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HERITAGE HALL NRSG AND REHAB	122 MORVEN PARK ROAD NW LEESBURG, VA 20176

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E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 4/17/18 through 4/19/18. The facility was in substantial compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities. No complaint(s) was/were investigated during the survey.	E 000		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 4/17/18 through 4/19/17. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. The census in this 164 certified bed facility was 139 at the time of the survey. The survey sample consisted of 30 current residents reviews (Residents # 9, 335, 124, 1, 62, 6, 42, 88, 10, 64, 91, 112, 52, 57, 84, 102, 65, 22, 83, 95, 2, 334, 130, 78, 77, 336, 110, 23, 36, and 29) and three closed record reviews (Residents #133, 134, and 135).	F 000		
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	F 622	**F622** **Corrective Action(s):** The facility staff failed to ensure all required documentation, Advance directives and comprehensive care plan goals were submitted to the receiving hospital for Residents #64, #110 and #134. A facility Incident & Accident Form has been completed for each resident involved.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Mary Shepard | TITLE: Administrator | (X6) DATE: 5/17/18

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

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F 622	Continued From page 1 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 § 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	F 622	**Identification of Deficient Practices/Corrective Action(s):** All other residents discharged and/or transferred from the facility may have been affected. The DON/designee will conduct a 100% audit of all residents who have been discharged and/or transferred from the facility in the past 30 days to identify residents that did not have the required documentation submitted to the receiving facility. A facility Incident & Accident Form will be completed for each negative finding. **Systemic Change(s):** Facility policy and procedures have been reviewed. No revisions are warranted at this time. The DON and/or Regional Nurse Consultant will inservice facility licensed staff on the documentation required to be submitted to the receiving facility when a resident is being transferred or discharged to the hospital or other outside health care facility. **Monitoring:** The DON/designee will be responsible for maintaining compliance. The DON and/or designee will conduct chart audits weekly of all residents who have been discharged and/or transferred from the facility to monitor for compliance. Any/all negative findings and or errors will be corrected at time of discovery. Aggregate findings of these audits will be reported to the Quality Assurance Committee quarterly for review, analysis, and recommendations for change in facility policy, procedure, and/or practice. **Completion Date: May 30, 2018**	

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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 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 all required documents were provided to the receiving

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hospital for three of 33 residents in the survey sample, Residents #110, #64 and #134.

1. The facility staff failed to provide evidence that all required information (including advance directives and comprehensive care plan goals) was provided to the hospital staff when Resident #110 was transferred to the hospital on 3/11/18.

2. The facility staff failed to provide evidence that all required information (including comprehensive care plan goals) was provided to the hospital staff when Resident #64 was transferred to the hospital on 01/30/18 and 02/05/18.

3. The facility staff failed to provide evidence that all required information (including comprehensive care plan goals) was provided to the hospital staff when Resident #134 was transferred to the hospital on 1/18/18.

The findings include:

1. The facility staff failed to provide evidence that all required information (including advance directives and comprehensive care plan goals) was provided to the hospital staff when Resident #110 was transferred to the hospital on 3/11/18.

Resident #110 was admitted to the facility on 11/9/12 and readmitted on 3/16/18. Resident #110's diagnoses included but were not limited to major depressive disorder, cognitive communication deficit and pneumonia. Resident #110's most recent MDS (minimum data set), a 30 day Medicare assessment with an ARD (assessment reference date) of 4/11/18, coded the resident's cognitive skills for daily decision-making as moderately impaired.

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Review of Resident #110's clinical record revealed a nurse's note that documented, "At 2000H (8:00 p.m.) resident observed walking out from his (sic), this nurse redirected the resident and him (sic) started to be agitated with this nurse and tried to hit to (sic) this nurse. Resident observed combative with staff when redirected. This nurse informed to (sic) DON (director of nursing) and MD (medical doctor) and received a T.O. (telephone order). Sent resident to ER (emergency room) for Eval (evaluation) and tx (treatment). POA (Power of attorney) was called and left message to call back."

Further review of Resident #110's clinical record failed to reveal documentation evidencing the information that was provided to the hospital when Resident #110 was transferred 3/11/18.

On 4/18/18 at 2:26 p.m., an interview was conducted with LPN (licensed practical nurse) #1. LPN #1 was asked to describe his role when a resident is transferred to the hospital. LPN #1 stated, "We get all the paperwork set up, call 911, call the doctor to let him know the resident is going out, make sure somebody is with the resident all the time then we call the hospital and give report so they know how to treat." When asked to explain the information that is provided to the hospital, LPN #1 stated, "Tell the hospital the reason we send the resident, medications, changes in the past history, so they know how to treat the resident." LPN #1 stated a face sheet, medication administration record, recent labs, doctor notes and a copy of a do not resuscitate order (if applicable) is also sent to the hospital. When asked if a resident's care plan goals are provided to the hospital staff, LPN #1 stated they

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are not. When asked how staff evidences the information provided to the hospital staff, LPN #1 stated, "We do nurses notes. Most of the time we say paperwork included and include our number in case they need anything extra."

On 4/18/18 at 5:10 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above findings.

On 4/19/18 at 7:15 a.m. (upon entrance into the facility conference room), a form was on the table (along with other requested documents). The form was a checklist that documented,
"(Name of facility)
PLACE ALL INFORMATION IN ENVELOPE FOR TRANSFER
__ Face Sheet
__ Current Medication List or Current MAR/TAR (medication administration record/treatment administration record)
__ Change in Conditions MD/Nurse Progress Notes
__ DNR (Do not resuscitate)/ Code Status
__ Most Recent History and Physical
__ Recent MD/NP/PA (medical doctor/nurse practitioner/physician assistant) and Specialist Orders
__ Relevant X-Rays and other Diagnostic Test Results
__ Copy of MD order to send to E.R
__ POA/RP (Power of attorney/responsible party) Notification
__ Verbal Report to E.R with Change in Condition
Res. (Resident) Baseline Level of Care"
The form was not filled out for any particular resident.

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On 4/19/18 at 8:44 a.m., ASM #2 was asked to explain the above form. ASM #2 stated the facility staff has a good relationship with the local hospital. ASM #2 stated she asked the hospital staff what they wanted facility staff to provide them (when a resident is transferred) and the items on the list are the items requested by the hospital staff. ASM #2 stated the facility staff also calls the hospital to give a report and even sometimes goes to the hospital to be with the resident until family can arrive. When asked to provide evidence of the information that was provided to hospital staff when Resident #110 was transferred to the hospital, ASM #2 stated she could call the head of the emergency room and ask for a copy of the information sent. When asked if the care plan goals are provided to the hospital staff, ASM #2 stated they are not.

On 4/19/18 at 11:50 a.m., ASM #2 provided a letter faxed by the emergency department clinical director on 4/19/18 that documented,
"To Whom it May Concern
This letter is to verify that (name of facility) does send patient information, including medication list and code status. In addition, they also call a nurse to nurse report before the patient is sent to the ER. All of these documents are scanned into the patient's records in the ER through our EPIC electronic charting system."

On 4/19/18 at approximately 1:00 p.m., ASM #2 provided a fax report from the hospital that included the documents that were sent to the hospital when Resident #110 was transferred on 3/11/18. The documents did not include advance directives or comprehensive care plan goals.

The facility policy titled, "Transfer or Discharge,

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Emergency" documented, "4. Should it become necessary to make an emergency transfer or discharge to a hospital or other related institution, our facility will implement the following procedures...b. Notify the receiving facility that the transfer is being made...d. Prepare a transfer form to send with the resident..."

No further information was provided prior to exit.

2. The facility staff failed to provide documented evidence of all transfer requirements for Resident #64 on 01/30/18 and 02/05/18.

Resident #64 was admitted to the facility on 01/05/17 with recent readmissions on 02/02/18 and 02/09/18, with diagnoses that included but were not limited to: dementia, hypoglycemia (low blood sugar) (1), depression, chronic kidney disease, arthritis, high blood pressure, and heart failure.

The most recent MDS (minimum data set) assessment, a 30 day Medicare assessment, with an assessment reference date of 03/07/18, coded the resident as scoring an "11" on the BIMS (brief interview for mental status) score, indicating she has moderate cognitive impairment of daily decision making. The resident was coded as requiring extensive assistance of one staff member for all of her activities of daily living.

The "Physician's Telephone Orders Form" dated 01/30/18, documented in part, "Send Resident to ER (emergency room) for evaluation. TO (telephone order) (name of doctor/name of nurse taking order)".

The nurse's note dated 01/30/18 at 12:57 p.m.

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documented in part, "Resident responding to family by opening eyes and moaning. Blood sugar 63 at 12:45 [p.m.]. MD (medical doctor) aware with order for glucagon (medicine used to treat severe low blood sugar) (2). Family would like Resident to go to hospital for CT (computed topography) Scan (a picture of the inside of a part of your body that is made by a computerized machine) (3). Famillly [sic] had said last evening that they wanted Resident to stay here and be kept comfortable, but have since changed their mind. MD aware with order to send to ER for evaluation."

