the physician is necessary."	F 695		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs;	F 758	**F758** Responses to the cited deficiencies do not constitute an admission or agreement by the facility of the truth of facts alleged or conclusions set forth in the Statement of Deficiencies. The Plan of Correction is prepared solely as a matter of compliance with federal and/or state law. 1. **With respect to the specific residents cited:** The Ambien order for Resident #15 was clarified on 2/1/18 to include a stop date of 2/8/18. The order was discontinued on 2/8/18. 2. **With respect to how the facility will identify residents with the potential for the identified concern and take corrective action:** An audit of PRN orders for psychoactive medications for current guests was completed on 2/14/18 by the Assistant Director of Nursing to verify that they included a stop date after 14 days. Orders found not to have a stop date were clarified with the physician or discontinued.	

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§483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and

§483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order.

§483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication.
This REQUIREMENT is not met as evidenced by:
Based on staff interview and clinical record review, it was determined the facility staff failed to ensure one of 15 residents in the survey sample, Resident #15, was free from unnecessary psychotropic medications.

The facility staff failed to indicate a stop date x (times) 14 days for Resident #15's prn (as needed) order of Ambien.

The findings include:

Resident #15 was admitted to the facility on 10/2/17 and readmitted on 1/25/18 with diagnoses that included but were not limited to acute kidney failure, muscle weakness, type two

3. **With respect to what systemic measures have been put in place to address the stated concern:** Refresher training and policy review will be conducted for the Medical Director, attending physicians and nurse practitioners by the Director of Nursing by 3/2/18 regarding the need to limit PRN orders for psychotropic drugs to 14 days and document the rationale for continuing the order beyond 14 days in the resident's medical record. Orders for PRN psychotropic medications will be audited weekly for the next three months by the Director of Nursing or his designee to verify that they include a stop date after 14 days. If an issue is identified, the order will be clarified or discontinued.

4. **With respect to how the plan of corrective measures will be monitored:** Over the next three months, the findings from the weekly PRN psychotropic medication order audits will be reviewed at Quality Assurance / Performance Improvement (QAPI) meetings. At the conclusion of the three months, the QAPI committee will re-evaluate and initiate any necessary action or extend the review period. The Executive Director and/or Administrator are responsible for ensuring implementation and ongoing compliance with the

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diabetes, heart failure, and insomnia, high blood pressure, atrial fibrillation, hypothyroidism, and heart failure. Resident #15's most recent MDS (minimum data set) was a 14 day scheduled assessment dated 10/16/17. Resident #15 was coded as being cognitively intact in the ability to make daily decisions scoring 15 out of 15 on the BIMS (Brief Interview for Mental Status) exam. Resident #15 was coded as requiring extensive assistance from one staff member with most all ADLS (activities of daily living).

Review of Resident #15's physician orders revealed the following order dated 1/10/18: "Ambien [1] Tablet 5 mg (milligrams) Give 1 tablet by mouth every 24 hours as needed for insomnia give po (by mouth) at HS (night)." There was no stop date for this prn (as needed) order indicating that this drug was limited to 14 days.

Review of Resident #15's January 2018 MAR (Medication Administration Record) revealed this order was discontinued on 1/12/18 when the resident was discharged to assisted living.

Review of the clinical record revealed Resident #15 was readmitted to the facility on 1/25/18.

Review of the current physician orders revealed the following order dated 1/26/18: "Ambien 5 MG (milligrams): Give 1 tablet by mouth every 24 hours as needed for insomnia." There was no stop date for this prn (as needed) order indicating that this drug was limited to 14 days.

Further review of Resident #15's January 2015 MAR revealed Resident #15 received Ambien on the following dates: 1/26/18, 1/28/18, 1/30/18.

F 758

components of this Plan of Correction and addressing and resolving variances that may occur. The Executive Director and/or Administrator are responsible for ensuring the status of this Plan of Correction is reviewed and discussed at QAPI meetings and action initiated if required.

5. Areas cited in F758 will be corrected by 3/16/18.

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On 2/01/18 at 4:49 p.m., an interview was conducted with ASM (administrative staff member) #3, the physician, regarding the process followed when ordering a prn (as needed) psychotropic [2] drug. ASM #3 stated psychotropic drugs were antipsychotic [3] medications. ASM #3 stated if a resident were on an antipsychotic, he would reassess every week for continued use. ASM #3 stated antipsychotics are never ordered prn. When asked if Ambien was considered a psychotropic drug, ASM #3 stated, "Ambien is a benzodiazepine [4], not a psychotropic drug. Psychotropic drugs are for people who are psychotic and need to be on an antipsychotic. Ambien is very different from this." ASM #3 stated that Ambien is ordered prn because sometimes a resident can't sleep. ASM #3 stated that he would not reassess the use for Ambien like he would an antipsychotic. ASM #3 was not aware of limiting the use of a prn psychotropic drug to 14 days initially.

