STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495358	A. BUILDING _____ B. WING _____	03/09/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMELIA NURSING CENTER	8830 VIRGINIA STREET AMELIA, VA 23002

(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 An unannounced Emergency Preparedness survey was conducted 03/06/18 through 03/09/18. Corrections are required for compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities.	E 000		
E 001 SS=C	Establishment of the Emergency Program (EP) CFR(s): 483.73 The [facility, except for Transplant Center] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility] must establish and maintain a comprehensive emergency preparedness program that meets the requirements of this section.* The emergency preparedness program must include, but not be limited to, the following elements: *[For hospitals at §482.15:] The hospital must comply with all applicable Federal, State, and local emergency preparedness requirements. The hospital must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach. *[For CAHs at §485.625:] The CAH must comply with all applicable Federal, State, and local emergency preparedness requirements. The CAH must develop and maintain a comprehensive emergency preparedness program, utilizing an all-hazards approach. This REQUIREMENT is not met as evidenced by: Based on staff interview and facility document review it was determined that the facility staff failed to have a complete emergency	E 001	1. Administrator will complete Emergency Preparedness Plan that meets Federal, State and local emergency Preparedness requirements utilizing an all hazards approach. 2. To ensure 100% accuracy Kent Emerson, Coordinatorof Emergency Management and Pete Svododa, CentralVirginia Healthcare Coalition Medically, Vulnerable Population Coordinator, and Roger Fracker AssistantAdministrator Heritage Hall, Blackstone will reviewand check for accuracy and compliance with all State and Federal Emergency Preparedness guidelines. 3. Inservice will be given on the Emergency Plan upon hire and to all departments and their employees on 04/18/18 and annually thereafter. 4. QA will review quarterly and sign off on it as well as go over any emergencies that came up during the quarter. Completion by 04/23/2018	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Virginia M. Sneed — TITLE: Administrator — (X6) DATE

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

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E 001	Continued From page 1 preparedness plan. The facility staff failed to develop a written policy of an emergency preparedness plan. The findings include: On 03/09/18 at 9:15 a.m. a review and interview of the facility's emergency preparedness plan was conducted with ASM (administrative staff member) # 1, administrator. Review of the facility's emergency preparedness plan failed to evidence a written policy of an emergency preparedness plan. ASM # 1 stated that the facility did not have it. We are still developing the emergency preparedness plan." On 03/09/18 at approximately 11:00 a.m. ASM (administrative staff member) # 1, administrator, and ASM # 2, director of nursing, were made aware of the findings. No further information was obtained prior to exit.	E 001		
E 006 SS=C	Plan Based on All Hazards Risk Assessment CFR(s): 483.73(a)(1)-(2) [(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do the following:] (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach.* *[For LTC facilities at §483.73(a)(1):] (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an	E 006	1. Administrator will complete Emergency Preparedness Plan that meets Federal, State, and local emergency preparedness requirements with special emphasis on all hazards approach and be based on and included documented facility-based and community based risk assessment, utilized on all-hazards approach including missing residents.	

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E 006	Continued From page 2 all-hazards approach, including missing residents. *[For ICF/IIDs at §483.475(a)(1):] (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing clients. (2) Include strategies for addressing emergency events identified by the risk assessment. * [For Hospices at §418.113(a)(2):] (2) Include strategies for addressing emergency events identified by the risk assessment, including the management of the consequences of power failures, natural disasters, and other emergencies that would affect the hospice's ability to provide care. This REQUIREMENT is not met as evidenced by: Based on staff interview and facility document review it was determined that the facility staff failed to have a complete emergency preparedness plan. The facility staff failed to provide documentation of the facility's risk assessment, associated strategies and that the risk assessment was based on an all-hazards approach specific to the geographical area. The findings include: On 03/09/18 at 9:15 a.m. a review and interview of the facility's emergency preparedness plan was conducted with ASM (administrative staff member) # 1, administrator. Review of the facility's emergency preparedness plan failed to evidence documentation of the facility's risk assessment, associated strategies and that the	E 006	2. To ensure 100% accuracy Kent Emerson, Coordinatorof Emergency Management and Pete Svododa, CentralVirginia Healthcare Coalation Medically, VulnerablePopulation Coordinator, and Roger Fracker Assistant Administrator Heritage Hall, Blackstone will review Emergency Plan. They will also make certain it is based on and included documented facility-based and community based Risk Assessments on all hazards approach including missing residents. 3. Inservice to staff on 04/18/18 will include the documented facility based and community based risk assessments on the all hazards approach including missing residents. Will have missing residents drill quarterly beginning 03/29/2018. 4. Administrator will report to QA the documented facility based and community based risk assessments and the all hazards approach including missing residents. Completion Date 04/23/2018	

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E 006	Continued From page 3 risk assessment was based on an all-hazards approach specific to the geographical area. On 03/09/18 at approximately 11:00 a.m. ASM (administrative staff member) # 1, administrator, and ASM # 2, director of nursing, were made aware of the findings. No further information was obtained prior to exit.	E 006		
E 007 SS=C	EP Program Patient Population CFR(s): 483.73(a)(3) [(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do the following:] (3) Address patient/client population, including, but not limited to, persons at-risk; the type of services the [facility] has the ability to provide in an emergency; and continuity of operations, including delegations of authority and succession plans.** *Note: ["Persons at risk" does not apply to: ASC, hospice, PACE, HHA, CORF, CMCH, RHC, FQHC, or ESRD facilities.] This REQUIREMENT is not met as evidenced by: Based on staff interview and facility document review it was determined that the facility staff failed to have a complete emergency preparedness plan. The facility staff failed to provide documentation that the written emergency plan included the facility's patient populations that would be at risk during an emergency event; how the facility would	E 007	1. Administrator will complete Emergency PreparenessPlan that meets Federal, State and local emergency Preparedness requirements that is reviewed, and updated at least annually. The plan will address patient/client population, including, but not limited to, persons at risk, the type of services the facility has the ability to provide in an emergency, and continuing of operations, including deligation of authority and sucession plans. 2. To ensure 100% accuracy Kent Emerson, Coordinatorof Emergency Management and Pete Svododa, CentralVirginia Healthcare Coalition Medically, Vulnerable Population Coordinator, and Roger Fracker Assistant Administrator Heritage Hall, Blackstone will review Emergency Plan and check for accuracy and compliance with all State and Federal and Local Emergency Preparedness guidelines.	

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E 007	Continued From page 4 continue operations during an emergency and the delegation of authority and succession. The findings include: On 03/09/18 at 9:15 a.m. a review and interview of the facility's emergency preparedness plan was conducted with ASM (administrative staff member) # 1, administrator. Review of the facility's emergency preparedness plan failed to evidence documentation that the written emergency plan included the facility's patient populations that would be at risk during an emergency event; how the facility would continue operations during an emergency and the delegation of authority and succession. ASM # 1 stated that the facility did not have it. We are still developing the emergency preparedness plan." On 03/09/18 at approximately 11:00 a.m. ASM (administrative staff member) # 1, administrator, and ASM # 2, director of nursing, were made aware of the findings. No further information was obtained prior to exit.	E 007	Cont. Paying special attention to the fact it must be updated annually and the plan will address patient/client population including, but not limited to, persons at risk; the type of services the facility has the ability to provide in an emergency, and continuity of operations, including deligations of authority and sucession plans. 3. Inservice will be given on the Emergency Plan upon hire and to all departments and their employees on 04/18/18 and annually thereafter. 4. QA will review quarterly and sign off on it as well as go over any emergencies that came up during the quarter. Completion date 04/23/2018	
E 013 SS=C	Development of EP Policies and Procedures CFR(s): 483.73(b) (b) Policies and procedures. [Facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. *Additional Requirements for PACE and ESRD	E 013	1. Administrator will complete Emergency Prepareness Plan that meets Federal, State and local emergency Preparedness requirements utilizing an all hazards approach with evidence documentation that the policies and procesure were developed based on the facility and community based risk assessments and communication plan utilizing an all hazards approach and evidence that the policies and procedure were reviewed and updated annually.	

STATEMENT OF OEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIOER/SUPPLIER/CLIA IOENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) OATE SURVEY COMPLETEO
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E 013	Continued From page 5 Facilities: *[For PACE at §460.84(b):] Policies and procedures. The PACE organization must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must address management of medical and nonmedical emergencies, including, but not limited to: Fire; equipment, power, or water failure; care-related emergencies; and natural disasters likely to threaten the health or safety of the participants, staff, or the public. The policies and procedures must be reviewed and updated at least annually. *[For ESRD Facilities at §494.62(b):] Policies and procedures. The dialysis facility must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. These emergencies include, but are not limited to, fire, equipment or power failures, care-related emergencies, water supply interruption, and natural disasters likely to occur in the facility's geographic area. This REQUIREMENT is not met as evidenced by: Based on staff interview and facility document review it was determined that the facility staff failed to have a complete emergency preparedness plan.	E 013	2. To ensure 100% accuracy Kent Emerson, Coordinatorof Emergency Management and Pete Svododa, CentralVirginia Healthcare Coalition Medically, Vulnerable Population Coordinator, and Roger Fracker Assistant Administrator Heritage Hall, Blackstone will review Emergency Plan and check for accuracy and compliance with all State, Federal and Local Emergency Preparedness guidelines. They will make certain the plan includes documentation that the policies and procedures were developed based on the facility and communicaty based risk assessment and communication plan utilizing an all hazard approach and evidence that the policies and procedures were reviewed and updated annually. 3. Inservice will be given on the Emergency Plan upon hire and to all departments and their employees on 04/18/18 and annually thereafter. 4. QA will review quarterly and sign off on it as well as go over any emergencies that came up during the quarter. Completion Date 04/23/18	

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E 013	Continued From page 6 The facility staff failed to provide documentation that the policies and procedures were developed based on the facility-and-community based risk assessment, and communication plan utilizing an all-hazards approach and evidence that the policies and procedure were reviewed and updated annually. The findings include: On 03/09/18 at 9:15 a.m. a review and interview of the facility's emergency preparedness plan was conducted with ASM (administrative staff member) # 1, administrator. Review of the facility's emergency preparedness plan failed to evidence documentation that the policies and procedures were developed based on the facility-and-community based risk assessment, and communication plan utilizing an all-hazards approach and evidence that the policies and procedure were reviewed and updated annually. ASM # 1 stated that the facility did not have it. We are still developing the emergency preparedness plan." On 03/09/18 at approximately 11:00 a.m. ASM (administrative staff member) # 1, administrator, and ASM # 2, director of nursing, were made aware of the findings. No further information was obtained prior to exit.	E 013		
E 015 SS=C	Subsistence Needs for Staff and Patients CFR(s): 483.73(b)(1) [(b) Policies and procedures. [Facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk	E 015	1. Administrator will complete Emergency Prepareness Plan that meets Federal, State and local emergency Preparedness requirements utilizing an all hazards approach to include development of policies and procedures for the provision of pharmaceutical supplies for patients and staff.	

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E 015	Continued From page 7 assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually.] At a minimum, the policies and procedures must address the following: (1) The provision of subsistence needs for staff and patients whether they evacuate or shelter in place, include, but are not limited to the following: (i) Food, water, medical and pharmaceutical supplies (ii) Alternate sources of energy to maintain the following: (A) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions. (B) Emergency lighting. (C) Fire detection, extinguishing, and alarm systems. (D) Sewage and waste disposal. *[For Inpatient Hospice at §418.113(b)(6)(iii):] Policies and procedures. (6) The following are additional requirements for hospice-operated inpatient care facilities only. The policies and procedures must address the following: (iii) The provision of subsistence needs for hospice employees and patients, whether they evacuate or shelter in place, include, but are not limited to the following: (A) Food, water, medical, and pharmaceutical supplies. (B) Alternate sources of energy to maintain the following: (1) Temperatures to protect patient health and safety and for the safe and sanitary storage	E 015	2. To ensure 100% accuracy Kent Emerson, Coordinator of Emergency Management and Pete Svododa, Central Virginia Healthcare Coalition Medically, Vulnerable Population Coordinator, and Roger Fracker Assistant Administrator Heritage Hall, Blackstone will review Emergency Plan and check for accuracy and compliance with all State, Federal and Local Emergency Preparedness guidelines, also making certain to develop policies and procedures for the provisions of pharmaceutical supplies for patients and staff. 3. Inservice will be given on the Emergency Plan upon hire and to all departments and their employees on 04/18/18 and annually thereafter. 4. QA will review quarterly and sign off on it as well as go over any emergencies that came up during the quarter. Completion Date 04/23/2018	

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E 015	Continued From page 8 of provisions. (2) Emergency lighting. (3) Fire detection, extinguishing, and alarm systems. (C) Sewage and waste disposal. This REQUIREMENT is not met as evidenced by: Based on staff interview and facility document review it was determined that the facility staff failed to have a complete emergency preparedness plan. The facility staff failed to develop policies and procedures for the provision of pharmaceutical supplies for patients and staff. The findings include: On 03/09/18 at 9:15 a.m. a review and interview of the facility's emergency preparedness plan was conducted with ASM (administrative staff member) # 1, administrator. Review of the facility's emergency preparedness plan revealed the facility staff failed to develop policies and procedures for the provision of pharmaceutical supplies for patients and staff. ASM # 1 stated that the facility did not have it. We are still developing the emergency preparedness plan." On 03/09/18 at approximately 11:00 a.m. ASM (administrative staff member) # 1, administrator, and ASM # 2, director of nursing, were made aware of the findings. No further information was obtained prior to exit.	E 015		
E 018 SS=C	Procedures for Tracking of Staff and Patients CFR(s): 483.73(b)(2)	E 018	1. Administrator will complete Emergency PreparenessPlan that meets Federal, State and local emergency Preparedness requirements utilizing an all hazards approach.	

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E 018	Continued From page 9 [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually.] At a minimum, the policies and procedures must address the following:] (2) A system to track the location of on-duty staff and sheltered patients in the [facility's] care during an emergency. If on-duty staff and sheltered patients are relocated during the emergency, the [facility] must document the specific name and location of the receiving facility or other location. *[For PRTFs at §441.184(b), LTC at §483.73(b), ICF/IIDs at §483.475(b), PACE at §460.84(b):] Policies and procedures. (2) A system to track the location of on-duty staff and sheltered residents in the [PRTF's, LTC, ICF/IID or PACE] care during and after an emergency. If on-duty staff and sheltered residents are relocated during the emergency, the [PRTF's, LTC, ICF/IID or PACE] must document the specific name and location of the receiving facility or other location. *[For Inpatient Hospice at §418.113(b)(6):] Policies and procedures. (ii) Safe evacuation from the hospice, which includes consideration of care and treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s) and primary and alternate means of communication with external sources of assistance.	E 018	Cont #1 Will include evidence of a tracking system to document locations of patients and staff. 2. To ensure 100% accuracy Kent Emerson, Coordinator of Emergency Management and Pete Svododa, Central Virginia Healthcare Coalition Medically, Vulnerable Population Coordinator, and Roger Fracker Assistant Administrator Heritage Hall, Blackstone will review Emergency Plan and check for accuracy and compliance with all State, Federal and Local Emergency Preparedness guidelines. Looking for evidence of a tracking systemto document location of patients and staff. 3. Inservice will be given on the Emergency Plan upon hire and to all departments and their employees on 04/18/18 and annually thereafter. 4. QA will review quarterly and sign off on it as well as go over any emergencies that came up during the quarter. Completion date 04/23/18	

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E 018	Continued From page 10 (v) A system to track the location of hospice employees' on-duty and sheltered patients in the hospice's care during an emergency. If the on-duty employees or sheltered patients are relocated during the emergency, the hospice must document the specific name and location of the receiving facility or other location. *[For CMHCs at §485.920(b):] Policies and procedures. (2) Safe evacuation from the CMHC, which includes consideration of care and treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s); and primary and alternate means of communication with external sources of assistance. *[For OPOs at § 486.360(b):] Policies and procedures. (2) A system of medical documentation that preserves potential and actual donor information, protects confidentiality of potential and actual donor information, and secures and maintains the availability of records. *[For ESRD at § 494.62(b):] Policies and procedures. (2) Safe evacuation from the dialysis facility, which includes staff responsibilities, and needs of the patients. This REQUIREMENT is not met as evidenced by: Based on staff interview and facility document review it was determined that the facility staff failed to have a complete emergency preparedness plan. The facility staff failed to develop a tracking system to document locations of patients and staff.	E 018		

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E 018	Continued From page 11 The findings include: On 03/09/18 at 9:15 a.m. a review and interview of the facility's emergency preparedness plan was conducted with ASM (administrative staff member) # 1, administrator. Review of the facility's emergency preparedness plan failed to evidence a tracking system to document locations of patients and staff. ASM # 1 stated that the facility did not have it. We are still developing the emergency preparedness plan." On 03/09/18 at approximately 11:00 a.m. ASM (administrative staff member) # 1, administrator, and ASM # 2, director of nursing, were made aware of the findings. No further information was obtained prior to exit.	E 018		
E 020 SS=C	Policies for Evac. and Primary/Alt. Comm. CFR(s): 483.73(b)(3) [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. At a minimum, the policies and procedures must address the following:] Safe evacuation from the [facility], which includes consideration of care and treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s); and primary and alternate means of communication with external sources of assistance.	E 020	1. Administrator will complete Emergency PreparenessPlan that meets Federal, State and local emergency Preparedness requirements utilizing an all hazards approach, with regards for policy and procedure for safe evacuation from the facility that include all of the required elements for safe evacuation. 1. Consideration of care needs of evacuees. 2. Staff responsibilities 3. Transportation 4. Identification of evacuation location 5. Primary and alternate means of comminication with external source of assistance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495358	A. BUILDING _____ B. WING _____	03/09/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMELIA NURSING CENTER	8830 VIRGINIA STREET AMELIA, VA 23002