The "Physician's Telephone Orders Form" dated 02/05/18, documented in part, "T.O. from M.D. Send Resident to ER for evaluation and treatment ...Dx (diagnosis) hypoglycemia (name of doctor/name of nurse taking order)".

The nurse's notes dated 02/05/18 documented in part, "5:23 PM: At 5pm called to room by staff ...observed Resident unresponsive, breathing normally, BS (blood sugar) checked 22, MD informed with new order to give glucagon. RP (responsible party) informed ...5:51 PM: Blood sugar rechecked 71. Resident became responsive now, talking ...son into visit. Informed also of blood sugar result ...8:05 PM: Blood sugar checked again 80. Son at bedside wanted Resident to go to ER. MD informed and spoke to son ...Report given to ER nurse (ER nurse's name)."

Review of the clinical record failed to evidence that a care plan with goals was included in the Resident #64's transfer documentation.

An interview was conducted with administrative

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staff member (ASM) #2, the director of nursing, on 04/19/18 at 08:45 a.m. ASM #2 provided the facility's "checklist" that documents the paper work that is to be sent in an envelope when a Resident is transferred to another facility. The checklist failed to document that a care plan is to be sent as well. When asked if the facility staff sends the comprehensive care plan with goals when a resident is transferred to the hospital, ASM #2 stated, "No". ASM #2 was made aware of the findings.

An interview was conducted with LPN (licensed practical nurse) #2 on 04/19/18 at 10:06 a.m., regarding the paperwork that is sent with a Resident when transferred to the hospital. LPN #2 stated, "once we get order from MD (medical doctor) to send a Resident to the hospital, we get face sheet w/ insurance info, any recent labs; any recent x-rays, code status, medical directive, nurses notes pertinent to situation and any pertinent MD notes." LPN #2 stated then we put paperwork in envelope and send it with patient by giving envelope to EMT (emergency medicine technician)". LPN #2 was asked if they send care plans or any documentation regarding resident goals. LPN #2 stated they do not send care plans or anything regarding goals when transferring Residents to the hospital.

ASM #1, the administrator, was made aware of the above findings on 4/19/18 at 10:45 a.m.

No further information was provided prior to exit.

(1) This information was obtained from the following website:
https://medlineplus.gov/hypoglycemia.html
(2) This information was obtained from the

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following website:
https://www.merriam-webster.com/dictionary/CT San
(3) This information was obtained from the following website:
https://www.mayoclinic.org/drugs-supplements/glucagon

3. The facility staff failed to provide evidence that all required information (including comprehensive care plan goals) was provided to the hospital staff whenResident #134 was transferred to the hospital on 1/18/18.

Resident #134 was admitted to the facility on 12/29/17 and discharged on 1/18/18 with the diagnoses of but not limited to respiratory failure with hypoxia, pneumonitis, malignant pleural effusion, hypoxemia, dysphagia, falls, diabetes, high blood pressure, osteoarthritis, cerebral aneurysm, cardiac arrhythmias, acute kidney failure, pacemaker, acidosis, heart failure, and lung cancer. The most recent MDS (Minimum Data Set) was an admission assessment with an ARD (Assessment Reference Date) of 1/5/18. The resident was coded as impaired in ability to make daily life decisions.

A review of the clinical record revealed a nurse's note dated 1/18/18 that documented, "This a.m. resident presented with respiratory distress, resp (respirations) 28, utilizing essesory [sic] muscles with breaths, breaths shallow, 80% (oxygen saturation) on 4L (four liters) of O2 (oxygen), BP (blood pressure) 130/74, temp (temperature) 98.5, skin warm, dry and ashy, lips cyanotic, HOB (head of bed) elevated the whole time. Resident able to respond to name being called. MD

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(medical doctor) made aware, 911 (emergency services number) activated, Duoneb [1] provided with 10L on 02 [sic]. Chest tube drained 250 MLs (milliliters) [sic] of red colored fluid. o2 [sic] sat (saturation) went to 97%, resident continued to utilize assessory [sic] muscles with resp. (respirations) Resp at 24. EMT's (Emergency Medical Technicians) arrived assessed resident, transported to hospital. Report called to hospital making them aware of resident being transferred. POA (Power of Attorney) phoned, left message to return call to facility, Call to POA placed again, left message to return call. POA later returned call and was aware of resident being in hospital. POA stated resient [sic] was being transferred to (another hospital). (Second hospital) phoned, resident admitted with respiratory failure."

Further review of the clinical record failed to reveal any evidence of what documentation was sent with the resident and/or what verbal information was provided to the hospital.

On 4/19/18 at 11:30 a.m., the facility provided a fax they received on 4/19/18 at 10:59 a.m., from the hospital, of copies of the documentation that was provided to the hospital emergency department at the time the resident was sent there. A review of the documents failed to reveal any evidence that the resident's care plan goals were provided, as required.

On 4/19/18 at approximately 8:44 a.m., in an interview with ASM #2 (Administrative Staff Member) the DON (Director of Nursing) she stated that the facility was not sending the care plan to the hospital because they did not know they had to provide the care plan goals, but that they "will be starting that today."

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F 622	Continued From page 12 On 4/19/18 at 10:51 a.m., ASM # 1, the administrator was made aware of the findings. No further information was provided. [1] Duoneb - A combination medication of albuterol and ipratropium used to prevent wheezing, difficulty breathing, chest tightness, and coughing in people with chronic obstructive pulmonary disease (COPD; a group of diseases that affect the lungs and airways) such as chronic bronchitis (swelling of the air passages that lead to the lungs) and emphysema (damage to the air sacs in the lungs). Information obtained from https://medlineplus.gov/druginfo/meds/a601063.html	F 622		
F 623 SS=D	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice.	F 623	**F623** **Corrective Action(s):** Resident #134's responsible party has been notified that the facility failed to provide a discharge/transfer notice for the resident's transfer to the hospital on 12/17/17. **Identification of Deficient Practices/Corrective Action(s):** All other residents discharged and/or transferred from the facility may have been affected. The Social Services Director and/or Admissions Director will conduct a 100% audit of all residents who have been discharged and/or transferred in the past 30 days. Residents identified at risk will be corrected at time of discovery and the required notifications to the residents' responsible party will be made. A facility Incident & Accident Form will be completed for each negative finding.	

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F 623	Continued From page 13 (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is 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	F 623	**Systemic Change(s):** Facility policy and procedures have been reviewed. No revisions are warranted at this time. The Administrator and/or Regional Nurse Consultant will inservice the facility's social worker(s) and nursing administration on the requirement that a resident's responsible party and the state ombudsman be notified of resident discharges/transfers. **Monitoring:** The Social Services Director will be responsible for maintaining compliance. The Social worker, and/or Admissions Director will conduct chart audits weekly of all residents who have been discharged and/or transferred from the facility. Any/all negative findings and or errors will be corrected at time of discovery and disciplinary action will be taken as needed. Aggregate findings of these audits will be reported to the Quality Assurance Committee quarterly for review, analysis, and recommendations for change in facility policy, procedure, and/or practice. **Completion Date: May 30, 2018**	

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Long-Term Care Ombudsman;
(vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and
(vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act.

§483.15(c)(6) Changes to the notice.
If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available.

§483.15(c)(8) Notice in advance of facility closure
In the case of facility closure, the individual who is the administrator of the facility must provide 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 and clinical record review, it was determined that facility staff failed

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to provide the required written notification to the resident representative for a facility-initiated transfer to the hospital for one of 33 residents in the survey sample; Resident #134.

The facility staff failed to provide Resident #134's representative with the required written notification of why the resident was sent to the hospital on 1/18/18.

The findings include:

Resident #134 was admitted to the facility on 12/29/17 and discharged on 1/18/18 with the diagnoses of but not limited to respiratory failure with hypoxia, pneumonitis, malignant pleural effusion, hypoxemia, dysphagia, falls, diabetes, high blood pressure, osteoarthritis, cerebral aneurysm, cardiac arrhythmias, acute kidney failure, pacemaker, acidosis, heart failure, and lung cancer. The most recent MDS (Minimum Data Set) was an admission assessment with an ARD (Assessment Reference Date) of 1/5/18. The resident was coded as impaired in ability to make daily life decisions.

A review of the clinical record revealed a nurse's note dated 1/18/18 that documented, "This a.m. resident presented with respiratory distress, resp (respirations) 28, utilizing essesory [sic] muscles with breaths, breaths shallow, 80% (oxygen saturation) on 4L (four liters) of O2 (oxygen), BP (blood pressure) 130/74, temp (temperature) 98.5, skin warm, dry and ashy, lips cyanotic, HOB (head of bed) elevated the whole time. Resident able to respond to name being called. MD (medical doctor) made aware, 911 (emergency services number) activated, Duoneb [1] provided

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with 10L on 02 [sic]. Chest tube drained 250 MLs (milliliters) [sic] of red colored fluid. o2 [sic] sat (saturation) went to 97%, resident continued to utilize assessory [sic] muscles with resp. Resp at 24. EMT's (Emergency Medical Technicians) arrived assessed resident, transported to hospital. Report called to hospital making them aware of resident being transferred. POA (Power of Attorney) phoned, left message to return call to facility, Call to POA placed again, left message to return call. POA later returned call and was aware of resident being in hospital. POA stated resient [sic] was being transferred to (another hospital). (Second hospital) phoned, resident admitted with respiratory failure."