On 2/02/18 at 9:00 a.m., an interview was conducted with OSM (other staff member) #7, the pharmacist. When asked the drug classification of Ambien, OSM #7 stated that Ambien was used for sleep and was considered a benzodiazepine. When asked if Ambien was also a psychotropic drug, OSM #7 stated that Ambien was not considered a psychotropic drug but was a hypnotic [5]. When asked what it means for a drug to be "psychotropic", OSM #7 stated that in a way Ambien was a psychotropic medication because it was a hypnotic and acts as a sedative.

On 2/1/18 at 5:16 p.m., ASM #1, the administrator and ASM #2, the DNS (Director of Nursing Services) were made aware of the above concerns. ASM #2 stated that the facility used

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Potter and Perry as a professional reference.

A policy could not be provided regarding the above concerns.

[1] Ambien is a non-barbiturate hypnotic used to treat insomnia by depressing the central nervous system. This information was obtained from The National Institutes of Health. https://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0012721/?report=details.

[2] Psychotropic medication used to treat certain mental disorders and conditions. Types of psychotropic medications include: anti-anxiety medications such as benzodiazepines, antidepressants, stimulants, antipsychotics and mood stabilizers. This information was obtained from The National Institutes of health. https://www.nimh.nih.gov/health/topics/mental-health-medications/index.shtml#part_149866

[3] Antipsychotic-used to treat psychotic disorders such as schizophrenia, psychosis and bipolar disorder. This information was obtained from The National Institutes of Health. https://livertox.nih.gov/AntipsychoticAgents.htm.

[4] Benzodiazepines are used for numerous indications, including anxiety, insomnia, muscle relaxation, relief from spasticity caused by central nervous system pathology, and epilepsy. This information was obtained from The National Institutes of Health. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3684331.

[5] Hypnotics are also known as sedatives, hypnotics, medications for sleep, sleeping aids.

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F 758	Continued From page 63 Several types of medications are used to treat insomnia or as sleeping aids, including barbiturates, antihistamines, various herbals, benzodiazepines and benzodiazepine receptor analogues. This information was obtained from The National Institutes of health. https://livertox.nlm.nih.gov/Sedatives_Hypnotics.htm.	F 758	**F812** Responses to the cited deficiencies do not constitute an admission or agreement by the facility of the truth of facts alleged or conclusions set forth in the Statement of Deficiencies. The Plan of Correction is prepared solely as a matter of compliance with federal and/or state law. 1. **With respect to the specific observation cited:** The expired peanut butter observed in the walk-in refrigerator was discarded at the time of survey. The dietary supervisor adjusted her hair restraint to contain all of her hair at the time of survey. 2. **With respect to how the facility will identify residents with the potential for the identified concern and take corrective action:** All refrigerators in the main kitchen and satellite kitchens were checked for expired food items, and staff were observed for appropriate hair restraints. No issues were identified. 3. **With respect to what systemic measures have been put in place to address the stated concern:**	
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and facility document review it was determined the facility staff failed to store and serve food in a sanitary manner. 1. An expired container full of peanut butter was	F 812		

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found in the walk-in refrigerator.

2. Dietary staff failed to appropriately wear hair restraints while taking the temperatures of food items prior to lunch.

The findings include:

1. On 1/30/18 at 11:56 a.m., observation of the facility kitchen was conducted with OSM (other staff member) #5, the executive sous chef. At 12:00 p.m., observation of the walk-in refrigerator was conducted. A 5 lb. (pound) container labeled "peanut butter" was observed with three dates written on the top of the lid, "12/22/17, 1/16/18 and 1/28/18." When OSM #5 was asked what the dates on the lid meant, OSM #5 stated the peanut butter was received on 12/22/17, opened on 1/16/18 and the expiration date was on 1/28/18. When asked if the peanut butter was expired, OSM #5 stated it was and should have been thrown out. OSM stated he would take care of the container.

On 2/1/18 at 5:16 p.m., ASM (administrative staff member) #1, the administrator and ASM #2, the DNS (Director of Nursing Services) were made aware of the above findings.

The facility policy titled, "Food Storage," documented the following: "Any expired or outdated food products should be discarded."

2. Dietary staff failed to appropriately wear hair restraints while taking the temperatures of food items prior to lunch.

On 1/31/18 at 11:42 a.m., observation of food

Refresher training was completed on 2/13/18 for kitchen and dietary staff by the Dining Services Coordinator and Registered Dietitian regarding food storage and proper use of hair restraints. Refrigerator audits will be conducted weekly for the next three months by the Executive Chef or his designee to verify that food items are discarded once their expiration date is reached and that hair restraints are properly utilized. If an issue is identified, the food item will be discarded immediately and/or the hair restraint will be adjusted. A new style of hair restraints that are larger and more secure on the head were obtained.