(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 020	Continued From page 12 *[For RNHCs at §403.748(b)(3) and ASCs at §416.54(b)(2):] Safe evacuation from the [RNHCI or ASC] which includes the following: (i) Consideration of care needs of evacuees. (ii) Staff responsibilities. (iii) Transportation. (iv) Identification of evacuation location(s). (v) Primary and alternate means of communication with external sources of assistance. * [For CORFs at §485.68(b)(1), Clinics, Rehabilitation Agencies, OPT/Speech at §485.727(b)(1), and ESRD Facilities at §494.62(b)(2):] Safe evacuation from the [CORF; Clinics, Rehabilitation Agencies, and Public Health Agencies as Providers of Outpatient Physical Therapy and Speech-Language Pathology Services; and ESRD Facilities], which includes staff responsibilities, and needs of the patients. * [For RHCs/FQHCs at §491.12(b)(1):] Safe evacuation from the RHC/FQHC, which includes appropriate placement of exit signs; staff responsibilities and needs of the patients. This REQUIREMENT is not met as evidenced by: Based on staff interview and facility document review it was determined that the facility staff failed to have a complete emergency preparedness plan. The facility staff failed to evidence documentation that the emergency preparedness plan included policies and procedures for safe evacuation from the facility and that it includes all of the required	E 020	2. To ensure 100% accuracy Kent Emerson, Coordinator of Emergency Management and Pete Svododa, Central Virginia Healthcare Coalition Medically, Vulnerable Population Coordinator, and Roger Fracker Assistant Administrator Heritage Hall, Blackstone will review Emergency Plan and check for accuracy and compliance with all State, Federal and Local Emergency Preparedness guidelines and make certain there are policies and procedurefor safe evacuation from the facility that includes all of the required 1. Consideration of care needs of evacuees. 2. Staff responsibilities 3. Transportation 4. Identification of evacuation location 5. Primary and alternate means of comminication with external source of assistance. Completion date: 04/23/2018	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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E 020	Continued From page 13 elements. The findings include: On 03/09/18 at 9:15 a.m. a review and interview of the facility's emergency preparedness plan was conducted with ASM (administrative staff member) # 1, administrator. Review of the facility's emergency preparedness plan failed to evidence documentation that the emergency preparedness plan included policies and procedures for safe evacuation from the facility and that it includes all of the required elements. ASM # 1 stated that the facility did not have it. We are still developing the emergency preparedness plan." On 03/09/18 at approximately 11:00 a.m. ASM (administrative staff member) # 1, administrator, and ASM # 2, director of nursing, were made aware of the findings. No further information was obtained prior to exit.	E 020		
E 022 SS=C	Policies/Procedures for Sheltering in Place CFR(s): 483.73(b)(4) [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. At a minimum, the policies and procedures must address the following:] (4) A means to shelter in place for patients, staff,	E 022	1. Administrator will complete Emergency PreparenessPlan that meets Federal, State and local emergency Preparedness requirements utilizing an all hazards approach including developing policies and procedure of how the facility will provide a means to shelter in place for patients, staff and volunteers who remain in the facility 2. To ensure 100% accuracy Kent Emerson, Coordinator of Emergency Management and Pete Svododa, Central Virginia Healthcare Coalition Medically, Vulnerable Population Coordinator, and Roger Fracker Assistant Administrator Heritage Hall,	

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E 022	Continued From page 14 and volunteers who remain in the [facility]. [(4) or (2),(3),(5),(6)] A means to shelter in place for patients, staff, and volunteers who remain in the [facility]. *[For Inpatient Hospices at §418.113(b):] Policies and procedures. (6) The following are additional requirements for hospice-operated inpatient care facilities only. The policies and procedures must address the following: (i) A means to shelter in place for patients, hospice employees who remain in the hospice. This REQUIREMENT is not met as evidenced by: Based on staff interview and facility document review it was determined that the facility staff failed to have a complete emergency preparedness plan. The facility staff failed to develop policies and procedures of how the facility will provide a means to shelter in place for patients, staff and volunteers who remain in the facility. The findings include: On 03/09/18 at 9:15 a.m. a review and interview of the facility's emergency preparedness plan was conducted with ASM (administrative staff member) # 1, administrator. Review of the facility's emergency preparedness plan revealed the facility staff failed to develop policies and procedures of how the facility will provide a means to shelter in place for patients, staff and volunteers who remain in the facility. ASM # 1 stated that the facility did not have it. We are still developing the emergency preparedness plan."	E 022	Cont #2 Blackstone will review Emergency Plan and check for accuracy and compliance with all State, Federal and Local Emergency Preparedness guidelines. Making certain there are policiesand procedures of how the facility will providea means to shelter in place for patients, staffand volunteers who remain in the facility 3. Inservice will be given on the Emergency Plan upon hire and to all departments and their employees on 04/18/18 and annually thereafter. 4. QA will review quarterly and sign off on it as well as go over any emergencies that came up during the quarter. Completion 04/23/18	

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E 022	Continued From page 15 On 03/09/18 at approximately 11:00 a.m. ASM (administrative staff member) # 1, administrator, and ASM # 2, director of nursing, were made aware of the findings. No further information was obtained prior to exit.	E 022		
E 023 SS=C	Policies/Procedures for Medical Documentation CFR(s): 483.73(b)(5) [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. At a minimum, the policies and procedures must address the following:] (5) A system of medical documentation that preserves patient information, protects confidentiality of patient information, and secures and maintains availability of records. [(5) or (3),(4),(6)] A system of medical documentation that preserves patient information, protects confidentiality of patient information, and secures and maintains availability of records. *[For RNHCIs at §403.748(b):] Policies and procedures. (5) A system of care documentation that does the following: (i) Preserves patient information. (ii) Protects confidentiality of patient information. (iii) Secures and maintains the availability of records. *[For OPOs at §486.360(b):] Policies and	E 023	1. Administrator will complete Emergency PreparenessPlan that meets Federal, State and local emergency Preparedness requirements utilizing an all hazards approach. To also include policies and procedures of how the facility preserves patient information, protects confidentialty of patient information secures and maintains availability of records. 2. To ensure 100% accuracy Kent Emerson, Coordinator of Emergency Management and Pete Svododa, Central Virginia Healthcare Coalition Medically, Vulnerable Population Coordinator, and Roger Fracker Assistant Administrator Heritage Hall, Blackstone will review Emergency Plan and check for accuracy and compliance with all State, Federal and Local Emergency Preparedness guidelines and look for policies and procedures how the facility preserves patient information, protects confidentialty of patient information secures and maintains availability of records.	

STATEMENT OF OEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIOER/SUPPLIER/CLIA IOENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) OATE SURVEY COMPLETEO
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E 023	Continued From page 16 procedures. (2) A system of medical documentation that preserves potential and actual donor information, protects confidentiality of potential and actual donor information, and secures and maintains the availability of records. This REQUIREMENT is not met as evidenced by: Based on staff interview and facility document review it was determined that the facility staff failed to have a complete emergency preparedness plan. The facility staff failed to develop policies and procedures of how the facility preserves patient information, protects confidentiality of patient information, and secures and maintains availability of records. The findings include: On 03/09/18 at 9:15 a.m. a review and interview of the facility's emergency preparedness plan was conducted with ASM (administrative staff member) # 1, administrator. Review of the facility's emergency preparedness plan revealed the facility staff failed to develop policies and procedures of how the facility preserves patient information, protects confidentiality of patient information, and secures and maintains availability of records. ASM # 1 stated that the facility did not have it. We are still developing the emergency preparedness plan." On 03/09/18 at approximately 11:00 a.m. ASM (administrative staff member) # 1, administrator, and ASM # 2, director of nursing, were made aware of the findings.	E 023	3. Inservice will be given on the Emergency Plan upon hire and to all departments and their employees on 04/18/18 and annually thereafter 4. QA will review quarterly and sign off on it as well as go over any emergencies that came up during the quarter. Completion Date: 04/23/2018	

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E 023	Continued From page 17 No further information was obtained prior to exit.	E 023		
E 024 SS=C	Policies/Procedures-Volunteers and Staffing CFR(s): 483.73(b)(6) [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. At a minimum, the policies and procedures must address the following:] (6) [or (4), (5), or (7) as noted above] The use of volunteers in an emergency or other emergency staffing strategies, including the process and role for integration of State and Federally designated health care professionals to address surge needs during an emergency. *[For RNHCIs at §403.748(b):] Policies and procedures. (6) The use of volunteers in an emergency and other emergency staffing strategies to address surge needs during an emergency. This REQUIREMENT is not met as evidenced by: Based on staff interview and facility document review it was determined that the facility staff failed to have a complete emergency preparedness plan. The facility staff failed to develop policies and procedures for the use of volunteers and other staffing strategies are in the emergency plan.	E 024	1. Administrator will complete Emergency PreparenessPlan that meets Federal, State and local emergency Preparedness requirements utilizing an all hazards approach. Also to develop policies and procedures for the use of volunteers and other stuffing stratagies in the emergecy plan. 2. To ensure 100% accuracy Kent Emerson, Coordinator of Emergency Management and Pete Svododa, Central Virginia Healthcare Coalition Medically, Vulnerable Population Coordinator, and Roger Fracker Assistant Administrator Heritage Hall, Blackstone will review Emergency Plan and check for accuracy and compliance with all State, Federal and Local Emergency Preparedness guidelines. Check for policies and procedures for the use of volunteers and other staffing stratagies in the emergency plan. 3. Inservice will be given on the Emergency Plan upon hire and to all departments and their employees on 04/18/18 and annually thereafter.	

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E 024	Continued From page 18 The findings include: On 03/09/18 at 9:15 a.m. a review and interview of the facility's emergency preparedness plan was conducted with ASM (administrative staff member) # 1, administrator. Review of the facility's emergency preparedness plan revealed the facility staff failed to develop policies and procedures for the use of volunteers and other staffing strategies are in the emergency plan. ASM # 1 stated that the facility did not have it. We are still developing the emergency preparedness plan." On 03/09/18 at approximately 11:00 a.m. ASM (administrative staff member) # 1, administrator, and ASM # 2, director of nursing, were made aware of the findings. No further information was obtained prior to exit.	E 024	4. QA will review quarterly and sign off on it as well as go over any emergencies that came up during the quarter. Completion by 04/23/2018	
E 025 SS=C	Arrangement with Other Facilities CFR(s): 483.73(b)(7) [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. At a minimum, the policies and procedures must address the following:] *[For Hospices at §418.113(b), PRFTs at §441.184,(b) Hospitals at §482.15(b), and LTC Facilities at §483.73(b):] Policies and procedures. (7) [or (5)] The development of arrangements with	E 025	1. Administrator will complete Emergency PreparenessPlan that meets Federal, State and local emergency Preparedness requirements utilizing an all hazards approach. Will also provide documentation or agreements with other facilities to receive patients in the event the facility is not able to care for them during an emergency. 2. To ensure 100% accuracy Kent Emerson, Coordinator of Emergency Management and Pete Svododa, Central Virginia Healthcare Coalition Medically, Vulnerable Population Coordinator, and Roger Fracker Assistant Administrator Heritage Hall, Blackstone will review Emergency Plan and check for accuracy and compliance with all State, Federal and Local Emergency Preparedness guidelines.	

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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E 025	Continued From page 19 other [facilities] [and] other providers to receive patients in the event of limitations or cessation of operations to maintain the continuity of services to facility patients. *[For PACE at §460.84(b), ICF/IIDs at §483.475(b), CAHs at §486.625(b), CMHCs at §485.920(b) and ESRD Facilities at §494.62(b):] Policies and procedures. (7) [or (6), (8)] The development of arrangements with other [facilities] [or] other providers to receive patients in the event of limitations or cessation of operations to maintain the continuity of services to facility patients. *[For RNHCIs at §403.748(b):] Policies and procedures. (7) The development of arrangements with other RNHCIs and other providers to receive patients in the event of limitations or cessation of operations to maintain the continuity of non-medical services to RNHCI patients. This REQUIREMENT is not met as evidenced by: Based on staff interview and facility document review it was determined that the facility staff failed to have a complete emergency preparedness plan. The facility staff failed to provide documentation of the arrangements and/or any agreements the facility has with other facilities to receive patients in the event the facility is not able to care for them during an emergency. The findings include: On 03/09/18 at 9:15 a.m. a review and interview of the facility's emergency preparedness plan was	E 025	cont. 2 make certain the plan provides documentation or agreements with other facilities to receive patients in the event the facility is not able to care for them during an emergency 3. Inservice will be given on the Emergency Planupon hire and to all departments and their employees on 04/18/18 and annually thereafter. 4. QA will review quarterly and sign off on it as well as go over any emergencies that came up during the quarter. Completion by 04/23/2018	

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E 025	Continued From page 20 conducted with ASM (administrative staff member) # 1, administrator. Review of the facility's emergency preparedness plan failed to evidence documentation of the arrangements and/or any agreements the facility has with other facilities to receive patients in the event the facility is not able to care for them during an emergency. ASM # 1 stated that the facility did not have it. We are still developing the emergency preparedness plan." On 03/09/18 at approximately 11:00 a.m. ASM (administrative staff member) # 1, administrator, and ASM # 2, director of nursing, were made aware of the findings. No further information was obtained prior to exit.	E 025		
E 026 SS=C	Roles Under a Waiver Declared by Secretary CFR(s): 483.73(b)(8) [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. At a minimum, the policies and procedures must address the following:] (8) [(6), (6)(C)(iv), (7), or (9)] The role of the [facility] under a waiver declared by the Secretary, in accordance with section 1135 of the Act, in the provision of care and treatment at an alternate care site identified by emergency management officials.	E 026	1. Administrator will complete Emergency PreparenessPlan that meets Federal, State and local emergency Preparedness requirements utilizing an all hazards approach. Must have policies and procedure is the plan that describes the facilities role in providing care and treatment at altered care sites under an 1135 waiver. 2. To ensure 100% accuracy Kent Emerson, Coordinator of Emergency Management and Pete Svododa, Central Virginia Healthcare Coalition Medically, Vulnerable Population Coordinator, and Roger Fracker Assistant Administrator Heritage Hall, Blackstone will review Emergency Plan and check for accuracy and compliance with all State, Federal and Local Emergency Preparedness guidelines.	

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E 026	Continued From page 21 *[For RNHCIs at §403.748(b):] Policies and procedures. (8) The role of the RNHCI under a waiver declared by the Secretary, in accordance with section 1135 of Act, in the provision of care at an alternative care site identified by emergency management officials. This REQUIREMENT is not met as evidenced by: Based on staff interview and facility document review it was determined that the facility staff failed to have a complete emergency preparedness plan. The facility staff failed to develop policies and procedures in the emergency plan that describe the facility's role in providing care and treatment at altered care sites under an 1135 waiver. The findings include: On 03/09/18 at 9:15 a.m. a review and interview of the facility's emergency preparedness plan was conducted with ASM (administrative staff member) # 1, administrator. Review of the facility's emergency preparedness plan failed to evidence policies and procedures in the emergency plan that describe the facility's role in providing care and treatment at altered care sites under an 1135 waiver. ASM # 1 stated that the facility did not have it. We are still developing the emergency preparedness plan." On 03/09/18 at approximately 11:00 a.m. ASM (administrative staff member) # 1, administrator, and ASM # 2, director of nursing, were made aware of the findings. No further information was obtained prior to exit.	E 026	Cont #2 Must have policies and procedure in the plan that describes the facilities role in providing care and treatment at altered care sites under an 1135 waiver. 3. Inservice will be given on the Emergency Plan upon hire and to all departments and their employees on 04/18/18 and annually thereafter. 4. QA will review quarterly and sign off on it as well as go over any emergencies that came up during the quarter. Completion by 04/23/18	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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AMELIA NURSING CENTER	8830 VIRGINIA STREET AMELIA, VA 23002

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E 029 SS=C	Continued From page 22 Development of Communication Plan CFR(s): 483.73(c) (c) The [facility] 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. This REQUIREMENT is not met as evidenced by: Based on staff interview and facility document review it was determined that the facility staff failed to have a complete emergency preparedness plan. The facility staff failed to evidence that the facility had a written communication plan and was reviewed on an annual basis. The findings include: On 03/09/18 at 9:15 a.m. a review and interview of the facility's emergency preparedness plan was conducted with ASM (administrative staff member) # 1, administrator. Review of the facility's emergency preparedness plan failed to evidence that the facility had a written communication plan and was reviewed on an annual basis. ASM # 1 stated that the facility did not have it. We are still developing the emergency preparedness plan." On 03/09/18 at approximately 11:00 a.m. ASM (administrative staff member) # 1, administrator, and ASM # 2, director of nursing, were made aware of the findings. No further information was obtained prior to exit.	E 029 E 029	1. Administrator will complete Emergency PreparenessPlan that meets Federal, State and local emergency Preparedness requirements utilizing an all hazards approach. To include a written communication plan and review and update on an annual basis. 2. To ensure 100% accuracy Kent Emerson, Coordinator of Emergency Management and Pete Svododa, Central Virginia Healthcare Coalition Medically, Vulnerable Population Coordinator, and Roger Fracker Assistant Administrator Heritage Hall, Blackstone will review Emergency Plan and check for accuracy and compliance with all State, Federal and Local Emergency Preparedness guidelines. Will also check for a written communication plan and review on an annual basis. 3. Inservice will be given on the Emergency Plan upon hire and to all departments and their employees on 04/18/18 and annually thereafter. 4. QA will review quarterly and sign off on it as well as go over any emergencies that came up during the quarter. Completion date: 04/23/2018	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495358	A. BUILDING _____ B. WING _____	03/09/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMELIA NURSING CENTER	8830 VIRGINIA STREET AMELIA, VA 23002

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E 030 E 030 SS=C	Continued From page 23 Names and Contact Information CFR(s): 483.73(c)(1) [(c) The [facility, except RNHCIs, hospices, transplant centers, and HHAs] 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:] (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians (iv) Other [facilities]. (v) Volunteers. *[For RNHCIs at §403.748(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Next of kin, guardian, or custodian. (iv) Other RNHCIs. (v) Volunteers. *[For ASCs at §416.45(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians. (iv) Volunteers.	E 030 E 030	1. Administrator will complete Emergency PreparenessPlan that meets Federal, State and local emergency Preparedness requirements utilizing an all hazards approach. Must include evidence that all facility contacts and contact information were included in the comminication plan to be reviewed annually. 2. To ensure 100% accuracy Kent Emerson, Coordinator of Emergency Management and Pete Svododa, Central Virginia Healthcare Coalition Medically, Vulnerable Population Coordinator, and Roger Fracker Assistant Administrator Heritage Hall, Blackstone will review Emergency Plan and check for accuracy and compliance with all State and Federal Emergency Preparedness guidelines. Ensure there is evidence that all facility contactsand contact information were included in the comminication plan to be reviewed annually. 3. Inservice will be given on the Emergency Plan upon hire and to all departments and their employees on 04/18/18 and annually thereafter.	