Further review of the clinical record failed to reveal any evidence the resident representative was provided written notification of why the resident was transferred to the hospital on 1/18/18.

On 4/19/18 at approximately 8:44 a.m., in an interview with ASM #2 (Administrative Staff Member) the DON (Director of Nursing) she stated that the facility was not sending the written notification at the time of this transfer (1/18/18) because they did not know at the time it was a requirement. ASM #2 stated that the facility did not start sending the written notifications until February, 2018. (Note: Closed records reviewed for the months of and after February 2018 did not reflect this deficiency.)

On 4/19/18 at 10:51 a.m., the Administrator was made aware of the findings. No further information was provided.

[1] Duoneb - A combination medication of

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F 623	Continued From page 17 albuterol and ipratropium used to prevent wheezing, difficulty breathing, chest tightness, and coughing in people with chronic obstructive pulmonary disease (COPD; a group of diseases that affect the lungs and airways) such as chronic bronchitis (swelling of the air passages that lead to the lungs) and emphysema (damage to the air sacs in the lungs). Information obtained from https://medlineplus.gov/druginfo/meds/a601063.html	F 623		
F 625 SS=D	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing	F 625	**F625** **Corrective Action(s):** Residents #110, #64, #134 and their RP's have been notified of the facilities bed-hold policy and procedure and the requirement that it reviewed and issued in writing to the resident and the RP when discharge to the hospital or when going out on therapeutic leave. An Incident and Accident report has been completed for each resident identified in the review. **Identification of Deficient Practice(s) and Corrective Action(s):** All other residents could potentially be affected. The Bed-Hold policy and forms are now kept at the nursing station for after hour's transfers to the hospital to be completed by the charge nurse. The Social Services director/Admissions director will be responsible for normal business hour transfer notification of all bed-holds to residents and/or Responsible parties. **Systemic Change(s):** The facility Policy and Procedure has been reviewed and no changes are warranted at this time. The Social Services Director, Admissions Director and licensed staff have been inserviced by the administrator on the bed-hold requirement and the proper use and notification of Bed-Hold policy.	

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F 625	Continued From page 18 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, facility document review and clinical record review, it was determined that the facility staff failed to evidence a written bed hold policy was provided within 24 hours of a facility initiated transfer for three of 33 residents in the survey sample, Residents #110, #64 and #134. 1. The facility staff failed to provide Resident #110's representative written notification of the bed hold policy when the resident was discharged to the hospital on 3/11/18. 2. The facility staff failed to provide written bed hold information to Resident #64's responsible party when the resident was discharged to the hospital on 01/30/18 and 02/05/18. 3. The facility staff failed to provide Resident #134's resident representative the required bed hold notification when the resident was sent to the hospital on 1/18/18. The findings include: 1. The facility staff failed to provide Resident #110's representative written notification of the bed hold policy when the resident was discharged to the hospital on 3/11/18. Resident #110 was admitted to the facility on 11/9/12 and readmitted on 3/16/18. Resident #110's diagnoses included but were not limited to	F 625	**Monitoring:** The Admissions Director and Social Service Director are responsible for compliance. All transfers/discharges from the facility will be audited the by the Social service director and/or Admissions Director to ensure proper bed-hold notification was completed at the time of transfer or therapeutic leave. Any/all negative findings will be corrected at time of discovery. The results of these audits will be forwarded to the Quality Assurance Committee quarterly for review, analysis, and recommendations for change in facility policy, procedure, and/or practice. **Completion Date: May 30, 2018**	

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major depressive disorder, cognitive communication deficit and pneumonia. Resident #110's most recent MDS (minimum data set), a 30 day Medicare assessment with an ARD (assessment reference date) of 4/11/18, coded the resident's cognitive skills for daily decision-making as moderately impaired.

Review of Resident #110's clinical record revealed a nurse's note that documented, "At 2000H (8:00 p.m.) resident observed walking out from his (sic), this nurse redirected the resident and him (sic) started to be agitated with this nurse and tried to hit to (sic) this nurse. Resident observed combative with staff when redirected. This nurse informed to (sic) DON (director of nursing) and MD (medical doctor) and received a T.O. (telephone order). Sent resident to ER (emergency room) for Eval (evaluation) and tx (treatment). POA (Power of attorney) was called and left message to call back."

Further review of Resident #110's clinical record failed to reveal the facility staff provided written information regarding the bed hold policy to Resident #110"s representative.

On 4/18/18 at 1:43 p.m., an interview was conducted with OSM (other staff member) #8 (the admissions director and the person responsible for providing the bed hold policy). OSM #8 was asked to explain the process for providing the bed hold policy to a resident's representative when a resident is discharged to the hospital. OSM #8 stated she calls the resident's family member and leaves a message if she is not able to reach the family member. OSM #8 stated when she speaks to the family member, she makes notation whether the family member elects or

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declines a bed hold. When asked if she provides written information regarding the bed hold policy, OSM #8 stated, "Not typically at the time because I'm not seeing them in person at the time so it's more verbal but it's done on admission."

On 4/18/18 at 1:51 p.m., OSM #8 provided the bed hold agreement related to Resident #110's discharge on 3/11/18. OSM #8 confirmed the bed hold information was provided over the phone. The form was dated 3/12/18 and documented, "Bed Hold Agreement
The undersigned wish to reserve a bed for (name of Resident #110), while he or she is away from the facility for a hospitalization or therapeutic leave. The resident shall be obligated to pay $305.00 per day to hold a bed. A deposit for three days is due in advance. The bed reservation will be effective beginning 3/11/18. This bed hold may be extended, by making a written request stating the number of days the undersigned wishes to reserve the bed and payment in advance of the bed hold charges as referenced above. The undersigned acknowledges that he/she has read and fully understands the provisions of the Bed Hold Agreement. I/We authorize (name of facility) to transfer funds from the Resident's personal account to pay the cost for the requested bed hold days. Yes___ No X. I/We understand that the Admission Agreement and all associated documents dated _____ remain in full force and effect throughout the bed hold period and when the Resident returns to the facility. This agreement is binding upon the parties, their heirs, assigns, successors and legal representatives."
The following handwritten notes were documented on the agreement:
"Spoke w/ (with) (name of Resident #110's

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daughter) 3/12 (Monday) 1:50p. Offered Bed hold @ (at) 305.00 a day. Wants to speak w/ her husband. Will Call me back with answer today. DTR (Daughter) called back 3:40 (p.m.) 3/13. Passing on Bed hold on North unit. She thinks he need (sic) Memory Care for his Dementia, if Bed available at time of D/C (discharge)."

On 4/18/18 at 5:10 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above findings.

No further information was provided prior to exit.
2. The facility staff failed to provide written bed hold information to Resident #64's responsible party when the resident was discharged to the hospital on 01/30/18 and 02/05/18.

Resident #64 was admitted to the facility on 01/05/17 with recent readmissions on 02/02/18 and 02/09/18, with diagnoses that included but were not limited to: dementia, hypoglycemia (low blood sugar) (1), depression, chronic kidney disease, arthritis, high blood pressure and heart failure.

The most recent MDS (minimum data set) assessment, a 30 day Medicare assessment, with an assessment reference date of 03/07/18, coded the resident as scoring an "11" on the BIMS (brief interview for mental status) score, indicating she has moderate cognitive impairment of daily decision making. The resident was coded as requiring extensive assistance of one staff member for all of her activities of daily living.

The "Physician's Telephone Orders Form" dated 01/30/18, documented in part, "Send Resident to

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ER (emergency room) for evaluation. TO (telephone order) (name of doctor/name of nurse taking order)".

The nurse's note dated 01/30/18 at 12:57 p.m. documented in part, "Resident responding to family by opening eyes and moaning. Blood sugar 63 at 12:45 [p.m.]. MD (medical doctor) aware with order for glucagon (medicine used to treat severe low blood sugar) (2). Family would like Resident to go to hospital for CT (computed topography) Scan (a picture of the inside of a part of your body that is made by a computerized machine) (3L). Famillly [sic] had said last evening that they wanted Resident to stay here and be kept comfortable, but have since changed their mind. MD aware with order to send to ER (emergency room) for evaluation."

The nurse's notes dated 02/05/18 documented in part, "5:23 PM: At 5pm called to room by staff ...observed Resident unresponsive, breathing normally, BS (blood sugar) checked 22, MD informed with new order to give glucagon. RP (responsible party) informed ...5:51 PM: Blood sugar rechecked 71. Resident became responsive now, talking ...son into visit. Informed also of blood sugar result ...8:05 PM: Blood sugar checked again 80. Son at bedside wanted Resident to go to ER. MD informed and spoke to son ...Report given to ER nurse (ER nurse's name)."