4. **With respect to how the plan of corrective measures will be monitored:** Over the next three months, the findings from the weekly refrigerator audits will be reviewed at Quality Assurance / Performance Improvement (QAPI) meetings. At the conclusion of the three months, the QAPI committee will re-evaluate and initiate any necessary action or extend the review period. The Executive Director and/or Administrator are responsible for ensuring implementation and ongoing compliance with the components of this Plan of Correction and addressing and resolving variances that may occur.

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temperatures were conducted in the kitchen area of the third floor health center. OSM (other staff member) #8, the dietary supervisor was observed taking food temperatures. Her hair restraint covered only the top of her hair. The back of her hair was exposed and some wisps of hair were coming out of the side of the hair net.

On 1/31/18 at 12:47 p.m., an interview was conducted with OSM #8. When asked the purpose of the hair restraint, OSM #8 stated the purpose of the hair restraint was to prevent hair from getting into the food. When asked the proper way to wear a hair net, OSM #8 stated the net must cover all hair. When asked if she was wearing her hair net properly. OSM #8 touched her head and stated, "I agree, it wasn't covering my entire hair."

On 2/1/18 at 5:16 p.m., ASM (administrative staff member) #1, the administrator and ASM #2, the DNS (Director of Nursing Services) were made aware of the above findings.

The facility policy titled, "Personal Hygiene," documents in part, the following: "Wear a clean hat or other hair restraint. Hair must be appropriately restrained or completely covered."

F 812

The Executive Director and/or Administrator are responsible for ensuring the status of this Plan of Correction is reviewed and discussed at QAPI meetings and action initiated if required.

5. Areas cited in F812 will be corrected by 3/16/18.

F 814 SS=F Dispose Garbage and Refuse Properly CFR(s): 483.60(i)(4)

§483.60(i)(4)- Dispose of garbage and refuse properly.
This REQUIREMENT is not met as evidenced by:
Based on observation, staff interview and facility document review, it was determined the facility staff failed to dispose of garbage and refuse in a

F 814

F814

Responses to the cited deficiencies do not constitute an admission or agreement by the facility of the truth of facts alleged or conclusions set forth in the Statement of Deficiencies. The Plan of Correction is prepared solely as a matter of compliance with federal and/or state law.

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sanitary manner.

The facility staff failed to ensure the trash compacter was free from debris around the surrounding area.

The findings include:

On 1/30/18 at 12:27 p.m., observation of the trash compacter area was conducted with OSM (other staff member) #4, the Director of Dietary Servives. A bag of trash was observed on the ground next to the dumpster/trash compactor. The bag was split open and a swarm of birds were eating out of the trash bag. The trash bag contained an empty sauce container, food wrappers and other food particles. A brief was also observed next to the trash compacter with a brown substance on the brief.

On 1/30/18 at 12:17 p.m., an interview was conducted with OSM #4. OSM #4 stated that he would get someone down to clean up the area right away. When asked who was responsible for ensuring the dumpster area was clean, OSM #4 stated it was a shared effort between kitchen staff, maintenance and any staff member. OSM #4 stated anytime a staff member goes to throw trash in the compacter, they should be checking to see if the surrounding area is free from debris on the ground.

On 2/1/18 at 5:16 p.m., ASM (administrative staff member) #1, the administrator and ASM #2, the DNS (Director of Nursing Services) were made aware of the above findings.

The facility policy titled, "Garbage and trashcans," documents in part, the following: "The dumpster

1. **With respect to the specific observation cited:** The area around the trash compactor was cleaned at the time of survey.

2. **With respect to how the facility will identify residents with the potential for the identified concern and take corrective action:** There is no other trash compactor for the facility.

3. **With respect to what systemic measures have been put in place to address the stated concern:** Refresher training was conducted for utility staff by the Dining Services Coordinator on 2/13/18 regarding the need for the area around the trash compactor to be free from debris. The cleaning process / schedule was revised so that the area is checked and cleaned daily by housekeeping and two times each day by dining utility staff. Periodic rounds will be conducted weekly for the next three months by the Dining Services Coordinator or his designee to verify that the area around the trash compactor is free from debris. If an issue is identified, the area will be cleaned and the cleaning schedule will be re-evaluated.

4. **With respect to how the plan of corrective measures will be monitored:** Over the next three

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F 814	Continued From page 67 area must be free of debris on the ground and the lid muse be closed."	F 814	months, the findings from periodic rounds will be reviewed at Quality Assurance / Performance Improvement (QAPI) meetings. At the conclusion of the three months, the QAPI committee will re-evaluate and initiate any necessary action or extend the review period. The Executive Director and/or Administrator are responsible for ensuring implementation and ongoing compliance with the components of this Plan of Correction and addressing and resolving variances that may occur. The Executive Director and/or Administrator are responsible for ensuring the status of this Plan of Correction is reviewed and discussed at QAPI meetings and action initiated if required. **5.** Areas cited in F814 will be corrected by 3/16/18.	