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E 030	Continued From page 24 *[For Hospices at §418.113(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Hospice employees. (ii) Entities providing services under arrangement. (iii) Patients' physicians. (iv) Other hospices. *[For OPOs at §486.360(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Volunteers. (iv) Other OPOs. (v) Transplant and donor hospitals in the OPO's Donation Service Area (DSA). This REQUIREMENT is not met as evidenced by: Based on staff interview and facility document review it was determined that the facility staff failed to have a complete emergency preparedness plan. The facility staff failed to evidence that all facility contacts and contact information were included in the communication plan and was reviewed annually. The findings include: On 03/09/18 at 9:15 a.m. a review and interview of the facility's emergency preparedness plan was conducted with ASM (administrative staff member) # 1, administrator. Review of the	E 030	4. QA will review quarterly and sign off on it as well as go over any emergencies that came up during the quarter. Completion date 04/23/18	

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E 030	Continued From page 25 facility's emergency preparedness plan failed to evidence that all facility contacts and contact information were included in the communication plan and was reviewed annually. ASM # 1 stated that the facility did not have it. We are still developing the emergency preparedness plan." On 03/09/18 at approximately 11:00 a.m. ASM (administrative staff member) # 1, administrator, and ASM # 2, director of nursing, were made aware of the findings. No further information was obtained prior to exit.	E 030		
E 032 SS=C	Primary/Alternate Means for Communication CFR(s): 483.73(c)(3) [(c) The [facility] 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: (3) Primary and alternate means for communicating with the following: (i) [Facility] staff. (ii) Federal, State, tribal, regional, and local emergency management agencies. *[For ICF/IIDs at §483.475(c):] (3) Primary and alternate means for communicating with the ICF/IID's staff, Federal, State, tribal, regional, and local emergency management agencies. This REQUIREMENT is not met as evidenced by: Based on staff interview and facility document review it was determined that the facility staff failed to have a complete emergency	E 032	1. Administrator will complete Emergency PreparenessPlan that meets Federal, State and local emergency Preparedness requirements utilizing an all hazards approach. Make certain communication plan includes primary and alternate means for communicating with facility, staff, federal, state tribal and local emergency management agencies. 2. To ensure 100% accuracy Kent Emerson, Coordinator of Emergency Management and Pete Svododa, Central Virginia Healthcare Coalition Medically, Vulnerable Population Coordinator, and Roger Fracker Assistant Administrator Heritage Hall, Blackstone will review Emergency Plan and check for accuracy and compliance with all State, Federal and Local Emergency Preparedness guidelines. Review complaince to make certain it includes primary and alternate means for communicating with facility, staff, federal, state tribal and local emergency management agencies.	

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E 032	Continued From page 26 preparedness plan. The facility staff failed to provide evidence of documentation that the communication plan includes primary and alternate means for communicating with facility staff, Federal, State, tribal, and local emergency management agencies by reviewing the communication plan. The findings include: On 03/09/18 at 9:15 a.m. a review and interview of the facility's emergency preparedness plan was conducted with ASM (administrative staff member) # 1, administrator. Review of the facility's emergency preparedness plan failed to evidence of documentation that the communication plan includes primary and alternate means for communicating with facility staff, Federal, State, tribal, and local emergency management agencies by reviewing the communication plan. ASM # 1 stated that the facility did not have it. We are still developing the emergency preparedness plan." On 03/09/18 at approximately 11:00 a.m. ASM (administrative staff member) # 1, administrator, and ASM # 2, director of nursing, were made aware of the findings. No further information was obtained prior to exit.	E 032	3. Inservice will be given on the Emergency Plan upon hire and to all departments and their employees on 04/18/18 and annually thereafter. 4. QA will review quarterly and sign off on it as well as go over any emergencies that came up during the quarter. Completion date 04/23/2018	
E 033 SS=C	Methods for Sharing Information CFR(s): 483.73(c)(4)-(6) [(c) The [facility] 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	E 033	1. Administrator will complete Emergency Prepareness Plan that meets Federal, State and local emergency Preparedness requirements utilizing an all hazards approach. Must contain documentation that the comminication plan includes a method for sharing information and medical documentation for patients under the facilitys care, as necessary, with other health providers to maintain	

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E 033	Continued From page 27 annually.] The communication plan must include all of the following: (4) A method for sharing information and medical documentation for patients under the [facility's] care, as necessary, with other health providers to maintain the continuity of care. (5) A means, in the event of an evacuation, to release patient information as permitted under 45 CFR 164.510(b)(1)(ii). [This provision is not required for HHAs under §484.22(c), CORFs under §485.68(c), and RHCs/FQHCs under §491.12(c).] (6) [(4) or (5)]A means of providing information about the general condition and location of patients under the [facility's] care as permitted under 45 CFR 164.510(b)(4). *[For RNHCIs at §403.748(c):] (4) A method for sharing information and care documentation for patients under the RNHCI's care, as necessary, with care providers to maintain the continuity of care, based on the written election statement made by the patient or his or her legal representative. *[For RHCs/FQHCs at §491.12(c):] (4) A means of providing information about the general condition and location of patients under the facility's care as permitted under 45 CFR 164.510(b)(4). This REQUIREMENT is not met as evidenced by: Based on staff interview and facility document review it was determined that the facility staff failed to have a complete emergency preparedness plan.	E 033	cont #1 the continuity of care by reviewing the comminication plan and documentation that the facility has developed policies and procedure that address the means the facility will use to release patient information to include the general conditions and location of patients by reviewing the communication plan. 2. To ensure 100% accuracy Kent Emerson, Coordinator of Emergency Management and Pete Svododa, Central Virginia Healthcare Coalition Medically, Vulnerable Population Coordinator, and Roger Fracker Assistant Administrator Heritage Hall, Blackstone will review Emergency Plan and check for accuracy and compliance with all State, Federal and Local Emergency Preparedness guidelines to make certain there is documentation the facility hass policies and procedures that address the means of facility will use to release patient information to include the general conditions and locationof patients by reviewing the communication plan.	

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E 033	Continued From page 28 The facility staff failed to provide evidence of documentation that the communication plan includes a method for sharing information and medical documentation for patients under the facility's care, as necessary, with other health providers to maintain the continuity of care by reviewing the communication plan and documentation that the facility has developed policies and procedures that address the means the facility will use to release patient information to include the general condition and location of patients by reviewing the communication plan. The findings include: On 03/09/18 at 9:15 a.m. a review and interview of the facility's emergency preparedness plan was conducted with ASM (administrative staff member) # 1, administrator. Review of the facility's emergency preparedness plan failed to evidence of documentation that the communication plan includes a method for sharing information and medical documentation for patients under the facility's care, as necessary, with other health providers to maintain the continuity of care by reviewing the communication plan and documentation that the facility has developed policies and procedures that address the means the facility will use to release patient information to include the general condition and location of patients by reviewing the communication plan. ASM # 1 stated that the facility did not have it. We are still developing the emergency preparedness plan." On 03/09/18 at approximately 11:00 a.m. ASM (administrative staff member) # 1, administrator, and ASM # 2, director of nursing, were made	E 033	3. Inservice will be given on the Emergency Plan upon hire and to all departments and their employees on 04/18/18 and annually thereafter. 4. QA will review quarterly and sign off on it as well as go over any emergencies that came up during the quarter. Completion Date 04/23/18	

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E 033	Continued From page 29 aware of the findings. No further information was obtained prior to exit.	E 033		
E 034 SS=C	Information on Occupancy/Needs CFR(s): 483.73(c)(7) [(c) The [facility] 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: (7) [(5) or (6)] A means of providing information about the [facility's] occupancy, needs, and its ability to provide assistance, to the authority having jurisdiction, the Incident Command Center, or designee. *[For ASCs at 416.54(c)]: (7) A means of providing information about the ASC's needs, and its ability to provide assistance, to the authority having jurisdiction, the Incident Command Center, or designee. *[For Inpatient Hospice at §418.113:] (7) A means of providing information about the hospice's inpatient occupancy, needs, and its ability to provide assistance, to the authority having jurisdiction, the Incident Command Center, or designee. This REQUIREMENT is not met as evidenced by: Based on staff interview and facility document review it was determined that the facility staff failed to have a complete emergency preparedness plan.	E 034	1. Administrator will complete Emergency PreparenessPlan that meets Federal, State and local emergency Preparedness requirements utilizing an all hazards approach. Will ensure the communication plan includes a means of providing information about the facilitys needs, and its ability to provide assistance to the authority having jursdiction the incident command center, or designee by reviewing the communication plan and documentation that the comminication plan includes a means of providing information about their occupancy. 2. To ensure 100% accuracy Kent Emerson, Coordinator of Emergency Management and Pete Svododa, Central Virginia Healthcare Coalition Medically, Vulnerable Population Coordinator, and Roger Fracker Assistant Administrator Heritage Hall, Blackstone will review Emergency Plan and check for accuracy and compliance with all State, Federal and Local Emergency Preparedness guidelines and ensure the comminication plan includes a means of providing information about the facilitys needs, and its ability to provide assistance to the authority having jursdiction the incident command center, or designee by reviewing the communication plan and documentation that the comminication plan includes a means of providing information about their occupancy.	

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

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E 034	Continued From page 30 The facility staff failed to provide evidence of documentation that the communication plan includes a means of providing information about the facility's needs, and its ability to provide assistance, to the authority having jurisdiction, the incident Command Center, or designee by reviewing the communication plan and documentation that the communication plan includes a means of providing information about their occupancy. The findings include: On 03/09/18 at 9:15 a.m. a review and interview of the facility's emergency preparedness plan was conducted with ASM (administrative staff member) # 1, administrator. Review of the facility's emergency preparedness plan failed to evidence of documentation that the communication plan includes a means of providing information about the facility's needs, and its ability to provide assistance, to the authority having jurisdiction, the incident Command Center, or designee by reviewing the communication plan. In addition, the facility's emergency preparedness plan failed to evidence documentation that the communication plan includes a means of providing information about their occupancy. ASM # 1 stated that the facility did not have it. We are still developing the emergency preparedness plan." On 03/09/18 at approximately 11:00 a.m. ASM (administrative staff member) # 1, administrator, and ASM # 2, director of nursing, were made aware of the findings. No further information was obtained prior to exit.	E 034	3. Inservice will be given on the Emergency Plan upon hire and to all departments and their employees on 04/18/18 and annually thereafter. 4. QA will review quarterly and sign off on it as well as go over any emergencies that came up during the quarter. Completion date 04/23/18	

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E 035 SS=C	Continued From page 31 LTC and ICF/IID Sharing Plan with Patients CFR(s): 483.73(c)(8) [(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 that the facility staff failed to have a complete emergency preparedness plan. The facility staff failed to provide evidence of documentation that the communication plan includes a method for sharing information from the emergency plan, and that the facility has determined it is appropriate with residents or clients and their families or representatives by reviewing the plan. The findings include: On 03/09/18 at 9:15 a.m. a review and interview of the facility's emergency preparedness plan was conducted with ASM (administrative staff member) # 1, administrator. Review of the facility's emergency preparedness plan failed to evidence of documentation that the communication plan includes a method for sharing information from the emergency plan,	E 035 E 035	1. Administrator will complete Emergency PreparenessPlan that meets Federal, State and local emergency Preparedness requirements utilizing an all hazards approach must include evidence of documentation that the comminication plan includes a method for sharing information from the emergency plan, and that the facility has determined it is appropriate with resident and their families or representative by reviewing the plan. 2. To ensure 100% accuracy Kent Emerson, Coordinator of Emergency Management and Pete Svododa, Central Virginia Healthcare Coalition Medically, Vulnerable Population Coordinator, and Roger Fracker Assistant Administrator Heritage Hall, Blackstone will review Emergency Plan and check for accuracy and compliance with all State and Federal Emergency Preparedness guidelines. Also ensure plan includes evidence of documentation that the comminication plan includes a method for sharing information from the emergency plan, and that the facility has determined it is appropriate with resident and their families or representative by receiving the plan. 3. Inservice will be given on the Emergency Plan upon hire and to all departments and their employees on 04/18/18 and annually thereafter. Letter to families regarding emergency prepardness and where they can find it. 4. QA will review quarterly and sign off on it as well as go over any emergencies that came up during the quarter. Completion date 04/23/18	

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E 035	Continued From page 32 and that the facility has determined it is appropriate with residents or clients and their families or representatives by reviewing the plan. ASM # 1 stated that the facility did not have it. We are still developing the emergency preparedness plan." On 03/09/18 at approximately 11:00 a.m. ASM (administrative staff member) # 1, administrator, and ASM # 2, director of nursing, were made aware of the findings. No further information was obtained prior to exit.	E 035		
E 039 SS=C	EP Testing Requirements CFR(s): 483.73(d)(2) (2) Testing. The [facility, except for LTC facilities, RNHCIs and OPOs] must conduct exercises to test the emergency plan at least annually. The [facility, except for RNHCIs and OPOs] must do all of the following: *[For LTC Facilities at §483.73(d):] (2) Testing. The LTC facility must conduct exercises to test the emergency plan at least annually, including unannounced staff drills using the emergency procedures. The LTC facility must do all of the following:] (i) Participate in a full-scale exercise that is community-based or when a community-based exercise is not accessible, an individual, facility-based. If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in a community-based or individual, facility-based full-scale exercise for 1 year following the onset of	E 039	1. Administrator will complete Emergency PreparenessPlan that meets Federal, State and local emergency Preparedness requirements utilizing an all hazards approach. Plan must include evidence of documentation of the facilitys exercise analysis and response and how the facililty updated its emergency program based on exercise analysis. 2. To ensure 100% accuracy Kent Emerson, Coordinator of Emergency Management and Pete Svododa, Central Virginia Healthcare Coalition Medically, Vulnerable Population Coordinator, and Roger Fracker Assistant Administrator Heritage Hall, Blackstone will review Emergency Plan and check for accuracy and compliance with all State, Federal and Local Emergency Preparedness guidelines. Check for evidence of documentation of the facilitys exercise analysis and response and how the facililty updated its emergency program based on exercise analysis.	

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E 039	Continued From page 33 the actual event. (ii) Conduct an additional exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, facility-based. (B) A tabletop exercise that includes a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed. *[For RNHCIs at §403.748 and OPOs at §486.360] (d)(2) Testing. The [RNHCI and OPO] must conduct exercises to test the emergency plan. The [RNHCI and OPO] must do the following: (i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group discussion led by a facilitator, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (ii) Analyze the [RNHCI's and OPO's] response to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCI's and OPO's] emergency plan, as needed. This REQUIREMENT is not met as evidenced by: Based on staff interview and facility document review it was determined that the facility staff failed to have a complete emergency preparedness plan.	E 039	3. Inservice will be given on the Emergency Plan upon hire and to all departments and their employees on 04/18/18 and annually thereafter. 4. QA will review quarterly and sign off on it as well as go over any emergencies that came up during the quarter. Completion date 04/23/18	

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	495358	A. BUILDING _____ B. WING _____	03/09/2018

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E 039	Continued From page 34 The facility staff failed to provide evidence of documentation of the facility's exercise analysis and response and how the facility updated its emergency program based on the exercise analysis. The findings include: On 03/09/18 at 9:15 a.m. a review and interview of the facility's emergency preparedness plan was conducted with ASM (administrative staff member) # 1, administrator. Review of the facility's emergency preparedness plan failed to evidence of documentation of the facility's exercise analysis and response and how the facility updated its emergency program based on the exercise analysis. ASM # 1 stated that the facility did not have it. We are still developing the emergency preparedness plan." On 03/09/18 at approximately 11:00 a.m. ASM (administrative staff member) # 1, administrator, and ASM # 2, director of nursing, were made aware of the findings. No further information was obtained prior to exit.	E 039		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted from 03/06/18 through 03/09/18. Corrections are required for compliance with the following 42 CFR Part 483 of the Federal Long Term Care requirements. The life safety code survey/report will follow. The census at this 100 certified bed facility was 85 at the time of the survey. The survey sample	F 000		

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F 000	Continued From page 35 consisted of 18 current residents Resident #s (56, 9, 33, 61, 41, 8, 31, 25, 70, 72, 6, 63,19,76,137,15,50,10) and two closed records, Residents #s (88 and 87).	F 000		
F 583 SS=D	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and	F 583	corrective action RN # 1 apologized to resident # 25 on 3/14/2018 for doing his treatment without closing window blinds. CNA #4 apologized to resident # 15 on 3/15/2018 for providing care without closing the window blinds. Other potential Any resident residing on the same unit as residents # 25 and 15 could have been at risk for receiving care or treatments without closing t he window blinds. System Changes 1. Clinical staff is being educated on resident privacy regarding closing the window treatments (blinds or curtains), closing the room door, pulling privacy curtain around resident and between resident and roommate during care and treatments 2. During rounds, the clinical leadership team, social worker, and administrator will observe to validate privacy is being respected during care and treatments, with attention to the window treatments (blinds or curtains).	

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

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F 583	Continued From page 36 administrative records in accordance with State law. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, facility document review, clinical record review, it was determined the facility staff failed to provide privacy during care for two of 20 residents in the survey sample, Residents # 15 and # 25. 1. The facility staff failed to close the window blinds while preparing and transferring Resident # 25 for a shower and during wound care. 2. The facility staff failed to close the window blinds while providing a bed bath to Resident # 15. The findings include: 1. The facility staff failed to close the window blinds while preparing and transferring Resident # 25 for a shower, and during wound care. Resident # 25 was admitted to the facility on 11/30/2017 with diagnoses that included but were not limited to malignant neoplasm of prostate (1) with mets [metastasis] (2) to the spine and spinal stenosis (3). Resident # 25's most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 12/07/17, coded Resident # 25 as scoring a 15 on the brief interview for mental status (BIMS) of a score of 0 - 15, 15 being cognitively intact for making daily decisions. Resident # 25 was coded as requiring limited assistance to being totally dependent of	F 583	3. 1:1 education will be provided to staff persons who are observed to be non-compliant with closing window blinds during care and treatments. 4. During resident council meetings, the Activities Director will ask residents if the window blinds or curtains are being closed during care and treatments. Any negative responses/concernsregarding the closure of window curtains for care will be relayed to the Director of Nursing for intervention with staff persons. Monitoring 1. A report of areas of non-compliance will be submitted to the Director of Nursing for analysis for trends. A report of areas of non-compliance will be submitted during the quarterly QAPI committee meeting for discussion and further recommendations. Completion Date 04/23/18	

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F 583	Continued From page 37	F 583		

one to two staff members for dressing, toileting, personal hygiene and bathing.