On 4/19/18 at 07:30 a.m., the facility provided copies of the "Bed Hold Agreement" for Resident #64's hospital admissions on 01/30/18 and 02/05/18 to this surveyor for review. On the 01/30/18 bed hold document, in the area provided for the Responsible Party's (RP) Signature

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documented, "Agreed via phone call". On the 02/05/18 bed hold document, in the area provided for the Responsible Party's Signature documented, "verbal agreement". The facility representative who signed each bed hold document was OSM (other staff member) #8, the admissions director.

During an interview with administrative staff member (ASM) #2, director of nursing, conducted on 04/19/18 at 08:52 a.m., ASM #2 was asked if the RP's were provided with a written copy of the bed hold. ASM #2 stated that she was unsure and she would check with OSM #8 to verify.

An interview was conducted with OSM #8, admissions director, at 09:00 a.m. on 04/19/18. OSM #8 was asked if written bed hold documents were provided to the RP. OSM #8 stated "No". ASM #2 was made aware of these findings.

ASM #1, the administrator, was made aware of the above findings on 4/19/18 at 10:45 a.m.

No further information was obtained prior to exit.

(1) This information was obtained from the following website:
https://medlineplus.gov/hypoglycemia.html
(2) This information was obtained from the following website:
https://www.merriam-webster.com/dictionary/CT San
(3) This information was obtained from the following website:
https://www.mayoclinic.org/drugs-supplements/glucagon

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3. The facility staff failed to provide Resident #134's resident representative the required bed hold notification when the resident was sent to the hospital on 1/18/18.

Resident #134 was admitted to the facility on 12/29/17 and discharged on 1/18/18 with the diagnoses of but not limited to respiratory failure with hypoxia, pneumonitis, malignant pleural effusion, hypoxemia, dysphagia, falls, diabetes, high blood pressure, osteoarthritis, cerebral aneurysm, cardiac arrhythmias, acute kidney failure, pacemaker, acidosis, heart failure, and lung cancer. The most recent MDS (Minimum Data Set) was an admission assessment with an ARD (Assessment Reference Date) of 1/5/18. The resident was coded as impaired in ability to make daily life decisions.

A review of the clinical record revealed a nurse's note dated 1/18/18 that documented, "This a.m. resident presented with respiratory distress, resp (respirations) 28, utilizing essesory [sic] muscles with breaths, breaths shallow, 80% (oxygen saturation) on 4L (four liters) of O2 (oxygen), BP (blood pressure) 130/74, temp (temperature) 98.5, skin warm, dry and ashy, lips cyanotic, HOB (head of bed) elevated the whole time. Resident able to respond to name being called. MD (medical doctor) made aware, 911 (emergency services number) activated, Duoneb [1] provided with 10L on 02 [sic]. Chest tube drained 250 MLs (milliliters) [sic] of red colored fluid. o2 [sic] sat (saturation) went to 97%, resident continued to utilize assessory [sic] muscles with resp. Resp at 24. EMT's (Emergency Medical Technicians) arrived assessed resident, transported to hospital. Report called to hospital making them aware of resident being transferred. POA (Power

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of Attorney) phoned, left message to return call to facility, Call to POA placed again, left message to return call. POA later returned call and was aware of resident being in hospital. POA stated resient [sic] was being transferred to (another hospital). (Second hospital) phoned, resident admitted with respiratory failure."

Further review of the clinical record failed to reveal any evidence the resident representative (RP) was provided with a written (or verbal) bed hold notification when the resident was sent to the hospital on 1/18/18.

On 4/19/18 at 9:00 a.m., in an interview with OSM #8 (Other Staff Member) the Admissions Director, she stated that a bed hold "was not provided for him (the resident representative)." OSM #8 stated, "He made it very clear from the get-go (time of admission) that he did not want to spend one dollar outside of what Medicare provided." OSM #8 stated, "He made it extremely clear several times." She stated that because of such, the resident representative was not provided a bed hold at all, in writing or verbally, other than what was included in the admission paperwork at the time of admission (12/29/17). OSM #8 stated that he refused to take financial responsibility for anything.

On 4/19/18 at 10:51 AM, the Administrator was made aware of the findings. No further information was provided.

[1] Duoneb - A combination medication of albuterol and ipratropium used to prevent wheezing, difficulty breathing, chest tightness, and coughing in people with chronic obstructive pulmonary disease (COPD; a group of diseases

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F 625	Continued From page 26 that affect the lungs and airways) such as chronic bronchitis (swelling of the air passages that lead to the lungs) and emphysema (damage to the air sacs in the lungs). Information obtained from https://medlineplus.gov/druginfo/meds/a601063.html	F 625		
F 638 SS=D	Qrtly Assessment at Least Every 3 Months CFR(s): 483.20(c) §483.20(c) Quarterly Review Assessment A facility must assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months. 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 complete a MDS (minimum data set) assessment within the required time frame for two of 33 residents in the survey sample, Residents #1 and #2. 1. The facility staff failed to complete Resident #1's quarterly MDS every three months. The resident's most recent completed MDS was an annual assessment with an ARD (assessment reference date) of 11/15/17. 2. The facility staff failed to complete Resident #2's quarterly MDS every three months. The resident's most recent completed MDS was a quarterly assessment with an ARD of 11/28/17. The findings include: 1. The facility staff failed to complete Resident	F 638	**F638** **Corrective Action(s):** Resident #1 & #2 have had a Comprehensive Significant Change Assessment completed to accurately assess each resident. Resident #1 & #2 have had their comprehensive care plan revised to reflect resident specific approaches and interventions to address their specific needs. **Identification of Deficient Practice and Corrective Action(s):** All other residents may have potentially been affected. A 100% review of resident assessments will be done by the RCC and/or designee to ensure that all residents requiring a quarterly MDS have had one completed in the last 92 days. Any/all negative findings will be reported to the resident care coordinator at time of discovery for immediate correction. Comprehensive care plans will be revised as needed to reflect resident specific measurable objectives and interventions. **Systemic Change(s):** The facility Policy and Procedure has been reviewed and no changes are warranted at this time. The RCC has been inserviced by the Regional Nurse Consultant on scheduling and completing MDS assessments per the Resident Assessment Instrument (RAI) manual guidelines.	

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F 638	Continued From page 27 #1's quarterly MDS every three months. The resident's most recent completed MDS was an annual assessment with an ARD (assessment reference date) of 11/15/17. Resident #1 was admitted to the facility on 12/23/16. Resident #1's diagnoses included but were not limited to muscle weakness, difficulty swallowing and abnormal posture. Review of Resident #1's clinical record revealed the most recently completed MDS was an annual MDS with an ARD of 11/15/17. On 4/19/18 at 9:17 a.m., an interview was conducted with RN (registered nurse) #1 (the MDS coordinator). RN #1 was asked when MDS assessments should be completed. RN #1 stated the assessments should be completed every quarter. When asked to clarify what every quarter meant, RN #1 stated, "Every 91 days." RN #1 was made aware of the above findings. RN #1 reviewed the computer and stated another assessment should have been completed on 2/7/18. RN #1 confirmed the assessment was not done. On 4/19/18 at 9:24 a.m., ASM (administrative staff member) #1 (the administrator) was made aware of the above findings. Chapter two of the Centers for Medicare and Medicaid Services Resident Assessment Instrument manual documented, "The Quarterly assessment is an OBRA (Omnibus Budget Reconciliation Act) non-comprehensive assessment for a resident that must be completed at least every 92 days following the previous OBRA assessment of any type. It is	F 638	**Monitoring:** The RCC is responsible for compliance. The RCC and/or designee weekly MDS audits coinciding with the MDS calendar to monitor for timely completion of MDS assessments per the RAI guidelines. Any/all negative findings will be reported to the DON and the RCC will make corrections at the time of discovery. Aggregate findings of the audits will be reported to the Quality Assurance Committee for review, analysis, and recommendations for change in facility policy, procedure, and/or practice. **Completion Date: May 30, 2018**	

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used to track a resident's status between comprehensive assessments to ensure critical indicators of gradual change in a resident's status are monitored. As such, not all MDS items appear on the Quarterly assessment. The ARD (A2300) must be not more than 92 days after the ARD of the most recent OBRA assessment of any type."

No further information was presented prior to exit.

2. The facility staff failed to complete Resident #2's quarterly MDS every three months. The resident's most recent completed MDS was a quarterly assessment with an ARD of 11/28/17.

Resident #2 was admitted to the facility on 8/29/11. Resident #2's diagnoses included but were not limited to shortness of breath, muscle weakness and difficulty in walking.

Review of Resident #2's clinical record revealed the most recently completed MDS was a quarterly MDS with an ARD of 11/28/17.