On 03/07/18 at approximately 11:05 a.m., three CNA's (certified nursing assistants) entered Resident # 25's room to transfer Resident # 25 to a shower chair. The CNAs closed the door to the room and pulled the privacy curtain dividing the A and B-side of the room. Resident # 25's bed was on the B-side of the room next to the window. The window looked on to the facility's parking lot and had blinds. Further observation of the blinds revealed they were raised and open. Resident # 25 was observed wearing a hospital gown with the back of the gown open exposing Resident # 25's backside. When the CNAs assisted Resident # 25, from the bed, his back was facing the window, the hospital gown was open exposing Resident # 25's backside to the window and potentially visible to anyone that may be outside the opened window.

On 3/7/18 at 11:28 a.m., a wound care observation was conducted for Resident #25 with RN (registered nurse) # 1 and CNA # 4. Once preparations for wound care was completed and set up, RN # 1 and CNA # 4 approached Resident #25's bedside. The door to the room was closed and the curtain between the door bed and window bed (Resident #25's bed) was pulled. The window blinds were noted to be approximately 1/3 of the way pulled up (open), and the yard and parking lot was visible from Resident #25's bed. CNA # 4 turned the resident onto his side for wound care by the nurse. The resident was positioned onto his left side, so that the front of his body was facing the open window. His hospital gown was pulled up and he was bare from the waist down. His penis was exposed and

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F 583	Continued From page 38 potentially visible to anyone that may be outside the opened window. The resident remained in this position from 11:37 a.m., to 12:22 p.m. . On 03/07/18 at 2:59 p.m., an interview was conducted with CNA # 4. When asked if she assisted with Resident # 25's wound care CNA # 4 stated yes. When asked about privacy during the wound care CNA # 4 stated, "The door was closed and the privacy curtain was pulled around the bed." When asked if the window blinds were closed during wound care, CNA # 4 stated, "No." On 03/07/18 at 1:43 p.m., an interview was conducted with RN (registered nurse) # 1, unit manager. When asked to describe the process followed for providing privacy during personal care and treatments, RN # 1 stated, "You need to pull the privacy curtain around the bed of the resident you are providing care to and shut the door. If the roommate in present at the time of care make sure, the roommate does not invade the other resident's privacy. When informed of the observation of the window blinds being open during the wound care and transfer care provided to Resident # 25, RN #1 stated, "Blinds should have been closed." On 03/08/18 at 9:20 a.m., an observation of Resident # 25 revealed he appeared clean and neat lying in bed. When asked about the window blinds being open during his transfer and wound care on 03/07/18, Resident# 25, "I don't know." Observation of Resident # 25's room revealed the window blind lowered, covering the window and closed. When asked if he preferred to have the window blinds open or closed Resident # 25 did not give a specific answer.	F 583		

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On 03/08/18 at approximately 9:30 a.m., an interview with was conducted with LPN (licensed practical nurse) # 1 regarding the cognitive ability of Resident # 25. LPN # 1 stated, "He is not always oriented. He has periods of confusion."

On 03/08/18 at 9:53 a.m., an interview was conducted with CNA # 2. When asked to describe how privacy is provided during a resident's care or transfer for preparation for a bath or shower, CNA # 2 stated, "Doors are closed and the privacy curtain is pulled." When asked if she assisted Resident # 25 into a shower chair with two other CNAs, CNA # 2 stated, "Yes." When asked if Resident # 25 was wearing a hospital gown and if the back of the gown was open, CNA # 2 stated, "Yes". When asked if she recalled the position of the blinds at the time of transfer, CNA # 2 stated, "No. We should have all checked the window to make sure the blinds were closed. It didn't even cross my mind to look at the window; I focused on helping with the transfer."

On 03/08/18 at 10:03 a.m., an interview was conducted with CNA #1 regarding privacy. When asked to describe how privacy is provided during a resident's care or transfer for preparation for a bath or shower, CNA # 1 stated, "Pull the curtain, and closed the door to the room and close the window blinds. When asked about closing the window blinds in Resident # 25's room during his transfer in his room, CNA # 1 stated, "(Resident # 25) has told me in the past that he doesn't want his blinds closed." When asked if Resident # 25's preference for not having the blinds closed was documented somewhere, CNA # 1 state, "No it is just word of mouth." When informed of the observation this morning of Resident # 25's

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F 583	Continued From page 40	F 583		

window blinds being closed and no concerns expressed by the Resident #25 regarding his window blinds, CNA # 1 stated, "I don't know."

The facility's policy "Resident's Rights" documented, "4. Privacy. C. To have privacy when care or medical treatment is being provided."

On 03/08/18 at approximately 5:00 p.m. ASM (administrative staff member) # 1, the administrator and ASM # 2, director of nursing were made aware of the findings.

No further information was provided prior to exit.

References:

(1) Prostate cancer is cancer that starts in the prostate gland. The prostate is a small, walnut-shaped structure that makes up part of a man's reproductive system. It wraps around the urethra, the tube that carries urine out of the body. This information was obtained from the website: https://medlineplus.gov/ency/article/000380.htm.

(2) To spread to other parts of the body by way of the blood or lymphatic vessels or membranous surfaces. This information was obtained from the website: http://www.dictionary.com/browse/metastasise

(3) A narrowing of the spinal column that causes pressure on the spinal cord, or narrowing of the openings (called neural foramina) where spinal nerves leave the spinal column. This information was obtained from the website: https://medlineplus.gov/ency/article/000441.htm.

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2. The facility staff failed to close the window blinds while providing a bed bath to Resident # 15.

Resident # 15 was admitted to the facility on 03/13/2014 with a readmission of 03/01/2017 with diagnoses that included but were not limited to cerebral infarction (1), chronic kidney disease (2), hypertension (3) dysphagia (4) and heart disease.

Resident # 15's most recent MDS (minimum data set), an annual assessment with an ARD (assessment reference date) of 12/13/17, coded Resident # 15 as scoring a 3 (three) on the brief interview for mental status (BIMS) of a score of 0 (zero) - 15, 3 (three) being severely impaired of cognition for making daily decisions. Resident # 15 was coded as being totally dependent of one to two staff members for activities of daily living.

An observation of Resident # 15's personal care was conducted on 03/07/18 at 10:34 a.m. Resident # 15 resided on B-side of the room with a window to the outside next to his bed. CNA (certified nursing assistant) # 4 was present in Resident # 15's room providing a bed bath to Resident # 15. Resident # 15's door was closed and bed curtain was pulled closed, to separate the A and B-sides of the room. The blinds on Resident # 15's window on the B-side of the room were left open during Resident # 15's bed bath. Resident # 15's window looked out onto the facility's parking lot and front entrance to the facility. At approximately 10:53 a.m. the unit manager RN (registered nurse) #9, the unit manager entered Resident # 15's room, went to the B-side of the room and asked CNA # 4 if she

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needed assistance, she then left the room while Resident # 15 was still being dressed.

On 03/07/18 at 2:59 p.m., an interview was conducted with CNA # 4 regarding the personal care provided to Resident # 15. CNA # 4 stated she provided a complete bed bath, mouth care and changed Resident # 15's clothes and dressed him. When asked to describe the process of providing privacy during personal care, CNA # 4 stated, "Knock on the resident's door, tell them what I'm going to do, pulled the privacy curtain, and close the door. Then proceed with ADL (activities of daily living) care." When asked if privacy was provided for Resident # 15 during his personal care, CNA #4 stated, "Yes." When informed of the observation of the window blinds being open during the care she provided to Resident # 15, CNA # 4 stated, "I forgot about the blinds. They should be closed during care."

On 03/07/18 at 1:43 p.m. an interview with RN (registered nurse) # 1, unit manager. When asked to describe the process for providing privacy during personal care, RN # 1 stated, "You need to pull the privacy curtain around the bed of the resident you are providing care to and shut the door. If the roommate in present at the time of care make sure, the roommate does not invade the other resident's privacy. When informed of the observation of the window blinds being open during the care provided by CNA # 4 to Resident # 15, RN #1 stated, "Blinds should have been closed. It didn't even cross my mind to check the window."

On 03/08/18 at approximately 5:00 p.m. ASM (administrative staff member) # 1, the administrator and ASM # 2, director of nursing

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F 583	Continued From page 43 were made aware of the findings. No further information was provided prior to exit.	F 583		
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 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	F 622	1.corrective action Resident #63 was transferred to hospital on 1/18/2018 per physician order due to a change in the resident's condition and required extensive hospitalization and treatment that could not be provided by the nursing facility. Resident did not experience negative outcome related to the lack of physician documentation justifying the hospital transfer. Resident #56 was transferred to the hospital ER on 12/30/17 per physician order due to a change in the resident's condition. Resident experienced no negative outcome related to lack of physician documentation justifying hospital transfer. 2.other potential Any resident residing in facility, who has been transferred to hospital ER for evaluation or admission could have been affected by the lack of documentation justifying the transfer to acute care setting. 3.Systemic Changes • Physician and non-physician practitioners will be educated on the importance of documenting reason for transfer to the acute care setting in the medical record and/or including reason f or transfer in their orders.	

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F 622	Continued From page 44 § 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 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	F 622	Licensed nurses will be educated on documentation of assessment of resident condition and communication to the provider. If a verbal order is obtained to transfer the resident to an acute care setting in the absence of the physician being on-site at the nursing facility, the physician order will include the reason for transfer to the acute care setting. 4.Monitoring • DON or designee will audit clinical records of residents who transferred to hospital to validate documentation of assessment supporting the reason for transfer as well as presence of a physician order or documentation stating reason for resident transfer to acute care setting. • DON or designee will submit a report of areas of non-compliance in the quarterly QAPI committee meeting for discussion and further recommendations. completion date 4/19/18	

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F 622	Continued From page 45 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 that the facility staff failed to ensure documentation by the physician in the clinical record provide when two of 20 residents in the survey sample; Residents #63 and #56, were transferred to the hospital. 1. Resident #63 was transferred and admitted to the hospital on 1/18/18. There were no physician notes documented in the clinical record justifying the reason the facility was not able to manage the resident's condition, and why Resident #63 required transfer to the hospital. 2. The facility staff failed to provide written documentation from the physician evidencing the specific needs the facility could not meet, facility's efforts to meet the those needs and the specific needs the receiving facility could provide to meet the needs of Resident # 56 for a facility initiated transfer to the hospital on 12/30/2017. The findings include:	F 622		

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F 622	Continued From page 46	F 622		

1. Resident #63 was transferred and admitted to the hospital on 1/18/18. There were no physician notes documented in the clinical record justifying the reason the facility was not able to manage the resident's condition, and why Resident #63 required transfer to the hospital.

Resident #63 was admitted to the facility on 6/9/08 and readmitted on 2/7/18, with the diagnoses of but not limited to traumatic brain hemorrhage, renal dialysis, genitourinary surgery, diabetes, benign prostatic hyperplasia, dysphagia, hemiplegia, cerebrovascular disease, hepatitis C, obesity, postconcussional syndrome, and high blood pressure. The most recent MDS (Minimum Data Set) was a readmission 5-day assessment with an ARD (Assessment Reference Date) of 2/28/18. The resident was coded as being severely cognitively impaired in ability to make daily life decisions and as requiring total care for all areas of activities of daily living.

A review of the clinical record revealed that on 1/18/18 Resident #63 was transferred to the hospital. The following notes were identified in the clinical record for 1/18/18:

1/18/18 at 12:21 AM, "Resident noted to be very warm to the touch, his cheeks are noted to be red and flushed. VS'S (vital signs) 101 (temperature) 97 (pulse) 18 (respirations) 135/82 (blood pressure) o2 sats (saturation) (level of oxygen in the blood) 96% on room air. Resident was adm. (administered) Tylenol [1] 360 mg (milligrams) at 0015 (12:15 AM). Will re-check temp. (temperature) in 30 mins (minutes)."

1/18/18 1:16 AM, "Resident temp (temperature)

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noted to be 102 orally. Cold compresses under arms and forehead."

1/18/18 4:26 AM, "Resident's temp rechecked at 0410 (4:10 AM). Resident continues with a fever of 102 agein [sic] he was packed under arms and forehead with cold compresses. Tylenol 650 mg adm. (administered) Resident lungs sounds with audible wheezing mainly in right lobe."

1/18/18 10:35 AM, "10:35 am: Discharge note: Resident D/C (discharged) to (hospital) and was admitted. Bed is not being held. Will follow up with hospital regarding return."

1/18/18 10:35 AM, "Resident sent to (hospital) via EMS. S/S (signs and symptoms) continuous elevated fever of 102, SOB (Shortness of Breath), labored breathing, bilateral wheezing noted. RP (responsible party) notified. Will contact hospital for follow up information."

A physician's order dated 1/18/18 at 9:16 a.m., documented, "Send resident to (hospital) ER for eval (evaluation). RE: Increased temp / Labored breathing / Abnormal lung sounds."

A review of the physician's notes revealed one dated 1/10/18, as the most recent prior to the hospitalization on 1/18/18, and one on 2/9/18, 2 days after readmission, which did not document anything relating to the resident's hospitalization and why he was hospitalized.

On 3/8/18 at 4:01 p.m., in an interview with ASM #3 (Administrative Staff Member, the physician), she stated the process for sending a resident to the hospital is, if it is during the day and she in in the facility, she evaluates the resident. If it is

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F 622	Continued From page 48 after hours, the facility calls the on-call physician, the nurse will describe the signs and symptoms and the physician will make a determination. When asked about the physician documenting the rationale for sending the resident to the hospital, she stated if they are seen by the physician, they will document it. Otherwise, the physician does not usually document anything; the nurses documents about the resident going to the hospital. A review of the facility policy, "Emergency Transfer to Acute Care Hospital" did not document the requirement that they physician specifically needs to document in the clinical record the rationale for transfer and why the facility was not able to manage the resident's condition. On 3/8/18 at 5:09 p.m., the Administrator (ASM [administrative staff member] #1) and Director of Nursing, ASM #2, was made aware of the findings. No further information was provided by the end of the survey. [1] Tylenol is used to relieve mild to moderate pain....and to reduce fever.... Information obtained from https://medlineplus.gov/druginfo/meds/a681004.html [1] Tylenol is used to relieve mild to moderate pain....and to reduce fever.... Information obtained from https://medlineplus.gov/druginfo/meds/a681004.html References: (1) A stroke. When blood flow to a part of the	F 622		

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brain stops. A stroke is sometimes called a "brain attack." If blood flow is cut off for longer than a few seconds, the brain cannot get nutrients and oxygen. Brain cells can die, causing lasting damage. This information was obtained from the website: https://medlineplus.gov/ency/article/000726.htm .

(2) Kidneys are damaged and can't filter blood as they should. This information was obtained from the website: https://medlineplus.gov/chronickidneydisease.html.

(3) High blood pressure. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/highbloodpressure.html.

(4) A swallowing disorder. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/swallowingdisorders.html.

2. The facility staff failed to provide written documentation from the physician evidencing the specific needs the facility could not meet, facility's efforts to meet the those needs and the specific needs the receiving facility could provide to meet the needs of Resident # 56 for a facility initiated transfer to the hospital on 12/30/2017.

Resident # 56 was admitted to the facility on 11/05/2011 and a readmitted on 12/30/17 with diagnoses that included but were not limited to convulsions (1), diabetes mellitus (2) and dyspepsia (3).

Resident # 56's most recent MDS (minimum data

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F 622	Continued From page 50 set), an annual assessment with an ARD (assessment reference date) of 02/09/18, coded Resident # 56 as scoring a 10 on the brief interview for mental status (BIMS) of a score of 0 (zero) - 15, 10 being mildly impaired of cognition for making daily decisions. Resident # 56 was coded as requiring limited assistance to extensive assistance of one staff member for activities for ADLs (activities of daily living). The nurse's "Progress Notes," dated 12/30/2017 for Resident # 56 documented, "9:54 p.m. Resident was noted to have low grade temp (temperature), Tylenol was administered with no effect, c/o (complaint of) abdominal pain, supervisor notified and further assessed, MD (medical doctor) notified and resident sent to (Name of Hospital) to evaluate." Review of the physician's progress notes dated 12/01/17 through 01/24/18 failed to evidence documentation of the specific needs the facility could not meet, facility's efforts to meet the those needs and the specific needs the receiving facility could provide to meet the needs of Resident # 56. On 3/8/18 at 4:01 p.m., in a telephone interview with ASM (Administrative Staff Member) #3, the physician she stated the process for sending a resident to the hospital is, if it is during the day and she in in the facility, she evaluates the resident. If it is after hours, the facility calls the on-call physician, the nurse will describe the signs and symptoms and the physician will make a determination. When asked about the physician documenting the rationale for sending the resident to the hospital, she stated if they were seen by the physician, they would document it.	F 622		

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F 622	Continued From page 51 Otherwise, the physician does not usually document anything; that the nurses documents about the resident going to the hospital. On 03/08/18 at approximately 5:00 p.m. ASM (administrative staff member) # 1, the administrator and ASM # 2, director of nursing were made aware of the findings. No further information was provided prior to exit. References: (1) The term "seizure" is often used interchangeably with "convulsion." A seizure is the physical findings or changes in behavior that occur after an episode of abnormal electrical activity in the brain. This information was obtained from the website: https://medlineplus.gov/ency/article/003200.htm. (2) A chronic disease in which the body cannot regulate the amount of sugar in the blood. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/ency/article/001214.htm. (3) Indigestion (dyspepsia) is a mild discomfort in the upper belly or abdomen. It occurs during or right after eating. It may feel like: Heat, burning, or pain in the area between the navel and the lower part of the breastbone; Unpleasant fullness that comes on soon after a meal begins or when the meal is over. This information was obtained from the website: https://medlineplus.gov/ency/article/003260.htm.	F 622		
F 623 SS=D	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8)	F 623	The facility social workers will be educated on the requirements for written notification of transfers and discharges.	