On 4/19/18 at 9:17 a.m., an interview was conducted with RN (registered nurse) #1 (the MDS coordinator). RN #1 was asked when MDS assessments should be completed. RN #1 stated the assessments should be completed every quarter. When asked to clarify what every quarter meant, RN #1 stated, "Every 91 days." RN #1 was made aware of the above findings and asked when the next MDS assessment should have been completed. RN #1 stated the MDS should have been done on 2/20/18 and confirmed it was not done.

On 4/19/18 at 9:24 a.m., ASM (administrative

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F 638	Continued From page 29 staff member) #1 (the administrator) was made aware of the above findings. No further information was presented prior to exit.	F 638		
F 641 SS=E	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, it was determined that the facility staff failed to complete an accurate MDS (minimum data set) assessment for six of 33 residents in the survey sample, Residents #10, #91, #95, #23, #42 and #78. 1. a. The facility staff inaccurately coded weight loss on Resident #10's quarterly MDS with an ARD (assessment reference date) of 11/7/17. 1. b. The facility staff inaccurately coded a diagnosis of psychotic disorder on Resident #10's quarterly MDS with an ARD of 1/22/18. 2. The facility staff inaccurately coded a diagnosis of psychotic disorder on Resident #91's quarterly MDS with an ARD of 3/26/18. 3. The facility staff inaccurately coded a diagnosis of psychotic disorder on Resident #95's quarterly MDS with an ARD of 3/30/18. 4. The facility staff failed to accurately code Resident # 23's diagnosis on the quarterly MDS (minimum data set) assessment with an ARD	F 641	**F641** **Corrective Action(s):** Resident #10 has had their most recent MDS modified to accurately code section K to reflect no significant weight loss and section I to accurately code their current medical diagnosis. A facility Incident & Accident form was completed for this incident. Resident #91, #95, #23, #42 and #78 have had their most recent MDS modified to accurately code section I to reflect the resident's current medical diagnosis. A facility Incident & Accident form was completed for this incident. **Identification of Deficient Practice(s) and Corrective Action(s):** All other residents may have potentially been affected. A 100% audit of all current resident assessments will be completed by the MDS Coordinator and/or designee to ensure that MDS section I – Active Diagnosis and Section K – Nutrition is assessed and coded correctly. All negative findings will be reported to the MDS department for immediate correction. A Modification will be completed for each discrepancy identified on the most current MDS.	

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F 641	Continued From page 30 (assessment reference date) of 02/02/18. 5. The facility staff inaccurately code Resident #42 as having a diagnosis of psychotic disorder on the annual MDS with an ARD of 2/16/18. 6. The facility staff inaccurately coded Section I - Active Diagnoses for Resident #78. The findings include: 1. a. The facility staff inaccurately coded weight loss on Resident #10's quarterly MDS with an ARD (assessment reference date) of 11/7/17. Resident #10 was admitted to the facility on 1/20/15. Resident #10's diagnoses included but were not limited to unspecified dementia (1) with behavioral disturbance, anxiety disorder and chronic kidney disease. Resident #10's most recent MDS, a quarterly assessment with an ARD of 4/16/18, coded the resident's cognition as severely impaired. Resident #10's quarterly MDS with an ARD of 11/7/17 documented, "K0300. Weight Loss. Loss of 5% or more in the last month or loss of 10% or more in the last 6 months- 2. Yes, not on physician-prescribed weight-loss regimen." Review of Resident #10's clinical record revealed the resident's weight was 98.5 pounds on 10/5/17 and 98 pounds on 11/5/17 (only a loss of 0.51 percent in one month). Further review of Resident #10's clinical record revealed the resident's weight was 106.3 pounds on 5/1/17 and 98 pounds on 11/5/17 (only a loss of 8.47 percent in six months).	F 641	**Systemic Change(s):** The Resident Interdisciplinary Care Team have been inserviced by the Regional Nurse consultant on the proper assessment and coding of all areas of the MDS to include sections I and K of the MDS. All comprehensive MDS's and quarterly MDS's will now be reviewed each week according to the MDS schedule by the RCC and/or DON to ensure the accuracy and integrity of resident data. **Monitoring:** The DON and RCC are responsible for monitoring compliance. The MDS assessment audit will be completed weekly coinciding with the MDS calendar to monitor for compliance. All negative findings from the audits will be reported to the DON and RCC at the time of discovery for immediate correction. Aggregate findings will be reported to the Quality Assurance Committee monthly for review, analysis, and recommendations for change in facility policy, procedure, and/or practice. **Completion Date: May 30, 2018**	

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On 4/18/18 at 4:34 p.m., an interview was conducted with RN (registered nurse) #1 (the MDS coordinator). RN #1 was made aware of the above concern. RN #1 stated Resident #10's weight had been stable. When asked if the resident had presented with a significant weight loss, RN #1 stated, "No." RN #1 confirmed Resident #10's MDS was inaccurately coded.

On 4/18/18 at 5:10 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above findings.

Chapter three of the Centers for Medicare and Medicaid Services Resident Assessment Instrument manual documented, "K0300: Weight Loss...Coding Instructions...Code 0, no or unknown if the resident has not experienced weight loss of 5% or more in the past 30 days or 10% or more in the last 180 days or if information about prior weight in not available...Code 2, yes, not on physician-prescribed weight-loss regimen: if the resident has experienced a weight loss of 5% or more in the past 30 days or 10% or more in the last 180 days, and the weight loss was not planned and prescribed by a physician."

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

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information was obtained from the website: https://medlineplus.gov/dementia.html

1. b. The facility staff inaccurately coded a diagnosis of psychotic disorder on Resident #10's quarterly MDS with an ARD of 1/22/18.

Section I "Active Diagnoses" of Resident #10's quarterly MDS with an ARD of 1/22/18 documented, "I. Active Diagnoses in the last 7 days- Check all that apply." A check was coded beside "I5950. Psychotic Disorder (2)..." Review of Resident #10's clinical record (including diagnoses, physician notes and psychiatry notes) failed to reveal Resident #10 presented with a psychotic disorder (or psychotic behaviors such as hallucinations or delusions).

On 4/18/18 at 2:01 p.m., an interview was conducted with RN (registered nurse) #1 (the MDS coordinator). RN #1 was asked to research and then explain why Resident #10's MDS coded the resident as having a psychotic disorder.

On 4/18/18 at 3:28 p.m., RN #1 stated Resident #10 was coded as having a psychotic disorder because the resident had a diagnosis of unspecified dementia with behavioral disturbance. When RN #1 was asked for her source used to classify unspecified dementia with behavioral disturbance as a psychotic disorder, RN #1 stated her previous boss taught her to.

On 4/18/18 at 4:34 p.m., another interview was conducted with RN #1. RN #1 was asked if a resident could have dementia with behavioral disturbance and not present with psychosis. RN #1 stated, "If they have dementia with behaviors they usually have psychosis that is causing the

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behavior like sundowners." RN #1 was asked if a resident with dementia could have behaviors that are not related to psychosis. RN #1 stated, "It all depends on what those behaviors are." RN #1 was asked to present evidence that Resident #10's behaviors were related to psychosis.

On 4/18/18 at 5:10 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above findings.

On 4/19/18 at 8:30 a.m., RN #1 stated review of Resident #10's clinical record only revealed "regular" behaviors such as yelling or hitting, with no psychotic features.

Chapter three of the Centers for Medicare and Medicaid Services Resident Assessment Instrument manual documented, "Section I: ACTIVE DIAGNOSES...Steps for Assessment...1. Identify diagnoses: The disease conditions in this section require a physician-documented diagnosis (or by a nurse practitioner, physician assistant, or clinical nurse specialist if allowable under state licensure laws) in the last 60 days...Coding Instructions: Code diseases that have a documented diagnosis in the last 60 days and have a direct relationship to the resident's current functional status, cognitive status, mood or behavior status, medical treatments, nursing monitoring, or risk of death during the 7-day look-back period..."

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

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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://medlineplus.gov/dementia.html

(2) "Psychotic disorders are severe mental disorders that cause abnormal thinking and perceptions. People with psychoses lose touch with reality. Two of the main symptoms are delusions and hallucinations. Delusions are false beliefs, such as thinking that someone is plotting against you or that the TV is sending you secret messages. Hallucinations are false perceptions, such as hearing, seeing, or feeling something that is 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=psychotic+disorder&_ga=2.157471289.2059850956.1524141461-139120270.1477942321

2. The facility staff inaccurately coded a diagnosis of psychotic disorder on Resident #91's quarterly MDS with an ARD of 3/26/18.

Resident #91 was admitted to the facility on 10/2/14. Resident #91's diagnoses included but were not limited to unspecified dementia with behavioral disturbance (1), chronic kidney disease and high blood pressure. Resident #91's most recent MDS, a quarterly assessment with an ARD of 3/26/18, coded the resident's cognitive skills for daily decision-making as moderately impaired. Section I "Active Diagnoses" of

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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
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Resident #91's MDS documented, "I. Active Diagnoses in the last 7 days- Check all that apply." A check was coded beside "I5950. Psychotic Disorder (2)..." Review of Resident #91's clinical record (including diagnoses, physician notes and psychiatry notes) failed to reveal Resident #91 presented with a psychotic disorder (or psychotic behaviors such as hallucinations or delusions).