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F 623	Continued From page 52 §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would 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	F 623	The facility Social Worker will contact the resident representative for resident #56 and apologize for not sending a written notification of the transfer to hospital on 12/30/17. The facility Social Worker will contact the resident representative for resident #63 on 1/18/18. Resident was diagnosed at hospital with a neutropenic fever and eventually diagnosed as sepsis requiring short term t reatment with dialysis. Social worker will talk with resident representative and apologize f or not sending the transfer letter. Other potential Any resident who may have been transferred to the ER/hospital may be at risk for written notification not being sent to the resident representative. System Changes 1. Social Workers will be educated on the requirements to send a written notification regarding the resident transfer to the resident r epresentative. 2. Social Worker will send the written notification of trasfer to resident representative as soon as possible (the day of admission or the day after an overnight transfer) after the transfer. When a resident is transferred to the hospital on a Friday or through the weekend, the letter will be sent on the following Monday. 3. Social Worker will document in progress notes when the letter is sent to the resident representative.	

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F 623	Continued From page 53 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to	F 623	Monitoring 1. QA Director will complete audit each month to validate letters were sent to representative of each resident who was sent to the hospital. A report of areas of non-compliance will be discussed in the quarterly QAPI committee meeting for discussion and further recommendations. Completion date 4/19/18	

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F 623	Continued From page 54 effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review, and facility document review, it was determined that facility staff failed to provide the required written notification to the resident representative prior to a facility-initiated transfer to the hospital, for two of 20 residents in the survey sample, Residents #63 and #56. 1. The facility staff failed to provide written documentation evidencing the resident representative (RR) was notified in writing, when Resident #63 was transferred to the hospital on 1/18/18. 2. The facility staff failed to provide written documentation evidencing Resident # 56's RP (responsible party) was notified in writing when Resident # 56 was transferred to the hospital on 12/30/17. The findings include:	F 623		

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1. The facility staff failed to provide written documentation evidencing the resident representative (RR) was notified in writing, when Resident #63 was transferred to the hospital on 1/18/18.

Resident #63 was admitted to the facility on 6/9/08 and readmitted on 2/7/18, with the diagnoses of but not limited to traumatic brain hemorrhage, renal dialysis, genitourinary surgery, diabetes, benign prostatic hyperplasia, dysphagia, hemiplegia, cerebrovascular disease, hepatitis C, obesity, postconcussioanl syndrome, and high blood pressure. The most recent MDS (Minimum Data Set) was a readmission 5-day assessment with an ARD (Assessment Reference Date) of 2/28/18. The resident was coded as being severely cognitively impaired in ability to make daily life decisions and as requiring total care for all areas of activities of daily living.

A review of the clinical record revealed that on 1/18/18 Resident #63 was transferred to the hospital. The following notes were identified in the clinical record for 1/18/18:

1/18/18 at 12:21AM, "Resident noted to be very warm to the touch, his cheeks are noted to be red and flushed. VS'S (vital signs) 101 (temperature) 97 (pulse) 18 (respirations) 135/82 (blood pressure) o2 sats (saturation) (level of oxygen in the blood) 96% on room air. Resident was adm. (administered) Tylenol [1] 360mg (milligrams) at 0015 (12:15 AM). Will re-check temp. (temperature) in 30 mins (minutes)."

1/18/18 1:16 AM, "Resident temp (temperature) noted to be 102 orally. Cold compresses under

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F 623	Continued From page 56 arms and forehead." 1/18/18 4:26 AM, "Resident's temp rechecked at 0410 (4:10 AM). Resident continues with a fever of 102 agein [sic] he was packed under arms and forehead with cold compresses. Tylenol 650 mg adm. (administered) Resident lungs sounds with audible wheezing mainly in right lobe." 1/18/18 10:35 AM, "10:35 am: Discharge note: Resident D/C (discharged) to (hospital) and was admitted. Bed is not being held. Will follow up with hospital regarding return." 1/18/18 10:35 AM, "Resident sent to (hospital) via EMS. S/S (signs and symptoms) continuous elevated fever of 102, SOB (Shortness of Breath), labored breathing, bilateral wheezing noted. RP (responsible party) notified. Will contact hospital for follow up information." A physician's order dated 1/18/18 at 9:1., documented, "Send resident to (hospital) ER for eval (evaluation). RE: Increased temp / Labored breathing / Abnormal lung sounds." On 3/8/18 at 2:31 p.m., in an interview with OSM #6 (Other Staff Member, the Admissions/Social Services staff member), regarding the requirement for written notification to the resident representative of a resident being hospitalized and why the resident was hospitalized, she stated, "I can tell you now, I don't have that." A review of the facility policy, "Emergency Transfer to Acute Care Hospital" did not document the requirement that the facility must provide written notification to the responsible party about the hospitalization.	F 623		

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F 623	Continued From page 57 On 3/8/18 at 5:09 p.m., the Administrator (ASM [administrative staff member] #1) and Director of Nursing, ASM #2, was made aware of the findings. No further information was provided by the end of the survey. [1] Tylenol is used to relieve mild to moderate pain....and to reduce fever.... Information obtained from https://medlineplus.gov/druginfo/meds/a681004.html [1] Tylenol is used to relieve mild to moderate pain....and to reduce fever.... Information obtained from https://medlineplus.gov/druginfo/meds/a681004.html 2. The facility staff failed to provide written documentation evidencing Resident # 56's RP (responsible party) was notified in writing when Resident # 56 was transferred to the hospital on 12/30/17. Resident # 56 was admitted to the facility on 11/05/2011 and a readmitted to the facility on 12/30/17 with diagnoses that included but were not limited to convulsions (1), diabetes mellitus (2) and dyspepsia (3). Resident # 56's most recent MDS (minimum data set), an annual assessment with an ARD (assessment reference date) of 02/09/18, coded Resident # 56 as scoring a 10 on the brief interview for mental status (BIMS) of a score of 0 (zero) - 15, 10 being mildly impaired of cognition for making daily decisions. Resident # 56 was coded as requiring limited assistance to extensive	F 623		

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F 623	Continued From page 58	F 623		

assistance of one staff member for activities for ADLs (activities of daily living).

The nurse's "Progress Notes," dated 12/30/2017 for Resident # 56 documented, "9:54 p.m. Resident was noted to have low grade temp (temperature), Tylenol was administered with no effect, c/o (complaint of) abdominal pain, supervisor notified and further assessed, MD (medical doctor) notified and resident sent to (Name of Hospital) to evaluate."

Review of the clinical record for Resident # 56 failed to evidence written notification to Resident # 56's family or RP (responsible party) of the facility initiated transfer to the hospital on 12/30/2017.

On 3/8/18 at 2:31 p.m.,, in an interview with OSM #6 (Other Staff Member, the Admissions/Social Services staff member), regarding the requirement for written notification to the resident representative of a resident being hospitalized and why the resident was hospitalized, she stated, "I can tell you now, I don't have that."

On 3/8/18 at 5:00 p.m., the Administrator (ASM [administrative staff member] #1) and Director of Nursing, ASM #2, was made aware of the findings. No further information was provided by the end of the survey.

[1] Tylenol is used to relieve mild to moderate pain....and to reduce fever....
Information obtained from https://medlineplus.gov/druginfo/meds/a681004.html

No further information was provided prior to exit.

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F 623	Continued From page 59 References: (1) The term "seizure" is often used interchangeably with "convulsion." A seizure is the physical findings or changes in behavior that occur after an episode of abnormal electrical activity in the brain. This information was obtained from the website: https://medlineplus.gov/ency/article/003200.htm. (2) A chronic disease in which the body cannot regulate the amount of sugar in the blood. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/ency/article/001214.htm. (3) Indigestion (dyspepsia) is a mild discomfort in the upper belly or abdomen. It occurs during or right after eating. It may feel like: Heat, burning, or pain in the area between the navel and the lower part of the breastbone; Unpleasant fullness that comes on soon after a meal begins or when the meal is over. This information was obtained from the website: https://medlineplus.gov/ency/article/003260.htm.	F 623		
F 625 SS=D	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to	F 625	Corrective Action Resident #63 did not hold his bed when he went to hospital on 1/18/18. When he returned from hospital on 02/07/18, he was readmitted to the same bed in which he previously resided. Resident # 56 was transferred to the emergency room on 12/30/17. Resident did return to facility without being admitted to the hospital. Resident experienced no negative outcome related to resident and resident representative not receiving a copy of the bed hold policy at the time of resident transfer to the emergency room;	

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F 625	Continued From page 60 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, clinical record review and facility document review, it was determined that the facility staff failed to provide a written bed hold policy/notification to the resident and/or resident representative, within 24 hours of a transfer to the hospital for one of 20 residents in the survey sample; Resident #63. The facility staff failed to provide a written bed hold policy/notification to Resident #63 and/or resident representative, within 24 hours of a transfer and admission to the hospital on 1/18/18. The findings include: Resident #63 was admitted to the facility on 6/9/08 and readmitted on 2/7/18, with the diagnoses of but not limited to traumatic brain	F 625	Other Potential Any resident transferred to hospital was at risk of not receiving the bed hold policy/form at the time of transfer. System Changes 1. The Notice of Bed Hold Policy/Form was reviewed and revised on 3/22/18. 2. When a resident is being sent to the emergency room/hospital, the nurse will inform the resident of the bed hold policy and that a copy of the form is being sent to the emergency room with him/her. 3. At the time the resident representative is notified of the transfer by the nurse, the nurse will notify him/her of the bed hold policy being sent to emergency room with resident. If the transfer is during regular business hours, the social worker will notify the resident and t he resident representative of the bed hold form/policy. 4. Nurses will be educated on the bed hold policy and their role in sending the form, notification and documentation. 5. Social Worker/admission staff will send a printed copy of the bed hold agreement to resident representative along with the written notice of transfer. Monitoring The ADON/QA nurse will audit records of residents sent to ER to validate the documentation of notification of bed hold and policy/form being sent with resident to the hospital. The DON will be notified of areas of non-compliance for follow up and 1:1 education with the involved nurse(s).	

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F 625	Continued From page 61 hemorrhage, renal dialysis, genitourinary surgery, diabetes, benign prostatic hyperplasia, dysphagia, hemiplegia, cerebrovascular disease, hepatitis C, obesity, postconcussioanl syndrome, and high blood pressure. The most recent MDS (Minimum Data Set) was a readmission 5-day assessment with an ARD (Assessment Reference Date) of 2/28/18. The resident was coded as being severely cognitively impaired in ability to make daily life decisions and as requiring total care for all areas of activities of daily living. A review of the clinical record revealed that on 1/18/18 Resident #63 was transferred to the hospital. The following notes were identified in the clinical record for 1/18/18: 1/18/18 at 12:21 AM, "Resident noted to be very warm to the touch, his cheeks are noted to be red and flushed. VS'S (vital signs) 101 (temperature) 97 (pulse) 18 (respirations) 135/82 (blood pressure) o2 sats (saturation) (level of oxygen in the blood) 96% on room air. Resident was adm. (administered) Tylenol [1] 360 mg (milligrams) at 0015 (12:15 AM). Will re-check temp. (temperature) in 30 mins (minutes)." 1/18/18 1:16 AM, "Resident temp (temperature) noted to be 102 orally. Cold compresses under arms and forehead." 1/18/18 4:26 AM, "Resident's temp rechecked at 0410 (4:10 AM). Resident continues with a fever of 102 agein [sic] he was packed under arms and forehead with cold compresses. Tylenol 650 mg adm. (administered) Resident lungs sounds with audible wheezing mainly in right lobe."	F 625	The ADON/QA director will present a compliance report to the quarterly QAPI committee for discussion and further recommendations in the presence of non-compliance. Completion date 4/23/18	

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1/18/18 10:35 AM, "10:35 am: Discharge note: Resident D/C (discharged) to (hospital) and was admitted. Bed is not being held. Will follow up with hospital regarding return."

1/18/18 10:35 AM, "Resident sent to (hospital) via EMS. S/S (signs and symptoms) continuous elevated fever of 102, SOB (Shortness of Breath), labored breathing, bilateral wheezing noted. RP (responsible party) notified. Will contact hospital for follow up information."

A physician's order dated 1/18/18 at 9:16 a.m., documented, "Send resident to (hospital) ER for eval (evaluation). RE: Increased temp / Labored breathing / Abnormal lung sounds."

On 3/8/18 at 3:03 PM, in an interview with OSM #6 (Other Staff Member, the Admissions/Social Services staff member), she stated that a bed hold policy is given at the time of initial admission to the facility. OSM #6 stated that when a resident is transferred to the hospital, a bed hold authorization is provided if they elect to hold the bed, but she does not provide a written notice if they refused to hold the bed. OSM #6 stated that she just documents that they refused and nothing in writing is provided to the resident or the resident's representative for a refusal.

A review of the facility policy, "Notice of Bed Hold Policy" documented, "You are being sent to the hospital today. If you are a Medicaid resident and you are admitted to the hospital, Virginia Medicaid does not pay to hold your bed. Whatever your payment source, unless the nursing home is paid to reserve the bed while you are in the hospital, the nursing home may move someone else into your room. However, even if the nursing home is

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F 625	Continued From page 63 not paid to hold your bed, you may have the right to return as soon as a bed is available in a semi-private room in this nursing home as long as your [sic] still need the services provided by this nursing home (and, if you are on Medicaid, you are eligible for Medicaid nursing home services...." On 3/8/18 at 5:09 p.m., the Administrator (ASM [administrative staff member] #1) and Director of Nursing, ASM #2, was made aware of the findings. No further information was provided by the end of the survey. [1] Tylenol is used to relieve mild to moderate pain....and to reduce fever.... Information obtained from https://medlineplus.gov/druginfo/meds/a681004.html	F 625		
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	F 656	Ftag 656 Corrective Action The care plan for resident #72 is being reviewed and revised as needed. The DON met with the physician on 3/23/18 to discuss resident diagnosis of dementia and the psychology note that recommended tapering off of Aricept as cognition is intact. Physician reassessed for diagnosis of dementia and cognition. The care plan will be updated following the completion of that assessment. The fall mats have been in place for resident #56 as indicated on the fall prevention care plan.	

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F 656	Continued From page 64 under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review and clinical record review, it was determined that the facility staff failed to develop and implement a comprehensive care plan for two of 20 residents in the survey sample, Residents #72 and #56 1. The facility staff failed to develop a comprehensive care plan to address Resident #72's dementia. 2. The facility staff failed to implement the fall prevention comprehensive care plan for Resident	F 656	Other Potential: At the time of observation that the fall mat was not in place per order/care plan, observations made of all other residents (5 residents) with all mats in place per order/care plan while residents in bed. Other residents with diagnosis of dementia could be at risk for not having a comprehensive care plan in place. A review will be completed of care plans of all residents with diagnosis of dementia to validate there is a care plan in place for dementia and individualized approaches specific to the care of the individual resident. System changes: 1. MDS and nurses will be re-educated on the implementation of comprehensive/individualized care plans for residents with the diagnosis of dementia 2. Education with nursing staff on the implementation of fall prevention interventions per care plan/orders with emphasis on fall mats. 3. Facility does not maintain a policy specifically identifying care of the resident with diagnosis of dementia. The Care Plan policy addresses this topic. Policies will be reviewed and revised/developed as needed. 4. DON will evaluate and revise as needed the process for including fall mats in a observation book at nurse station.	

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F 656	Continued From page 65 # 56.	F 656		

The findings include:

1. The facility staff failed to develop a comprehensive care plan to address Resident #72's dementia.

Resident #72 was admitted to the facility on 1/12/18. Resident #72's diagnoses included but were not limited to heart disease, major depressive disorder and dementia (1). Resident #72's most recent MDS (minimum data set), a 30 day Medicare assessment with an ARD (assessment reference date) of 2/20/18, coded the resident as cognitively intact. Section I documented an active diagnosis of Non-Alzheimer's dementia.

Review of Resident #72's clinical record revealed the resident received Aricept (2) per physician's order during January 2018, February 2018 and March 2018. A physician's note dated 2/5/18 documented, "3. dementia w/ (with) behaviors- on Aricept..."

Resident #72's comprehensive care plan dated 1/24/18 documented information regarding the resident's behaviors but failed to document information (including treatment and services) regarding dementia.

On 3/8/18 at 11:38 a.m., an interview was conducted with RN (registered nurse) #2. RN #2 stated Resident #72 "Comes off cognitively intact but is fairly unstable."

On 3/8/18 at 1:58 p.m., an interview was conducted with CNA (certified nursing

5. Fall mats will be added to an observation book which is maintained at the nurse station. Nursing staff will be expected to sign off on the presence of fall mats each shift

6. Nurses will also document the use /presence of fall mats on the TAR each shift.

7. Staff is being re-educated on care of residents with dementia.

8. Care plans will be updated as indicated for any resident with diagnosis of dementia to include diagnosis and individualized approaches.

9. Unit managers will review care plans and educate staff on the care of the individual residents with diagnosis of dementia residing on their units.

10. Unit managers will review with staff the location of care plans, how to use care plans , and how to identify the dementia care plan with the unit staff.

Monitoring:
During rounds, the clinical leaders will monitor the use of fall mats as identified on the care plan. 1:1 education will be provided to nursing assistant if fall mats are not present as per order/care plan.

QA Director will review the care plan of new residents with dementia diagnosis to validate a care plan has been initiated with individualized approaches .

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F 656	Continued From page 66 assessment) #5 (a CNA who was familiar with Resident #72 and routinely worked with the resident until one month before the survey). CNA #5 was asked if Resident #72 had dementia. CNA #5 stated, "Not that I know of. It hasn't been told to us. I know she's been emotional before. It got better then she got emotional again and it's tapered off." On 3/8/18 at 3:09 p.m., an interview was conducted with ASM (administrative staff member) #2 (the director of nursing). ASM #2 was asked to describe the facility dementia care guidelines and protocols. ASM #2 stated, "What we normally do, the comprehensive care plan, we have that set aside and centered toward resident centered care, dementia, or anxiety. It's centered to the resident's care specifically." ASM #2 was asked if information regarding dementia should be documented on a resident's care plan if the resident has a diagnosis of dementia. ASM #2 stated, "Yes. There should be." On 3/8/18 at 4:01 p.m., an interview was conducted with ASM #3 (Resident #72's physician). ASM #3 stated she thought Resident #72 was diagnosed with dementia in the hospital. When asked to describe Resident #72's cognitive ability, ASM #3 stated, "Cognitively she goes in and out as far as memory but she's able to carry on a conversation and change some of her behavior." On 3/8/18 at 4:58 p.m. ASM #1 (the administrator) and ASM #2 were made aware of the above findings. The facility policy titled, "COMPREHENSIVE CARE PLAN" documented, "3. The	F 656	QA Director will do a weekly audit of those residents who were discussed in quarterly care plan to validate there is an individualized plan of care for residents with dementia. This will be done weekly for 3 months. If compliance with care planning for dementia is maintained, then a quarterly audit will be conducted for 3 quarters. A report of areas of non-compliance will be submitted to the quarterly QAPI committee for discussion and further recommendations. Completion date 04/23/2018	

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F 656	Continued From page 67 comprehensive care plan addresses the individualized needs of the resident, making the care plan a resident centered document. 4. The Interdisciplinary Team will work collaboratively to develop the care plan that addresses the resident specific diagnosis related needs: such as cardiac status, renal (dialysis) conditions; end of life conditions; impaired skin integrity; dementia (cognitive impairment, delirium, confusion, psychosocial needs), etc..." No further information was provided prior to exit. (1) "Dementia is the name for a group of symptoms caused by disorders that affect the brain. It is not a specific disease. People with dementia may not be able to think well enough to do normal activities, such as getting dressed or eating. They may lose their ability to solve problems or control their emotions. Their personalities may change. They may become agitated or see things that are not there." This information was obtained from the website: https://vsearch.nlm.nih.gov/vivisimo/cgi-bin/query-meta?v%3Aproject=medlineplus&v%3Asources=medlineplus-bundle&query=dementia&_ga=2.16129535.891036110.1520856028-139120270.1477942321 (2) Aricept is used to treat dementia. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a697032.html 2. The facility staff failed to implement the fall prevention comprehensive care plan for Resident # 56. Resident # 56 was admitted to the facility on 11/05/2011 and readmitted to the facility on	F 656		

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F 656	Continued From page 68 12/30/17 with diagnoses that included but were not limited to convulsions (1), diabetes mellitus (2) and dyspepsia (3). Resident # 56's most recent MDS (minimum data set), an annual assessment with an ARD (assessment reference date) of 02/09/18, coded Resident # 56 as scoring a 10 on the brief interview for mental status (BIMS) of a score of 0 (zero) - 15, 10 being mildly impaired of cognition for making daily decisions. Resident # 56 was coded as requiring limited assistance to extensive assistance of one staff member for activities for ADLs (activities of daily living). An observation was made of Resident # 56 on 03/06/18 at 3:06 p.m. Resident # 56 was lying in bed asleep. The bed was low to floor and one fall mat was on floor next to left side of the bed. The other fall mat was leaning against the wall. A bed alarm observed attached to Resident # 56 and the resident had a wander guard on his left ankle. Nurses entered the room after knocking and tested the bed alarm to ensure it was working. The fall mat observed leaning against the wall remained there after the nurses left the room. An observation was made of Resident # 56 on 03/07/18 at 1:19 p.m. Resident # 56 was sitting up in bed dressed neat and clean. A CNA (certified nursing assistant) was present assisting Resident # 56 with his lunch. He required total assistance. Observation of the room revealed a fall mat on the floor next to the left side of the bed. The other fall mat was observed leaning against the wall. An observation was made of Resident # 56 on 03/08/18 at 2:10 p.m. Resident # 56 was lying in	F 656		

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F 656	Continued From page 69	F 656		

bed dressed neat and clean, the bed was positioned low to floor and one fall mat was on floor next to left side of the bed. The other fall mat was observed leaning against the wall.

The current signed physician's orders dated 12/08/17 - 01/08/18 and signed by the physician on 01/24/18 documented, "BL (bilateral) [two] Floor mats bedside bed while in bed. Every shift; Day shift, Evening shift, Night shift. 02/22/2017."

The comprehensive care plan dated 02/16/2018 for Resident # 56 documented, "Problem. Category: Falls. History of falls. Will attempt to transfer without asking for assist (assistance). Increased agitation with behavior issues receives psychotropic meds (medication) daily; Fall alarm, low bed with mats; No recent falls this review." Under "Approach" it documented, "Low bed with mats beside. Approach Start Date: 02/16/2018."

On 03/08/18 at approximately 2:40 p.m. an interview and observation of Resident # 56's room was conducted with LPN (licensed practical nurse) # 1. Upon entering Resident # 56's room, LPN # 1 verbally acknowledged that a fall mat was on floor next to left side of the bed and the other fall mat was leaning against the wall. When asked if Resident # 56 was to have a fall mat on the right and left side of the bed when Resident # 56 was in bed, LPN # 1 stated, "I need to check the orders." After reviewing the physician's orders for Resident # 56 on the EHR (electronic health record), LPN # 1 stated, "The orders say a mat on both sides of the bed." LPN # 1 then proceeded to Resident # 56's room and placed the other fall mat on the floor to the right side of Resident # 56's bed.

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F 656	Continued From page 70 On 03/09/18 at 8:30 a.m., an interview was conducted with RN (registered nurse) # 1, unit manager. When asked to describe the purpose of the care plan RN # 1 stated, "To serve as a guideline for us (staff) for the care of the resident." RN #1 was informed of the above observations of Resident # 56's fall mat not being put in place. Resident #56's physician's orders dated 12/08/17 - 01/08/18 and the care plan for Resident # 56 were reviewed with RN #1. RN # 1 was then asked if the fall care was being implemented for resident # 56. RN # 1 stated, "No." On 03/09/18 at 8:45 a.m., an interview was conducted with ASM (administrative staff member) # 2, director of nursing. When asked to describe the purpose of the care plan, ASM # 2 stated, "Identify the needs of the resident and what we are going to do for the resident." After being informed of the above observations of Resident # 56's fall mat not being put in place, review of the physician's orders dated 12/08/17 - 01/08/18 for Resident # 56 and the care plan for Resident # 56, ASM #2 was asked if the fall care was being implemented for resident # 56. ASM # 2 stated, "No." On 03/08/18 at approximately 5:00 p.m. ASM (administrative staff member) # 1, the administrator and ASM # 2, director of nursing were made aware of the findings. No further information was provided prior to exit. References: (1) The term "seizure" is often used interchangeably with "convulsion." A seizure is the physical findings or changes in behavior that	F 656		

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F 656	Continued From page 71 occur after an episode of abnormal electrical activity in the brain. This information was obtained from the website: https://medlineplus.gov/ency/article/003200.htm. (2) A chronic disease in which the body cannot regulate the amount of sugar in the blood. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/ency/article/001214.htm. (3) Indigestion (dyspepsia) is a mild discomfort in the upper belly or abdomen. It occurs during or right after eating. It may feel like: Heat, burning, or pain in the area between the navel and the lower part of the breastbone; Unpleasant fullness that comes on soon after a meal begins or when the meal is over. This information was obtained from the website: https://medlineplus.gov/ency/article/003260.htm.	F 656		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and clinical record, it was determined that the facility staff failed to implement a fall prevention intervention to prevent accidents for one of 20 residents in the survey sample, Resident # 56.	F 689	F689 Corrective Action Upon notification, the fall mats were replaced at the bedside for resident #56. The nursing assistants on that unit have been re-educated on the fall prevention approach of use of fall mats. Fall mats have been observed to be in place as ordered since then. Other Potential Any resident with orders or care plan approaches for the use of fall mats at bedside could have been at risk for them not being in place. Five other residents with fall mats have been observed with the mats in place as ordered/care planned.	

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F 689	Continued From page 72 The facility staff failed to place bilateral (two) fall mats on the floor next to bed for Resident # 56. The findings include: Resident # 56 was admitted to the facility on 11/05/2011 and readmitted to the facility on 12/30/17 with diagnoses that included but were not limited to convulsions (1), diabetes mellitus (2) and dyspepsia (3). Resident # 56's most recent MDS (minimum data set), an annual assessment with an ARD (assessment reference date) of 02/09/18, coded Resident # 56 as scoring a 10 on the brief interview for mental status (BIMS) of a score of 0 (zero) - 15, 10 being mildly impaired of cognition for making daily decisions. Resident # 56 was coded as requiring limited assistance to extensive assistance of one staff member for activities for ADLs (activities of daily living). An observation was made of Resident # 56 on 03/06/18 at 3:06 p.m. Resident # 56 was lying in bed asleep. The bed was low to floor and one fall mat was on floor next to left side of the bed. The other fall mat was leaning against the wall. A bed alarm observed attached to Resident # 56 and the resident had a wander guard on his left ankle. Nurses entered the room after knocking and tested the bed alarm to ensure it was working. The fall mat observed leaning against the wall remained there after the nurses left the room. An observation was made of Resident # 56 on 03/07/18 at 1:19 p.m. Resident # 56 was sitting up in bed dressed neat and clean. A CNA (certified nursing assistant) was present assisting	F 689	System Changes 1. Nursing Assistants have been re-educated on the use of fall mats as fall approach. 2. The clinical leadership team. Administrator, Social Services will observe the placement of fall mats during daily rounds. Observations of missing fall mats will result in immediate action to replace the mat as bedside as ordered. 3. A review will be conducted of care plans and orders to ensure all residents with care plan approach for fall mats will have them in place per care plan/ orders. 4. An updated listing of residents with fall mats will be maintained in a binder at the nurse station. 5. Nursing Assistants will be initial the use of fall mats in the observation book and licensed nurses will document the use of the falls mats on the TAR each shift.	

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F 689	Continued From page 73 Resident # 56 with his lunch. He required total assistance. Observation of the room revealed a fall mat on the floor next to the left side of the bed. The other fall mat was observed leaning against the wall. An observation was made of Resident # 56 on 03/08/18 at 2:10 p.m. Resident # 56 was lying in bed dressed neat and clean, the bed was positioned low to floor and one fall mat was on floor next to left side of the bed. The other fall mat was observed leaning against the wall. The current signed physician's orders dated 12/08/17 - 01/08/18 and signed by the physician on 01/24/18 documented, "BL (bilateral) [two] Floor mats bedside bed while in bed. Every shift; Day shift, Evening shift, Night shift. 02/22/2017." The comprehensive care plan dated 02/16/2018 for Resident # 56 documented, "Problem. Category: Falls. History of falls. Will attempt to transfer without asking for assist (assistance). Increased agitation with behavior issues receives psychotropic meds (medication) daily; Fall alarm, low bed with mats; No recent falls this review." Under "Approach" it documented, "Low bed with mats beside. Approach Start Date: 02/16/2018." On 03/08/18 at approximately 2:40 p.m. an interview and observation of Resident # 56's room was conducted with LPN (licensed practical nurse) # 1. Upon entering Resident # 56's room, LPN # 1 verbally acknowledged that a fall mat was on floor next to left side of the bed and the other fall mat was leaning against the wall. When asked if Resident # 56 was to have a fall mat on the right and left side of the bed when Resident # 56 was in bed, LPN # 1 stated, "I need to check	F 689	MONITORING: • The placement of fall mats will be observed by clinical leadership daily during rounds. • Charge nurses and supervisors will observe placement of fall mats on evening and night shifts and submit an audit form to the DON each day validating the placement of devices. • DON will review the observation book weekly to determine if the nursing assistants are compliant with the placement and signing of fall mat placement. • A report of areas of non-compliance will be prepared and submitted to the quarterly QAPI committee for discussion and further recommendations. Completion date 04/23/2018	

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F 689	Continued From page 74	F 689		

the orders." After reviewing the physician's orders for Resident # 56 on the EHR (electronic health record), LPN # 1 stated, "The orders say a mat on both sides of the bed." LPN # 1 then proceeded to Resident # 56's room and placed the other fall mat on the floor to the right side of Resident # 56's bed.

On 03/09/18 at 8:30 a.m., an interview was conducted with RN (registered nurse) # 1, unit manager. After being informed of the above observations of Resident # 56's fall mat not being put in place, reviewing of the physician's orders dated 12/08/17 - 01/08/18 for Resident # 56 and the care plan for Resident # 56, RN # 1 was asked if the fall mats were being implemented for Resident # 56. RN # 1 stated, "No."

On 03/09/18 at 8:45 a.m., an interview was conducted with ASM (administrative staff member) # 2, director of nursing. After being informed of the above observations of Resident # 56's fall mat not being put in place, reviewing the physician's orders dated 12/08/17 - 01/08/18 for Resident # 56 and the care plan for Resident # 56, ASM # 2 was asked if the fall mats were being implemented for Resident # 56. ASM # 2 stated, "No."

On 03/08/18 at approximately 5:00 p.m. ASM (administrative staff member) # 1, the administrator and ASM # 2, director of nursing were made aware of the findings.

No further information was provided prior to exit.

References:
(1) The term "seizure" is often used interchangeably with "convulsion." A seizure is

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F 689	Continued From page 75 the physical findings or changes in behavior that occur after an episode of abnormal electrical activity in the brain. This information was obtained from the website: https://medlineplus.gov/ency/article/003200.htm. (2) A chronic disease in which the body cannot regulate the amount of sugar in the blood. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/ency/article/001214.htm. (3) Indigestion (dyspepsia) is a mild discomfort in the upper belly or abdomen. It occurs during or right after eating. It may feel like: Heat, burning, or pain in the area between the navel and the lower part of the breastbone; Unpleasant fullness that comes on soon after a meal begins or when the meal is over. This information was obtained from the website: https://medlineplus.gov/ency/article/003260.htm.	F 689		
F 744 SS=D	Treatment/Service for Dementia CFR(s): 483.40(b)(3) §483.40(b)(3) A resident who displays or is diagnosed with dementia, receives the appropriate treatment and services to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, it was determined that the facility staff failed to provide dementia treatment and services for one of 20 residents in the survey sample, Residents #72. The facility staff failed to assess Resident #72's	F 744	Corrective Action Recent evaluation in facility by psychologist indicates resident is cognitively intact and recommended discontinue of Aricept. A comprehensive MDS was completed on the resident on 01/19/2018 with a BIMS score of 15. Resident's order for Xanax was discontinued on 3/19/18 and physician plans to discontinue Aricept on 3/26/18, as recommended by the psychologist, related to no signs of cognitive impairment. The resident's plan of care will be reviewed and updated. The resident's active diagnosis list will be revised.	

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F 744	Continued From page 76 dementia related needs and develop a plan of care to provide treatment and services for the resident's dementia. The findings include: The facility staff failed to assess Resident #72's dementia related needs and develop a plan of care to provide treatment and services for the resident's dementia. Resident #72 was admitted to the facility on 1/12/18. Resident #72's diagnoses included but were not limited to heart disease, major depressive disorder and dementia (1). Resident #72's most recent MDS (minimum data set), a 30 day Medicare assessment with an ARD (assessment reference date) of 2/20/18, coded the resident as cognitively intact. Section I documented an active diagnosis of Non-Alzheimer's dementia. Review of Resident #72's clinical record revealed the resident received Aricept (2) per physician's order during January 2018, February 2018 and March 2018. A physician's note dated 2/5/18 documented, "3. dementia w/ (with) behaviors- on Aricept..." A speech therapy evaluation dated 3/5/18 documented, "Reason for Referral: Pt (Patient) was referred to ST (speech therapy) by nursing in order for Mini Mental State Exam to be administered, as the first step to determining pt's mental status, in order to allow her to independently apply prescribed cream...Assessment Summary- Impressions: Clinical Impressions: Pt able to follow 2-3 step	F 744	Other potential The MDS/Care plan nurses will complete an audit of care plans of all residents with diagnosis of dementia to validate each has a comprehensive individualized care plan for dementia as related to the resident's dementia needs. System Changes 1. Facility staff will be re-educated on care of the dementia residents, using the Hand in Hand Dementia Training. 2. Care plans of each resident with diagnosis of dementia will be reviewed and updated as indicated to ensure the care plan is addressing the diagnosis of dementia and has individualized approaches specific to the resident diagnosis, behaviors, and level of cognition. 3. Staff assigned to the care of resident's with dementia will be educated on the care and needs of the individual resident. 4. Care Plan policy, which discusses the care planning of specific resident diagnosis, will be reviewed and updated as indicated. Monitoring The DON will be provided with information regarding the audit of care plans for residents with diagnosis of dementia. Information will be analyzed and a report will be submitted to quarterly QAPI committee for discussion and further recommendations regarding the care planning of dementia residents.	

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F 744	Continued From page 77 directions and has good verbal reasoning skills..." Further review of Resident #72's clinical record failed to reveal an assessment of the resident's dementia related needs. Resident #72's comprehensive care plan dated 1/24/18 documented information regarding the resident's behaviors but failed to document information (including treatment and services) regarding dementia care. On 3/8/18 at 11:38 a.m., an interview was conducted with RN (registered nurse) #2. RN #2 stated Resident #72 "Comes off cognitively intact but is fairly unstable." RN #2 was asked to describe the facility dementia care guidelines and protocols. RN #2 stated, "I think that's individualized for each specific resident. I don't know how you could broad spectrum that. I don't know if we have protocols. I think that is more individualized for each resident with dementia. Each resident is going to progress differently." RN #2 was asked to provide evidence of the dementia care provided to Resident #72, including the assessment of the resident's dementia related needs and care planning. On 3/8/18 at 1:58 p.m., an interview was conducted with CNA (certified nursing assessment) #5 (a CNA who was familiar with Resident #72 and routinely worked with the resident until one month before the survey). CNA #5 was asked if Resident #72 had dementia. CNA #5 stated, "Not that I know of. It hasn't been told to us. I know she's been emotional before. It got better then she got emotional again and it's tapered off." When asked if the facility had guidelines or protocols for dementia care, CNA #5 stated, "I don't know the answer to that question.	F 744	The care plans for residents with diagnosis of dementia will be reviewed during the quarterly care plan meetings to validate the care plans are updated with individualize approaches as the resident dementia needs change Completion Date 04/23/2018	

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F 744	Continued From page 78	F 744		

I have prior experience prior to coming here." When asked if she was provided dementia training at the facility, CNA #5 stated, "Yes." At this time, CNA #5 was made aware Resident #72 had a diagnosis of dementia. CNA #5 confirmed she was not aware the resident had dementia and had not received specialized instructions on how to care for the resident's dementia. CNA #5 stated, "No I didn't even know she had dementia but I have never had troubles with her."