On 4/18/18 at 2:01 p.m., an interview was conducted with RN (registered nurse) #1 (the MDS coordinator). RN #1 was asked to research and then explain why Resident #91's MDS coded the resident as having a psychotic disorder.

On 4/18/18 at 3:28 p.m., RN #1 stated Resident #91 was coded as having a psychotic disorder because the resident had a diagnosis of unspecified dementia with behavioral disturbance. When RN #1 was asked for her source used to classify unspecified dementia with behavioral disturbance as a psychotic disorder, RN #1 stated her previous boss taught her to.

On 4/18/18 at 4:34 p.m., another interview was conducted with RN #1. RN #1 was asked if a resident could have dementia with behavioral disturbance and not present with psychosis. RN #1 stated, "If they have dementia with behaviors they usually have psychosis that is causing the behavior like sundowners." RN #1 was asked if a resident with dementia could have behaviors that are not related to psychosis. RN #1 stated, "It all depends on what those behaviors are." RN #1 was asked to present evidence that Resident #91's behaviors were related to psychosis.

On 4/18/18 at 5:10 p.m., ASM (administrative

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

On 4/19/18 at 8:30 a.m., RN #1 stated review of Resident #91's clinical record only revealed "regular" behaviors such as yelling or hitting, with no psychotic features.

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://medlineplus.gov/dementia.html

(2) "Psychotic disorders are severe mental disorders that cause abnormal thinking and perceptions. People with psychoses lose touch with reality. Two of the main symptoms are delusions and hallucinations. Delusions are false beliefs, such as thinking that someone is plotting against you or that the TV is sending you secret messages. Hallucinations are false perceptions, such as hearing, seeing, or feeling something that is 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=psychotic+disorder&_ga=2.157471289.2059850956.1524141461-139120270.1477942321

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3. The facility staff inaccurately coded a diagnosis of psychotic disorder on Resident #95's quarterly MDS (minimum data set) with an ARD (assessment reference date) of 3/30/18.

Resident #95 was admitted to the facility on 1/26/16. Resident #95's diagnoses included but were not limited to unspecified dementia with behavioral disturbance, high blood pressure and diabetes. Resident #95's most recent MDS, a quarterly assessment with an ARD of 3/30/18, coded the resident's cognition as severely impaired. Section I "Active Diagnoses" of Resident #95's MDS documented, "I. Active Diagnoses in the last 7 days- Check all that apply." A check was coded beside "I5950. Psychotic Disorder (2)..." Review of Resident #95's clinical record (including diagnoses, physician notes and psychiatry notes) failed to reveal Resident #95 presented with a psychotic disorder (or psychotic behaviors such as hallucinations or delusions).

On 4/18/18 at 2:01 p.m., an interview was conducted with RN (registered nurse) #1 (the MDS coordinator). RN #1 was asked to research and then explain why Resident #95's MDS coded the resident as having a psychotic disorder.

On 4/18/18 at 3:28 p.m., RN #1 stated Resident #95 was coded as having a psychotic disorder because the resident had a diagnosis of unspecified dementia with behavioral disturbance. When RN #1 was asked for her source used to classify unspecified dementia with behavioral disturbance as a psychotic disorder, RN #1 stated her previous boss taught her to.

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On 4/18/18 at 4:34 p.m., another interview was conducted with RN #1. RN #1 was asked if a resident could have dementia with behavioral disturbance and not present with psychosis. RN #1 stated, "If they have dementia with behaviors they usually have psychosis that is causing the behavior like sundowners." RN #1 was asked if a resident with dementia could have behaviors that are not related to psychosis. RN #1 stated, "It all depends on what those behaviors are." RN #1 was asked to present evidence that Resident #95's behaviors were related to psychosis.

On 4/18/18 at 5:10 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above findings.

On 4/19/18 at 8:30 a.m., RN #1 stated review of Resident #95's clinical record only revealed "regular" behaviors such as yelling or hitting, with no psychotic features.

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://medlineplus.gov/dementia.html

(2) "Psychotic disorders are severe mental disorders that cause abnormal thinking and

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perceptions. People with psychoses lose touch with reality. Two of the main symptoms are delusions and hallucinations. Delusions are false beliefs, such as thinking that someone is plotting against you or that the TV is sending you secret messages. Hallucinations are false perceptions, such as hearing, seeing, or feeling something that is 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=psychotic+disorder&_ga=2.157471289.2059850956.1524141461-1391 20270.1477942321

4. The facility staff failed to accurately code Resident # 23's diagnosis on the quarterly MDS (minimum data set) assessment with an ARD (assessment reference date) of 02/02/18.

Resident # 23 was admitted to the facility on 11/24/15 with diagnoses that included but were not limited to dementia with behavioral disturbances (1), major depressive disorder (2), osteoporosis (3) and dysphagia (4).

Resident # 23's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 02/02/18 coded Resident # 23 as being severely impaired of cognition for making daily decisions. Resident # 23 was coded as requiring extensive assistance to being totally dependent of one staff member for activities of daily living. Review of "Section E Behavior" documented zeros for the presence and frequency of behavioral symptoms. Under "Section I Active Diagnoses" it documented, "I. Active Diagnoses in the last 7 (seven) days - Check all that apply." Under "Psychiatric/Mood

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Disorder", there was a check mark in the box identifying "I5950. Psychiatric Disorder (other than schizophrenia)."

The POS (physician's order sheet) dated April 2018 documented, "Dx (diagnosis): Unspecified dementia with behavioral disturbance."

On 04/19/18 at 10:45 a.m., an interview was conducted with RN (registered nurse) # 1, MDS (minimum data set) coordinator. When asked about the diagnosis of psychiatric disorder documented on Resident # 23's quarterly MDS assessment with an ARD (assessment reference date) of 02/02/18, RN # 1 stated, "I thought of dementia with behavioral disturbances as a psychiatric disorder."

On 04/19/18 at 12:00 p.m. ASM (administrative staff member) # 1, the administrator, and ASM # 2, the director of nursing, were made aware of the above concerns.

No further information was provided prior to exit.

References:
(1) Psychological symptoms and behavioral abnormalities are common and prominent characteristics of dementia. They include symptoms such as depression, anxiety psychosis, agitation, aggression, disinhibition, and sleep disturbances. Approximately 30% to 90% of patients with dementia suffer from such behavioral disorders. There are complex interactions between cognitive deficits, psychological symptoms, and behavioral abnormalities. This information was obtained from the website:
https://www.ncbi.nlm.nih.gov/pmc/articles/PMC31

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81717/.

(2) Major depression is a mood disorder. It occurs when feelings of sadness, loss, anger, or frustration get in the way of your life over a long period of time. It also changes how your body works. This information was obtained from the website: https://medlineplus.gov/ency/article/000945.htm.

(3) Makes your bones weak and more likely to break. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/osteoporosis.html.

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

5. The facility staff inaccurately code Resident #42 as having a diagnosis of psychotic disorder on the annual MDS (minimum data set) with an ARD (assessment reference date) of 2/16/18.

Resident #42 was admitted on 4/14/17 with the diagnoses of but not limited to cerebral vascular disease, anxiety disorder, insomnia, falls, depression, migraines, dysphagia, osteoarthritis, dementia with behaviors, and high blood pressure. 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 moderately impaired in ability to make daily life decisions. The resident was coded as requiring extensive assistance with bathing and hygiene; limited assistance with transfers and dressing; supervision for ambulation, eating, and toileting; and as

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incontinent of bowel and bladder.

A review of the above MDS revealed in Section I, Active Diagnoses, under "Psychiatric/Mood Disorder" the box next to I5950 "Psychotic Disorder [1] (other than schizophrenia)" was checked.

A review of the clinical record failed to reveal a physician-documented diagnosis of psychotic disorder.

On 4/19/18 at 10:03a.m. in an interview with RN #1 (Registered Nurse) the MDS nurse, she stated that because the resident had a diagnosis of "Unspecified dementia with behavioral disturbance [2]", she was taught by a previous supervisor to code those residents as psychotic. RN #1 stated she was told wrong and the MDS was therefore not coded accurately for diagnoses.

On 4/19/18 at 10:51 a.m., the Administrator was made aware of the findings. No further information was provided.

[1] Psychotic Disorder - Disorders in which there is a loss of ego boundaries or a gross impairment in reality testing with delusions or prominent hallucinations.
Information obtained from https://www.ncbi.nlm.nih.gov/mesh/?term=%22psychotic%20disorders%22%5BMeSH%20Terms%5D&cmd=DetailsSearch

[2] Unspecified dementia with behavioral disturbance - Psychological symptoms and behavioral abnormalities are common and

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prominent characteristics of dementia. They include symptoms such as depression, anxiety psychosis, agitation, aggression, disinhibition, and sleep disturbances. Approximately 30% to 90% of patients with dementia suffer from such behavioral disorders.
Information obtained from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3181717/

6. The facility staff failed to accurately code Section I - Active Diagnoses for Resident #78.

Resident #78 was admitted to the facility on 1/31/13 with diagnoses that included but were not limited to: unspecified dementia with behavioral disturbance, high blood pressure, diabetes, and depression.

The most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 4/19/18, coded the resident as having both short and long-term memory difficulties and as being severely impaired to make daily cognitive decisions. Resident #78 was coded in Section I - Active Diagnoses as having a Psychotic Disorder (Disorders in which there is a loss of ego boundaries or a gross impairment in reality testing with delusions or prominent hallucinations) (1).

The clinical record was reviewed. There was no documented evidence of Resident #78 having a psychotic disorder. The physician order summary for April 2018 failed to evidence any documented diagnosis of a psychotic disorder. The resident was documented as having unspecified dementia with behavioral disturbances.

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The physician progress notes going back to 3/22/17, failed to evidence documentation of a psychotic disorder.

An interview was conducted with RN (registered nurse) #1, the MDS nurse, on 4/18/18 at 3:40 p.m. When asked why(Resident #78) was coded as having a psychotic disorder, RN #1 stated, "I was taught by the previous MDS nurse that if a resident has a diagnosis of unspecified dementia with behavioral disturbance I was to code it as a psychotic disorder. When asked if unspecified dementia with behavioral disturbance is a psychotic disorder, RN #1 stated she would get back with the survey team.

RN #1 returned to this surveyor on 4/18/18 at 4:20 p.m. and presented a paper "Frontiers in Neurology" form 2012. The article was reviewed by the survey team members and did not feel it was appropriate. RN #1 was asked to locate any documentation of the resident having psychotic components of unspecified dementia with behavioral disturbances.

On 4/19/18 at 8:30 a.m., RN #1 stated the resident had regular behaviors but no documentation of psychotic features.

A request was made on 4/19/18 at approximately 9:30 a.m. for a copy of any psychiatry/psychology progress notes. None were provided.

On 4/19/18, administrative staff member (ASM) #3, the corporate nurse, informed this surveyor the facility staff uses the RAI (resident instrument manual) for completing the MDS assessments.

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F 641	Continued From page 45 The administrator was made aware of the above concern on 4/19/18 at 10:10 a.m. (1) This information was obtained from the following website: https://www.ncbi.nlm.nih.gov/mesh/?term=%22psychotic%20disorders%22%5BMeSH%20Terms%5D&cmd=DetailsSearch	F 641		
F 812 SS=D	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined that the facility staff failed to serve food in a sanitary manner in one of three dining areas.	F 812	**F812** **Corrective Action(s):** The Dietary Aide observed passing desert bowls improperly in the dining room observation has been inserviced on the proper procedure for wearing and changing gloves during food preparation and delivery. A Facility Incident & Accident form has been completed for this incident. **Identification of Deficient Practices & Corrective Action(s):** All other residents may have been potentially affected. The Food Service Manager or designee will monitor the tray line and dining room meal pass process during all meal services for 3 days to identify any negative findings. All negative findings will be corrected at time of discovery. A Risk Management Incident Report will be completed for each negative finding identified. All negative findings will result in appropriate disciplinary action.	

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F 812	Continued From page 46 The facility staff failed to change gloves between pushing a serving cart and serving residents' desserts in the main dining room. The findings include: On 04/17/18 at 11:20 a.m., an observation of the lunch meal was conducted in the main dining room. OSM (other staff member) # 1, dietary aide, was observed pushing a serving cart throughout the dining room while wearing disposable gloves. The serving cart had two shelves on it and the shelves contained numerous small-uncovered dessert bowls containing sliced pears. OSM # 1 stopped at each dining room table, pick up a bowl of pears wearing the same gloves she use to push the serving cart and placed the bowl of pears in front of each resident at the table. Further observation of OSM # 1 picking up the bowls of pears revealed her thumb was placed on the inside lip of the bowl. OSM # 1 was observed serving 25 dessert bowls to residents in the dining room in this manner. On 04/17/18 at 1:08 p.m., an interview was conducted with OSM # 1, dietary aide. When asked why she was wearing gloves when serving the dessert OSM # 1 stated, "It's so you don't touch the resident's food." When asked how the resident's dessert bowls should be handled OSM # 1 demonstrated using an empty bowl and placed her right thumb on the top inside edge of the bowl. When asked if it was appropriate to grasp the bowls using the same-gloved hands that were used to push the serving cart OSM #1 stated, "I don't think so." On 04/17/18 at 1:19 p.m., an interview was	F 812	**Systemic Change(s):** Current facility policy & procedure has been reviewed and no changes are warranted at this time. The consulting Registered Dietician will inservice the CDM and dietary staff on the proper preparing, storing and distribution of food under sanitary conditions, as well as the policy and procedure for proper glove usage and hand washing. **Monitoring:** The CDM is responsible for maintaining compliance. The Administrator and/or Food service manager will complete 3 meal pass audits weekly to monitor and maintaining compliance. The results of these audits will be reported to the Quality Assurance Committee for review, analysis, & recommendations for change in facility policy, procedure, and/or practice. **Completion Date: May 30, 2018**	

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F 812	Continued From page 47 conducted with OSM # 2, dietary manager. When asked to describe the purpose for wearing gloves for meal service, OSM # 2 stated, "So the resident's food is not touched with the staff's bare hands. You should not use the same gloved hands for the same task." When informed of the observation of OSM # 1 during lunch in the main dining room, OSM # 2 stated OSM # 1 should have changed her gloves before serving the residents. The facility's policy "Safety and Sanitation -Section E. IX. Glove Use" documented, "Policy: Gloves will be worn to maintain safe and sanitary food preparation and service. PROCEDURE: 3. Proper use of gloves: d) Change gloves whenever you change an activity, the type of food being worked with, or whenever you leave the work station." On 04/18/18 at 5:05 p.m. ASM (administrative staff member) # 1, the administrator, and ASM # 2, the director of nursing, were made aware of the above concerns. No further information was provided prior to exit.	F 812		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so.	F 842	**F842** **Corrective Action(s):** Resident #336's attending physician has been notified that the facility staff failed to accurately document that the resident was receiving oxygen therapy on the Nursing daily skilled assessment. A facility Incident & Accident form has been completed for this incident.	

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	495261	A. BUILDING _____ B. WING _____	04/19/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HALL NRSG AND REHAB	122 MORVEN PARK ROAD NW LEESBURG, VA 20176

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F 842	Continued From page 48 §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when	F 842	**Identification of Deficient Practices & Corrective Action(s):** All other Skilled residents may have potentially been affected. A 100% review of all current Medicare Part A Skilled Resident's Medical Records will be conducted by the DON, ADON, and/or Unit Managers to identify residents at risk. All negative findings will be correct as applicable at time of discovery. A facility Incident & Accident form will be completed for each negative finding. **Systemic Change(s):** The facility policy and procedure has been reviewed and no changes are warranted at this time. All licensed nursing staff will be inserviced by the DON on the clinical documentation standards per facility policy and procedure. This training will include the standards for maintaining accurate medical records and clinical documentation to include Nursing Daily Skilled assessment and departmental notes according to the acceptable professional standards and practices. **Monitoring:** The DON is responsible for maintaining compliance. The DON, ADON and/or designee will conduct weekly chart audits coinciding with the Care Plan schedule to monitor for compliance. Any/all negative findings will be clarified and corrected at time of discovery and disciplinary action will be taken as needed. The results of this audit will be provided to the Quality Assurance Committee for analysis and recommendations for change in facility policy, procedure, and/or practice. **Completion Date: May 30, 2018**	

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there is no requirement in State law; or
(iii) For a minor, 3 years after a resident reaches legal age under State law.

§483.70(i)(5) The medical record must contain-
(i) Sufficient information to identify the resident;
(ii) A record of the resident's assessments;
(iii) The comprehensive plan of care and services provided;
(iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State;
(v) Physician's, nurse's, and other licensed professional's progress notes; and
(vi) Laboratory, radiology and other diagnostic services reports as required under §483.50.
This REQUIREMENT is not met as evidenced by:
Based on staff interview and clinical record review, it was determined the facility staff failed to maintain a complete and accurate medical record for one of 33 residents in the survey sample, Resident # 336.

The facility staff failed to ensure the facility's "Nursing Assessments" dated 04/16/18 and 04/17/18 accurately reflected Resident # 336's medical status.

The findings include:

Resident # 336 was admitted to the facility on 05/04/17 and a readmission on 04/13/18 with diagnoses that included but were not limited to fractured femur (1), cerebral infarction (2), hypertension (3) atrial fibrillation (4), benign prostatic hyperplasia (5) and anemia (6).

Resident # 336's admission MDS (minimum data

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F 842	Continued From page 50	F 842		

set) was not due at the time of the survey. Observations of Resident # 336 during the days of the survey revealed he was receiving oxygen at two liters per minute by nasal cannula.