On 3/8/18 at 3:09 p.m., an interview was conducted with ASM (administrative staff member) #2 (the director of nursing). ASM #2 was asked to describe the facility dementia care guidelines and protocols. ASM #2 stated, "What we normally do, the comprehensive care plan, we have that set aside and centered toward resident centered care, dementia, or anxiety. It's centered to the resident's care specifically." ASM #2 was asked if information regarding dementia should be documented on a resident's care plan if the resident has a diagnosis of dementia. ASM #2 stated, "Yes. There should be." ASM #2 was asked if any dementia related assessments were completed for residents with dementia. ASM #2 stated the facility staff looks at the type of dementia the resident is diagnosed with, and then the physician evaluates the resident and prescribes medication. When asked to describe dementia related care that is provided to residents, ASM #2 stated, "To provide a safe and secure environment. Orient, reorient, referrals from the hospital, home, talk with the family." ASM #2 was made aware of the above findings for Resident #72 and asked how the facility staff ensures the best dementia care and services are provided to Resident #72. ASM #2 stated, "Let me think about that. The main thing is providing

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F 744	Continued From page 79	F 744		

a safe and secure environment, re-orienting, one to one and providing calendars depending on the stage of dementia." At this time, ASM #2 was asked to provide any facility policies regarding dementia care and services. ASM #2 stated the facility did not have the requested policies.

On 3/8/18 at 4:01 p.m., an interview was conducted with ASM #3 (Resident #72's physician). ASM #3 stated she thought Resident #72 was diagnosed with dementia in the hospital. When asked to describe Resident #72's cognitive ability, ASM #3 stated, "Cognitively she goes in and out as far as memory but she's able to carry on a conversation and change some of her behavior." ASM #3 stated Resident #72's behavior had improved since the initiation of psychotherapy.

On 3/8/18 at 4:58 p.m. ASM #1 (the administrator) and ASM #2 were made aware of the above findings.

Review of facility documentation revealed staff training on dementia care.

No further information was provided prior to exit.

(1) "Dementia is the name for a group of symptoms caused by disorders that affect the brain. It is not a specific disease. People with dementia may not be able to think well enough to do normal activities, such as getting dressed or eating. They may lose their ability to solve problems or control their emotions. Their personalities may change. They may become agitated or see things that are not there." This information was obtained from the website: https://vsearch.nlm.nih.gov/vivisimo/cgi-bin/query-

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F 744	Continued From page 80 meta?v%3Aproject=medlineplus&v%3Asources=medlineplus-bundle&query=dementia&_ga=2.16129535.891036110.1520856028-139120270.1477942321 (2) Aricept is used to treat dementia. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a697032.html	F 744		
F 756 SS=E	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to	F 756	Ftag 756 Corrective Action Resident #6 experienced no negative outcome related to the facility Medication Regimen Review Policy having no identified time frame for the management of the pharmacy recommendations. Resident #70 experienced no negative outcome related to the facility Medication Regimen Review Policy having no identified time frame for the management of the pharmacy recommendations. Resident #72 experienced no negative outcome related to the facility Medication Regimen Review Policy having no identified time frame for management of the pharmacy recommendations. Resident #19 experienced no negative outcome related to the facility Medication Regimen Review Policy having no identified time frame for the management of the pharmacy recommendations. Resident #50 experienced no negative outcome related to the facility Medication Regimen Review Policy having no identified time frame for the management of the pharmacy recommendations	

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F 756	Continued From page 81 be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, and clinical record review, it was determined the facility staff failed to ensure the monthly pharmacy medication regimen review policy included all the required components for five of 20 residents in the survey sample; Resident #6, #70, #72, #19, and #50. 1. The facility staff failed to develop and implement policies that addressed the time frames for the steps of the monthly medication regimen review to guide staff on the process for acting on gradual dose reduction recommendations by the pharmacist for Resident #6. 2. The facility staff failed to develop and implement policies that addressed the time frames for the steps of the monthly medication regimen review to guide staff on the process for acting on gradual dose reduction recommendations by the pharmacist for Resident #70. 3. The facility staff failed to develop and implement policies that addressed the time	F 756	Other Potential Other residents residing in facility may have the potential to be affected by the Medication Regimen Review Policy not identifying a time frame in which the pharmacy recommendations must be managed. There have been no known negative outcomes related to the recommendations and the lack of a time frame written into the policy. System Changes 1. The policy for Medication Regimen Review will be reviewed and revised to indicate a time frame for the recommendations to be managed by facility and physician. 2. Licensed nurses will be educated on the revised policy for management of pharmacy recommendations. 3. Physicians will be notified of the amended policy which will indicate a specific time frame for management of the recommendations. 4. Unit managers will be responsible for management of the pharmacy recommendations in compliance with the revised policy. Monitoring 1. Upon physician review with approval or decline of a pharmacy recommendation, the unit manager will manage the new orders and then submit a copy of the Medication Regimen Review form to the DON.	

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F 756	Continued From page 82 frames for the steps of the monthly medication regimen review to guide staff on the process for acting on gradual dose reduction recommendations by the pharmacist for Resident #72. 4. The facility staff failed to develop and implement policies that addressed the time frames for the steps of the monthly medication regimen review to guide staff on the process for acting on gradual dose reduction recommendations by the pharmacist for Resident #19. 5. The facility staff failed to develop and implement policies that addressed the time frames for the steps of the monthly medication regimen review to guide staff on the process for acting on gradual dose reduction recommendations by the pharmacist for Resident #50. The findings include: 1. The facility staff failed to develop and implement policies that addressed the time frames for the steps of the monthly medication regimen review to guide staff on the process for acting on gradual dose reduction recommendations by the pharmacist for Resident #6. Resident #6 was admitted to the facility on 3/19/12 and readmitted on 6/6/17, with the diagnoses of but not limited to diabetes, spastic hemiplegia, stroke, mood disorder, dementia, depression, anxiety, insomnia, and high blood pressure. The most recent MDS (Minimum Data	F 756	2. The DON will review the completed forms to validate they were managed within the time frame as specified by the revised policy. 3. DON will submit a report of areas of non-compliance to the quarterly QAPI committee for discussion and further recommendations. 4. Medical Director will assist the DON in addressing other attending physicians who are non-compliant with the policy to discuss and ensure those physicians understand and will become compliant with facility policy. Completion Date 04/23/18	

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Set) was a quarterly assessment with an ARD (Assessment Reference Date) of 12/5/17. The resident was coded as being mildly cognitively impaired in ability to make daily life decisions.

A review of the most recent Physician's Order Sheet dated 2/8/18 in the clinical record revealed that Resident #6 was on the following medications that may require a GDR (Gradual Dose Reduction):

Lexapro [1] 20 mg daily, order dated 9/6/17
Seroquel [2] 50 mg daily, order dated 1/5/18

Based on the dates of the orders, a GDR was not yet required for the above medications. However, a review of the facility policy "Medication Regimen Review" documented, "7. Facility should encourage Physician/Prescriber or other Responsible Parties reviewing the MRR and the Director of Nursing to act upon the recommendations contained in the MRR. For those issues that require Physician/Prescriber intervention, Facility should encourage Physician/Prescriber to either (a) accept and act upon the recommendations contained within the MRR, or (b) reject all or some of the recommendations contained in the MRR and provide an explanation as to why the recommendation was rejected." The policy failed to reveal any evidence of specific time frames in which a physician is to review and act upon any GDR recommendations the pharmacy may make.

On 3/8/18 at 3:10 p.m., in an interview with ASM #2 (Administrative Staff Member, the Director of Nursing), she stated that for the monthly medication review process, the pharmacy makes recommendations, then she reviews the

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F 756	Continued From page 84 recommendations and sends them to the Unit Manager to review with the doctor. ASM #2 stated if there are any changes, the unit manager takes off the orders and the care plan is updated. When asked if there is a specific time frame in which the doctor must act upon the GDR, ASM #2 stated she did not know of a time frame but thought that it should be within the month. On 3/8/18 at 4:33 p.m., ASM #2 stated she could not locate any policy that addressed the time frame for the steps of GDR's. On 3/8/18 at 5:09 p.m., the Administrator and Director of Nursing was made aware of the findings. No further information was provided by the end of the survey. [1] Lexapro is used to treat depression and generalized anxiety disorder. Information obtained from https://medlineplus.gov/druginfo/meds/a603005.html [2] Seroquel can be used along with other medications to treat depression. Information obtained from https://medlineplus.gov/druginfo/meds/a698019.html 2. The facility staff failed to develop and implement policies that addressed the time frames for the steps of the monthly medication regimen review to guide staff on the process for acting on gradual dose reduction recommendations by the pharmacist for Resident #70.	F 756		

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Resident #70 was admitted on 4/2/12 with the diagnoses of but not limited to anxiety, dementia, urinary retention, restless leg syndrome, osteoporosis, glaucoma, high blood pressure, and hypothyroidism. The most recent MDS (Minimum Data Set) was an annual assessment with an ARD (Assessment Reference Date) of 2/16/18. The resident was coded as being significantly cognitively impaired in ability to make daily life decisions.

A review of the most recent Physician's Order Sheet dated 2/8/18 in the clinical record revealed that Resident #6 was on the following medications that may require a GDR (Gradual Dose Reduction):

Lexapro 10 [1] mg daily, order dated 12/14/17
Seroquel 25 [2] mg daily, order dated 1/9/18

Based on the dates of the orders, a GDR was not yet required for the above medications. However, a review of the facility policy "Medication Regimen Review" documented, "7. Facility should encourage Physician/Prescriber or other Responsible Parties reviewing the MRR and the Director of Nursing to act upon the recommendations contained in the MRR. For those issues that require Physician/Prescriber intervention, Facility should encourage Physician/Prescriber to either (a) accept and act upon the recommendations contained within the MRR, or (b) reject all or some of the recommendations contained in the MRR and provide an explanation as to why the recommendation was rejected." The policy failed to reveal any evidence of specifying time frames in which a physician is to review and act upon any

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F 756	Continued From page 86 GDR recommendations the pharmacy may make. On 3/8/18 at 3:10 p.m., in an interview with ASM #2 (Administrative Staff Member, the Director of Nursing), she stated that for the monthly medication review process, the pharmacy makes recommendations, then she reviews the recommendations and sends them to the Unit Manager to review with the doctor. ASM #2 stated if there are any changes, the unit manager takes off the orders and the care plan is updated. When asked if there is a specific time frame in which the doctor must act upon the GDR, ASM #2 stated she did not know of a time frame but thought that it should be within the month. On 3/8/18 at 4:33 p.m., ASM #2 stated she could not locate any policy that addressed the time frame for the steps of GDR's. On 3/8/18 at 5:09 p.m.,, the Administrator and Director of Nursing was made aware of the findings. No further information was provided by the end of the survey. [1] Lexapro is used to treat depression and generalized anxiety disorder. Information obtained from https://medlineplus.gov/druginfo/meds/a603005.html [2] Seroquel can be used along with other medications to treat depression. Information obtained from https://medlineplus.gov/druginfo/meds/a698019.html 3. The facility staff failed to develop and implement policies that addressed the time frames for the steps of the monthly medication	F 756		

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regimen review to guide staff on the process for acting on gradual dose reduction recommendations by the pharmacist for Resident #72.

Resident #72 was admitted to the facility on 1/12/18. Resident #72's diagnoses included but were not limited to heart disease, major depressive disorder and dementia (1). Resident #72's most recent MDS (minimum data set), a 30 day Medicare assessment with an ARD (assessment reference date) of 2/20/18, coded the resident as cognitively intact.

Review of Resident #72's clinical record revealed a pharmacy recommendation dated 2/15/18 that documented, "(Name of Resident #72) has a PRN (as needed) order for an anxiolytic (anxiety medication), which has been in place for greater than 14 days without a stop date: Alprazolam (2). Recommendation: If the medication cannot be discontinued at this time, current regulations require that the prescriber document the indication for use, the intended duration of therapy, and the rational for the extended time period..." The physician signed the recommendation on 2/21/18 and a check was documented beside, "I accept the recommendation(s) above, please implement as written."

A review of the facility policy regarding medication regimen reviews and pharmacy recommendations failed to include any documentation regarding the time frames that a pharmacy recommendation is required to be provided to the physician and acted upon by the physician. Although the above pharmacy recommendation was acted upon, the policy did

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not meet regulatory requirements of specifying those time frames.

On 3/8/18 at 3:09 p.m., an interview was conducted with ASM (administrative staff member) #2 (the director of nursing). ASM #2 was asked about the facility policy for acting upon pharmacy recommendations. ASM #2 stated she receives the recommendations from the pharmacy, reviews the recommendations and then gives the recommendations to the physician. ASM #2 stated if a change in a physician's order is required due to the recommendation then the unit managers note the order change and update the care plans. When asked if the facility process for acting upon pharmacy recommendations contains any time frames, ASM #2 stated, "I'm sure we do. It should be within the month." When asked if the time frames were documented in the facility policy, ASM #2 stated she would look.

On 3/8/18 at 4:33 p.m., ASM #2 confirmed the facility policy for medication regimen reviews and pharmacy recommendations did not contain any time frames.

On 3/8/18 at 4:58 p.m. ASM #1 (the administrator) and ASM #2 were made aware of the above findings.

No further information was presented prior to exit.

(1) "Dementia is the name for a group of symptoms caused by disorders that affect the brain. It is not a specific disease. People with dementia may not be able to think well enough to do normal activities, such as getting dressed or eating. They may lose their ability to solve

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F 756	Continued From page 89 problems or control their emotions. Their personalities may change. They may become agitated or see things that are not there." This information was obtained from the website: https://vsearch.nlm.nih.gov/vivisimo/cgi-bin/query-meta?v%3Aproject=medlineplus&v%3Asources=medlineplus-bundle&query=dementia&_ga=2.16129535.891036110.1520856028-139120270.1477942321 (2) "Alprazolam is used to treat anxiety disorders and panic disorder (sudden, unexpected attacks of extreme fear and worry about these attacks)." This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a684001.html 4. The facility staff failed to develop and implement policies that addressed the time frames for the steps of the monthly medication regimen review to guide staff on the process for acting on gradual dose reduction recommendations by the pharmacist for Resident #19. Resident #19 was admitted to the facility on 8/29/13. Resident #19's diagnoses included but were not limited to heart failure, high blood pressure and anxiety disorder. Resident #19's most recent MDS (minimum data set), a significant change in status assessment with an ARD (assessment reference date) of 12/20/17, coded the resident's cognition as severely impaired. Review of Resident #19's clinical record revealed a pharmacy recommendation dated 12/8/17 that documented, "(Name of Resident #19) has a PRN (as needed) order for an anxiolytic (anxiety	F 756		

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F 756	Continued From page 90 medication), which has been in place for greater than 14 days without a stop date: Lorazepam (1) 0.5 mg (milligrams) twice daily prn. Recommendation: If the medication cannot be discontinued at this time, NEW regulations require that the prescriber document the indication for use, the intended duration of therapy, and the rationale for the extended time period." The physician signed the recommendation on 12/11/17 and documented, "D/C (Discontinue) Lorazepam." A review of the facility policy regarding medication regimen reviews and pharmacy recommendations failed to include any documentation regarding the time frames that a pharmacy recommendation is required to be provided to the physician and acted upon by the physician. Although the above pharmacy recommendation was acted upon, the policy did not meet regulatory requirements of specifying those time frames. On 3/8/18 at 3:09 p.m., an interview was conducted with ASM (administrative staff member) #2 (the director of nursing). ASM #2 was asked the facility policy for acting upon pharmacy recommendations. ASM #2 stated she receives the recommendations from the pharmacy, reviews the recommendations and then gives the recommendations to the physician. ASM #2 stated if a change in a physician's order is required due to the recommendation then the unit managers note the order change and update the care plans. When asked if the facility process for acting upon pharmacy recommendations contains any time frames, ASM #2 stated, "I'm sure we do. It should be within the month." When asked if the time frames were documented	F 756		

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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 756	Continued From page 91 in the facility policy, ASM #2 stated she would look. On 3/8/18 at 4:33 p.m., ASM #2 confirmed the facility policy for medication regimen reviews and pharmacy recommendations did not contain any time frames. On 3/8/18 at 4:58 p.m. ASM #1 (the administrator) and ASM #2 were made aware of the above findings. No further information was presented prior to exit. (1) Lorazepam is used to treat anxiety. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a682053.html 5. The facility staff failed to develop and implement policies that addressed the time frames for the steps of the monthly medication regimen review to guide staff on the process for acting on gradual dose reduction recommendations by the pharmacist for Resident #50. Resident #50 was admitted to the facility on 9/1/15. Resident #50's diagnoses included but were not limited to urinary tract infection, constipation and anxiety disorder. Resident #50's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 2/7/18, coded the resident's cognition as severely impaired. Review of Resident #50's clinical record revealed	F 756		

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F 756	Continued From page 92 a pharmacy recommendation dated 2/15/18 that documented, "(Name of Resident #50's) PRN (as needed) order(s) below have not been used within the previous 60 day. 1. Senna (1) 2. Bisacodyl (2) 3. Triamicinolone (3) Please consider discontinuing due to lack of use." The physician signed the recommendation on 2/28/18 and documented a check beside, "I accept the recommendation(s) above, please implement as written." A review of the facility policy regarding medication regimen reviews and pharmacy recommendations failed to include any documentation regarding the time frames that a pharmacy recommendation is required to be provided to the physician and acted upon by the physician. Although the above pharmacy recommendation was acted upon, the policy did not meet regulatory requirements of specifying those time frames. On 3/8/18 at 3:09 p.m., an interview was conducted with ASM (administrative staff member) #2 (the director of nursing). ASM #2 was asked the facility policy for acting upon pharmacy recommendations. ASM #2 stated she receives the recommendations from the pharmacy, reviews the recommendations and then gives the recommendations to the physician. ASM #2 stated if a change in a physician's order is required due to the recommendation then the unit managers note the order change and update the care plans. When asked if the facility process for acting upon pharmacy recommendations contains any time frames, ASM #2 stated, "I'm sure we do. It should be within the month."	F 756		

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F 756	Continued From page 93 When asked if the time frames were documented in the facility policy, ASM #2 stated she would look. On 3/8/18 at 4:33 p.m., ASM #2 confirmed the facility policy for medication regimen reviews and pharmacy recommendations did not contain any time frames. On 3/8/18 at 4:58 p.m. ASM #1 (the administrator) and ASM #2 were made aware of the above findings. No further information was presented prior to exit. (1) Senna is used to treat constipation. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a601112.html (2) Bisacodyl is used to treat constipation. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a611051.html (3) Triamcinolone is used to treat skin conditions. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a601124.html	F 756		
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:	F 758	Corrective Action Res. # 72 has order in place for Alprazolam po be given once a day a needed. The PRN order for Xanax was discontinued on 3/19/18 with resident being in agreement with that plan.	