The POS (physician's order sheet) for Resident # 336 dated April 2018 documented, "Oxygen at 2 (two) liters via (by) NC (nasal cannula) continuous. DX (diagnosis): SOB (shortness of breath). Date Ordered: 04/16/18. Start Date: 04/16/18."

The "Nursing Daily Assessment Of Skilled Resident" for Resident # 336 dated 04/16/18 and 04/17/18 failed to document the physician ordered oxygen.

On 04/19/18 at 7:35 a.m., an interview was conducted with LPN (licensed practical nurse) # 3. When asked about the discrepancy between The POS dated April 2018 and the "Nursing Daily Assessment Of Skilled Resident" for Resident # 336 dated 04/16/18 and 04/17/18, LPN # 3 stated the nursing daily assessments were incorrect. LPN # 3 then provided this surveyor with copies of the "Nursing Daily Assessment Of Skilled Resident" for Resident # 336 dated 04/16/18 and 04/17/18. Further review of the assessments revealed evidence documenting Resident # 336's physician ordered oxygen. LPN # 3 stated, "These were corrected this morning they correctly reflect the resident's current status and the physician's orders."

On 04/19/18 at 10:20 a.m., an interview was conducted with ASM (administrative staff member) # 2, director of nursing. When asked to describe the role of the facility's "Nursing Daily Assessment Of Skilled Resident" form ASM # 2

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F 842	Continued From page 51	F 842		

stated, "The nurse's complete the nursing daily assessment each day until the comprehensive assessment is completed." After reviewing the "Nursing Daily Assessment Of Skilled Resident" dated 04/16/18 and 04/17/18 for Resident # 336, ASM # 2 stated the assessments were not accurate concerning the physician's ordered oxygen.

On 04/19/18 at 12:00 p.m. ASM (administrative staff member) # 1, the administrator, and ASM # 2, the director of nursing, were made aware of the above concerns.

No further information was provided prior to exit.

References:
(1) You had a fracture (break) in the femur in your leg. It is also called the thigh bone. You may have needed surgery to repair the bone. You may have had surgery called an open reduction internal fixation. In this surgery, your surgeon will make a cut to open your fracture. This information was obtained from the website: https://medlineplus.gov/ency/patientinstructions/000166.htm.

(2) A stroke. When blood flow to a part of the 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 .

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

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essure.html.

(4) A problem with the speed or rhythm of the heartbeat. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/atrialfibrillation.html.

(5) An enlarged prostate. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/enlargedprostatebph.html.

(6) Low iron. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/anemia.html.

State of Virginia

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F 000	Initial Comments	F 000		

An unannounced biennial State Licensure Inspection was conducted 4/17/18 through 4/19/18. Corrections are required for compliance with 42CFR Part 483 Federal Long Term Care requirements and Virginia Rules and Regulations for the Licensure of Nursing Facilities.

The census in this 164 certified bed facility was 139 at the time of the survey. The survey sample consisted of 30 current residents reviews (Residents # 9, 335, 124, 1, 62, 6, 42, 88, 10, 64, 91, 112, 52, 57, 84, 102, 65, 22, 83, 95, 2, 334, 130, 78, 77, 336, 110, 23, 36, and 29) and three closed record reviews (Residents #133, 134, and 135).

F 001 Non Compliance — F 001

The facility was out of compliance with the following state licensure requirements:

This RULE: is not met as evidenced by:
12 VAC 5 - 371 - 340 cross references to F 812

12 VAC 5 - 371 - 360 - cross references to F 842

12VAC5-371-110. Management and administration
Cross reference to F625

12VAC5-371-140. Policies and procedures
Cross reference to F622, F623, and F625

12VAC5-371-150. Resident rights
Cross reference to F622, F623, and F625

12VAC5-371-250. Resident assessment and care planning
Cross reference to F641

F 001
12 VAC 5-371-340
Cross Reference to F 812

Cross Reference POC for F 812

12 VAC 5-371-360
Cross Reference to F 842

Cross Reference POC for F 842

12 VAC 5-371-110. Management and Administration
Cross Reference to F 625

Cross Reference POC for F 625

12 VAC 5-371-140. Policies and procedures
Cross Reference to F622, F623, and F625

Cross Reference POC for F622, F623, and F625

12 VAC 5-371-150. Resident Rights
Cross Reference to F622, F623, and F625

Cross Reference POC for F622, F623, and F625

12 VAC 371-250. Resident Assessment and Care Planning
Cross Reference to F641

Cross Reference POC for F641

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

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F 001	Continued From Page 1 12VAC5-371-360. Clinical records Cross reference to F622 12VAC5-371-250. Resident Assessment and Care Planning cross reference to F638 12VAC5-371-250. Resident Assessment and Care Planning cross reference to F641 12VAC5-371-140 Based on staff interview, facility document review, employee record review and the Code of Virginia 12VAC5-371-140E3, the facility staff failed to implement policies and procedures for abuse and neglect for three of 25 employees hired in the last two years. OSM (other staff member) # 9, OTR (Occupational Therapist, Registered) had a hire date of 01/02/2016. There was no sworn statement on file. OSM # 10, OTR had a hire date of 08/21/2017. There was no criminal background check on file. OSM # 11, COTA (Certified Occupational Therapy Assistant) had a hire date of 12/19/2017. There was no criminal background check on file. The findings include: A review of 25 employees hired in the last two years was conducted and revealed the following: OSM (other staff member) # 9, OTR (Occupational Therapist, Registered) had a hire date of 01/02/2016. There was no sworn	F 001	**12 VAC 5-371-360. Clinical Records** Cross Reference to F622 Cross Reference POC for F622 **12 VAC 5-371-250. Resident Assessment and Care Planning** Cross Reference to F638 Cross Reference POC for F638 **12 VAC 5-371-250. Resident Assessment and Care Planning** Cross Reference to F641 Cross Reference to POC for F641 **12 VAC 5-371-140 E.3** **Corrective Action(s):** Employee #9, OTR now has a sworn disclosure statement completed. A facility Incident and Accident for has been completed for this incident. Employee #10 (OTR) and #11 (COTA) have both had a background check completed by the appropriate state agency. A facility Incident & Accident form has been completed for this incident. **Identification of Deficient Practices & Corrective Action(s):** All other contract employees may have been potentially affected. The Therapy Company Human Resources department will audit 100% of all active contract therapy employee records to identify employees at risk. Any/all negative findings will be corrected at the time of discovery. A Facility Incident and Accident Report will be completed for any/all negative findings.	

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F 001	Continued From Page 2	F 001		

statement on file.

OSM # 10, OTR had a hire date of 08/21/2017. There was no criminal background check on file.

OSM # 11, COTA (Certified Occupational Therapy Assistant) had a hire date of 12/19/2017. There was no criminal background check on file.

On 04/19/18 at 11:00 a.m., an interview was conducted with OSM # 12, director of (Name of Rehabilitation Company's) rehabilitation department regarding the above information. OSM # 12 stated, "We are unable to locate the sworn statement for (OSM # 9). The background checks were not done for (OSM # 10 and # 11) in the correct time frame."

OSM # 4, human resources director was interviewed on 04/19/18 at approximately 11:15 a.m. regarding the above information. When asked who reviews the employee files for the (Name of Rehabilitation Company) OSM # 4 stated, "We're (Name of facility) is not responsible for making sure the paperwork for the contract employees is correct. It's the contract company's responsibility to ensure the employee's paperwork is accurate."

On 04/19/18 at 12:00 p.m., an interview was conducted with ASM (administrative staff member) # 1, administrator regarding the above information. ASM # 1 stated, "Last night (OSM # 4) and I checked the employee files of the rehabilitation department who are contracted." When asked if the contract employee files were check by the facility to ensure they were accurate prior to last evening ASM # 1 stated, "No. We're responsible to do so."

Systemic Change(s):
The facility policy and procedure has been reviewed and no changes are warranted at this time. The Contract Therapy Program manager was inserviced and issued a copy of the policy & procedure regarding abuse prevention and pre-employment procedures by the Administrator. Perspective employees will not be allowed to work until all required documentation has been obtained and verified by the Contract Therapy Program manager.

Monitoring:
The Administrator is responsible for maintaining compliance. The Administrator and/or Human Resources Director will conduct monthly audits of all new hire contract therapy employee files each month to maintain compliance. The administrator will review all audits and report aggregate findings to the Quality Assurance Committee for review, analysis, and recommendations for changes in policy, procedure, and/or facility practice.
Completion Date: May 30, 2018

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F 001	Continued From Page 3	F 001		

A review of the facility's policy titled "Abuse, Neglect and Exploitation Prevention and reporting" documented, "The facility must: 3d. Background, reference and credentials's checks should be conducted on employees prior to or at the time of employment, by facility administration, in accordance with applicable state and federal regulations."

On 04/19/18 at 12:00 p.m. ASM (administrative staff member) # 1, the administrator, and ASM # 2, the director of nursing, were made aware of the above concerns.

No further information was provided prior to exit.