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F 758	Continued From page 94 (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; §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	F 758	Other Potential An audit will be completed of orders for each active resident in facility to identify other residents who may have prn psychotropic medication. Clarification orders will be obtained for any resident having such orders but containing no time limit. System Change 1. Licensed nurses will be educated on the requirements for use of psychotropic medications 2. The Director of Nursing will meet with the attending physician/medical director to discuss the regulation for the orders in addition to the notes she is entering into the records. 3. New orders for PRN psychotropic medications will be identified on the 24 hour report. 4. Unit managers will review those records to validate the appropriateness of the orders and the inclusion of time frames being written into the order. 5. the facility policy for use of PRN psychotropic medications will be reviewed and revised if indicated. Licensed nurses will be re-educated on policy.	

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F 758	Continued From page 95 prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, it was determined that the facility staff failed to ensure one of 20 residents in the survey sample, Resident #72, was free of unnecessary medication. The facility staff failed to ensure Resident #72's physician addressed the continued need for as needed anxiety medication within a 14 day period and failed to ensure the physician documented the duration for the medication order. The findings include: Resident #72 was admitted to the facility on 1/12/18. Resident #72's diagnoses included but were not limited to heart disease, major depressive disorder and dementia (1). Resident #72's most recent MDS (minimum data set), a 30 day Medicare assessment with an ARD (assessment reference date) of 2/20/18, coded the resident as cognitively intact. Section N document Resident #72 received anxiety medication two days during the seven-day look back period. Review of Resident #72's clinical record revealed a physician's order dated 1/26/18 for alprazolam (2) 0.25 mg (milligrams) once a day as needed. No stop date was documented. Review of Resident #72's January 2018 and February 2018 eMARs (electronic medication administration records) revealed the resident received as needed alprazolam on 1/23/18,	F 758	Monitoring : 1. Unit managers will submit audits of PRN psychotropic medications to the Director of Nursing. 2. Any nurse who is non-compliant with protocol will receive 1:1 counselling. 3. DON will analyze and trend audit results and will submit a report of areas of non-compliance in the quarterly QAPI committee meeting. Completion Date 04/23/18	

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F 758	Continued From page 96 1/24/18, 1/25/18, 2/14/18, 2/16/18 and 2/23/18. Resident #72's comprehensive care plan dated 1/24/18 documented, "Psychotropics and anxiety meds (medications) added on admission d/t (due to) increase in anxiety and inappropriate behaviors such as cussing staff and throwing food..." The care plan failed to address physician review of alprazolam every 14 days or physician documentation of the duration of the medication. A note signed by the physician on 2/5/18 documented, "Reviewed Xanax (alprazolam) for continued need. It continues to be a valid therapeutic intervention for her. This medication continues to be necessary to help prevent harm to self and others..." Although the rational for the continued need for alprazolam was documented, the duration for the as needed medication order was not documented. Further review of Resident #72's clinical record revealed the physician did not address the continued need for alprazolam again until 2/21/18 (16 days from 2/5/18). The physician's note dated Wednesday, 2/21/18 documented, "Reviewed Xanax for continued need. It continues to be a valid therapeutic intervention for her. This medication continues to be necessary to help prevent harm to self and others..." The physician did not address the continued need for alprazolam within 14 days and the duration for the as needed medication, order was not documented. On 3/8/18 at 3:09 p.m., an interview was conducted with ASM (administrative staff member) #2 (the director of nursing). ASM #2 was asked when the continued use for an as	F 758		

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F 758	Continued From page 97 needed anxiety medication should be reviewed. ASM #2 stated, "I would say within two weeks." On 3/8/18 at 4:01 p.m. an interview was conducted with ASM #3 (Resident #72's physician) regarding the prescribing of as needed anxiety medication. ASM #3 stated she attempts other interventions before prescribing as needed anxiety medication, but of course, some patients are aggressive and can harm staff or other patients, so sometimes she has to prescribe medication. When asked her process for evaluating the continued need for as needed anxiety medication, ASM #3 stated she evaluates all medications during residents' 60-day recertification periods, but now with the new regulations, she has to evaluate the continued need for as needed anxiety medication every two weeks. When asked if she documents the duration for the continued use of as needed anxiety medication, ASM #3 stated she does not document the duration because she will evaluate the continued need for the medication in two weeks. At this time, ASM #3 was made aware the continued need for Resident #72's alprazolam was not evaluated from 2/5/18 until 2/21/18. ASM #3 stated the 14th day may have occurred on a weekend so she may have followed up the following Monday. On 3/8/18 at 4:58 p.m. ASM #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above findings. The facility psychotropic medication protocol documented, "3. The Consultant pharmacist monitors the use of psychotropic medications and recommends gradual dosage reduction quarterly...7. The Primary Care Physician will	F 758		

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F 758	Continued From page 98 document the need for continuation of psychotropic medication at the same dosage or agree with the GDR (Gradual Dose Reduction) and write orders reducing the medication..." The protocol failed to document information regarding the above concern. No further information was presented prior to exit. (1) "Dementia is the name for a group of symptoms caused by disorders that affect the brain. It is not a specific disease. People with dementia may not be able to think well enough to do normal activities, such as getting dressed or eating. They may lose their ability to solve problems or control their emotions. Their personalities may change. They may become agitated or see things that are not there." This information was obtained from the website: https://vsearch.nlm.nih.gov/vivisimo/cgi-bin/query-meta?v%3Aproject=medlineplus&v%3Asources=medlineplus-bundle&query=dementia&_ga=2.16129535.891036110.1520856028-139120270.1477942321 (2) "Alprazolam is used to treat anxiety disorders and panic disorder (sudden, unexpected attacks of extreme fear and worry about these attacks)." This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a684001.html	F 758		
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	F 812	Corrective Action: Nursing Assistant #1, who touched the toast using her bare hands, was counselled by the DON on 03/08/18 regarding the proper use of gloves to handle residents food.	

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F 812	Continued From page 99 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 and staff interview, it was determined that the facility staff failed to serve food in a sanitary manner. The facility staff failed to wear gloves while preparing toast for three residents in the dining room during breakfast. The findings include: On 03/07/18 at approximately 8:30 a.m., the following observations of the dining room were conducted during the breakfast meal: On 03/07/18 at approximately 8:50 a.m., a staff member was observed with their finger against the side of the resident's toast to hold it in place while she buttered it. On 03/07/18 at approximately 8:55 a.m., a staff member was observed with their finger against the side of the resident's toast to hold it in place	F 812	Other potential Other residents who were assisted with breakfast meal in the dining room could have been at risk for that same employee handling their food without gloves. There have been no concerns expressed by residents and no resident has displayed a negative outcome related to food possibly being touched by bare hands. System Changes: 1. Nursing Assistants will be re-educated on feeding technique, with emphasis on handling of resident food and glove use 2. An Administrative nurse will be assigned to observe the dining room through at least one meal each day to validate staff using proper technique (wearing gloves) in handling resident food. 3. A weekly report will be submitted to the DON on the dining observations 4. Facility policy for assisting residents with food will be reviewed and revised as indicated. Monitoring The DON will analyze the weekly reports of dining observations and will submit a report of areas of non-compliance to the quarterly QAPI committee. Any staff person observed handling resident food with bare hands will be immediately e ducated on appropriate technique Completion Date 04/23/18	

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F 812	Continued From page 100 while she buttered it. On 03/07/18 at approximately 9:30 a.m., an interview was conducted with OSM (other staff member) # 1, food service director. When asked to describe the procedure to be followed by staff for handling a resident's food, OSM # 1 stated, "They should wear gloves." On 03/07/18 at 10:40 a.m. an interview was conducted with CNA (certified nursing assistant) # 1. When asked if she was in the dining room this morning serving breakfast trays, CNA #1 stated "Yes." When ask to describe the procedure followed when handling a resident's food, CNA # 1 stated, "You don't use you bare hands. Should wear gloves." When informed of the above observations of holding the resident's toast in place with her bare finger while buttering the toast, CNA # 1 stated, "I tried not to touch the toast." The facility's policy "Bare Hand Contact with Food and Use of Plastic Gloves" documented, "2. Staff use clean barriers such as single use gloves, tongs, deli paper and spatulas to prevent food borne illness." According to the Federal Food Code: "(B) Except when washing fruits and vegetables as specified under §3-302.15 or as specified in (D) and (E) of this section, FOOD EMPLOYEES may not contact exposed, READY-TO-EAT FOOD with their bare hands and shall use suitable UTENSILS such as deli tissue, spatulas, tongs, single-use gloves, or dispensing EQUIPMENT." On 03/08/18 at approximately 5:00 p.m., ASM (administrative staff member) # 1, the	F 812		

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F 812	Continued From page 101 administrator and ASM # 2, director of nursing were made aware of the findings. No further information was provided prior to exit.	F 812		
F 838 SS=C	Facility Assessment CFR(s): 483.70(e)(1)-(3) §483.70(e) Facility assessment. The facility must conduct and document a facility-wide assessment to determine what resources are necessary to care for its residents competently during both day-to-day operations and emergencies. The facility must review and update that assessment, as necessary, and at least annually. The facility must also review and update this assessment whenever there is, or the facility plans for, any change that would require a substantial modification to any part of this assessment. The facility assessment must address or include: §483.70(e)(1) The facility's resident population, including, but not limited to, (i) Both the number of residents and the facility's resident capacity; (ii) The care required by the resident population considering the types of diseases, conditions, physical and cognitive disabilities, overall acuity, and other pertinent facts that are present within that population; (iii) The staff competencies that are necessary to provide the level and types of care needed for the resident population; (iv) The physical environment, equipment, services, and other physical plant considerations that are necessary to care for this population; and (v) Any ethnic, cultural, or religious factors that may potentially affect the care provided by the	F 838	1. No resident's were identified to have been impacted by the incomplete Facility Assessment 2. All residents had the potential to be affected by the incomplete Facility Assessment. The organization will complete the Facility Assessment. 3. Additional information has been obtained and will be compiled into a complete Facility Assessment with input from the Medical Director and key facility leadership, The Facility Assessment will address all required components including: a facility based and community based all-hazard risk assessment, health information technology resources and electronically sharing information with other organizations. Where needed, appropriate polcies / procedures / protocols will be refined and/or developed and scheduled for implementation to support the processes addressed in the Facility Assessment. 4. The completed Facility Assessment will be reviewed and revised annually. Completion date 04/23/2018	

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F 838	Continued From page 102 facility, including, but not limited to, activities and food and nutrition services. §483.70(e)(2) The facility's resources, including but not limited to, (i) All buildings and/or other physical structures and vehicles; (ii) Equipment (medical and non- medical); (iii) Services provided, such as physical therapy, pharmacy, and specific rehabilitation therapies; (iv) All personnel, including managers, staff (both employees and those who provide services under contract), and volunteers, as well as their education and/or training and any competencies related to resident care; (v) Contracts, memorandums of understanding, or other agreements with third parties to provide services or equipment to the facility during both normal operations and emergencies; and (vi) Health information technology resources, such as systems for electronically managing patient records and electronically sharing information with other organizations. §483.70(e)(3) A facility-based and community-based risk assessment, utilizing an all-hazards approach. This REQUIREMENT is not met as evidenced by: Based on staff interview and facility document review, it was determined that the facility staff failed to develop a complete facility assessment. The facility assessment failed to address a facility-based and community-based risk assessment, utilizing an all-hazards approach and failed to address health information technology resources, such as systems for electronically managing patient records and	F 838		

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F 838	Continued From page 103 electronically sharing information with other organizations. The findings include: Review of the facility assessment failed to reveal evidence of a facility-based and community-based risk assessment, utilizing an all-hazards approach and failed to address health information technology resources, such as systems for electronically managing patient records and electronically sharing information with other organizations. On 3/8/18 at 2:22 p.m., an interview was conducted with ASM (administrative staff member) #1 (the administrator). ASM #1 stated someone from a consulting group would be coming to the facility and working on the facility assessment with her. ASM #1 stated she met with the local coordinator of emergency services on October 24th and determined the facility was more at risk for a power outage. ASM #1 was asked to provide evidence that a facility-based and community-based risk assessment was completed. When asked for information regarding health information technology resources, ASM #1 stated OSM (other staff member) #4 (the business office manager) could provide that documentation. On 3/9/18 at 8:22 a.m., OSM #4 presented a business associate agreement and stated to look at section 3.b. Section 3.b. documented, "Safeguards. BUSINESS ASSOCIATE will establish and maintain appropriate safeguards and warrants that it has established sufficient safeguards, reasonably to prevent any use or disclosure of the PHI (Protected Health	F 838		

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	495358	A. BUILDING _____ B. WING _____	03/09/2018

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F 838	Continued From page 104 Information), other than as provided by the Prior Agreement, as amended by this Agreement, or as required by law. Without limiting the foregoing, BUSINESS ASSOCIATE agrees to implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of Electronic PHI. BUSINESS ASSOCIATE further warrants that it will not use or disclose any PHI in any manner that will violate HIPAA (Health Insurance Portability and Accountability Act) Regulations if (name of Facility Company) engaged in such activity." The agreement failed to address the facility's health information technology resources. On 3/9/18 at 9:13 a.m., ASM #1 was made aware the business associate agreement did not address the facility's health information technology resources. ASM #1 was also made aware this surveyor still needed evidence of an emergency risk assessment. ASM #1 stated she tried to "type something up last night." When asked if she had evidence of a risk assessment prior to the previous day, ASM #1 confirmed she did not. On 3/9/18 at 10:31 a.m., ASM #1 stated the facility did not have a policy regarding the facility assessment. No further information was presented prior to exit.	F 838		
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program	F 880	corrective Action 1. The facility adopted a policy for Water Management Program to Prevent Legionnaires Disease on 3/7/18.	

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F 880	Continued From page 105 designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the	F 880	2. There have been no negative outcomes related to the facility not having previously implemented the policy. Other Potential No resident was identified in this citation, but there could have been potential for any resident to be impacted in the event of contaminated water causing illness. 3. System Changes 1. Legionella policy was adopted by the facility on 3/7/18. 2. Facility staff will be educated on the policy 3. Nursing staff will be educated on Legionella, causes/signs and symptoms. Monitoring 1. Town of Amelia checks water samples twice a month and the Town of Amelia will notify us of any concerns with samples. 2. QA nurse upon monthly infection control tracking will nofiy DON regarding concerns. 3. QAPI committee will discuss the Legionnaires Policy that has been enforced and updated on preventing Legionella disease and discuss system changes. Completion date 04/23/2018	

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F 880	Continued From page 106 least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on staff interview and facility document review, it was determined that the facility staff failed to develop a complete infection control program. The facility staff failed to develop a protocol to address legionella (1). The findings include: On 03/06/18 at approximately 1:30 p.m., during the entrance conference with ASM (administrative staff member) # 1, administrator a request was made for the facility's legionella protocol.	F 880		

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F 880	Continued From page 107 On 03/07/17 at approximately 1:55 p.m. ASM # 1 provided this surveyor with a document entitled "Water Management Program to Prevent Legionnaire's Disease." Further review of the policy documented, "Approved by: (ASM # 3), medical director. Original Date: 3/7/18, (ASM # 1) administrator. Original Date: 3/7/18." On 03/07/18 at approximately 1:55 p.m. an interview was conducted with ASM # 1, administrator. When asked when the policy regarding legionella was developed, ASM # 1 stated, "It was done today." No further information was provided prior to exit. References: (1) Is a respiratory disease caused by Legionella bacteria. Sometimes the bacteria cause a serious type of pneumonia (lung infection) called Legionnaires' disease. The bacteria can also cause a less serious infection called Pontiac fever that has symptoms similar to a mild case of the flu. It is found naturally in freshwater environments, like lakes and streams. It can become a health concern when it grows and spreads in human-made water systems like showers and faucets, Cooling towers (air-conditioning units for large buildings), hot tubs that aren't drained after each use, decorative fountains and water features, hot water tanks and heaters, and large plumbing systems. This information was obtained from the website: https://www.cdc.gov/legionella/about/causes-transmission.html.	F 880		

State of Virginia

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F 000	Initial Comments An unannounced biennial State Licensure Inspection was conducted 03/06/18 through 03/09/18. Corrections are required for compliance with the following Virginia Rules and Regulations for the Licensure of Nursing Facilities. The census at this 100 certified bed facility was 85 at the time of the survey. The survey sample consisted of 18 current residents Resident #s (56, 9, 33, 61, 41, 8, 31, 25, 70, 72, 6, 63,19,76,137,15,50,10) and two closed records, Residents #s (88 and 87).	F 000		
F 001	Non Compliance The facility was out of compliance with the following state licensure requirements: This RULE: is not met as evidenced by: 12VAC5-371-250. Resident Assessment and Care Planning cross reference to F656.	F 001	Please reference plan of correction for FTag 656 for correction plan.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Virginia M. Snead | Administrator