STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495334	A. BUILDING _____ B. WING _____	04/26/2018

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E 000	Initial Comments The unannounced Standard Medicaid/Medicare survey was conducted on 04/24/18 through 04/26/18. Corrections are required for compliance with the Emergency Preparedness requirements and with 42 CFR Part 483 Federal Long Term requirements. The Life Safety Code report will follow. The census in this136 bed facility at the time of the survey was 75. The survey sample consisted of 31 current and closed records.	E 000		
E 006 SS=C	Plan Based on All Hazards Risk Assessment CFR(s): 483.73(a)(1)-(2) [(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do the following:] (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach.* *[For LTC facilities at §483.73(a)(1):] (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing residents. *[For ICF/IIDs at §483.475(a)(1):] (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing clients. (2) Include strategies for addressing emergency events identified by the risk assessment. * [For Hospices at §418.113(a)(2):] (2) Include	E 006	E006- Plan Based on all Hazards Risk Assessment 1. The EPP will be updated to include the Hazard Risk Assessment. 2.All residents have the potential to be affected by this deficient practice 3.All current staff and new hires will be trained by the maintenance director on the importance of the EPP.	C 6/10/18

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed Lisa Hollingham TITLE: Administrator (X6) DATE: 5-23-18

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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E 006	Continued From page 1 strategies for addressing emergency events identified by the risk assessment, including the management of the consequences of power failures, natural disasters, and other emergencies that would affect the hospice's ability to provide care. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility staff failed to have documentation that the facility's emergency preparedness plan was based on an all-hazards approach specific to the facilities geographic location and associated strategies. The findings included: During the Emergency Preparedness Review on 4/26/18 at 10:15 A.M. with the Administrator and Maintenance Director the facility staff failed to have documentation of which risk assessments and associated strategies were included and why based on the potential hazards and how they were conducted. The Maintenance Director stated there was no documentation for the facility's Emergency Preparedness risk assessment. The facility staff failed to have documentation of the facility's risk assessments and associated strategies.	E 006	4.EPP will be reviewed at least annually and as needed.	
E 007 SS=C	EP Program Patient Population CFR(s): 483.73(a)(3) [(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do the following:]	E 007		

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E 007	Continued From page 2 (3) Address patient/client population, including, but not limited to, persons at-risk; the type of services the [facility] has the ability to provide in an emergency; and continuity of operations, including delegations of authority and succession plans.** *Note: ["Persons at risk" does not apply to: ASC, hospice, PACE, HHA, CORF, CMCH, RHC, FQHC, or ESRD facilities.] This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility staff failed to include plans of how the facility plan to continue during an emergency and delegation of authority plans. The findings included: During an interview on 4/26/18 at 10:20 A.M. with the administrator and maintenance director they were asked for documentation for the facility's plan to continue operation during an emergency. The Administrator stated, they did not have documentation for the continuation of operation during an emergency. The administrator was asked if the facility had documentation for the delegation of authority plan during an emergency. The administrator and maintenance director stated, they did not have documentation for delegation of authority during an emergency. The facility staff failed to have documentation for how the facility will continue to operate during an emergency and delegation of authority during an emergency.	E 007	E007- EPP Patient Program 1.The EPP will be updated to include the operational plan for how the facility will continue to operate during an emergency and delegation of authority during an emergency. 2. All residents have the potential to be affected by this deficient practice 3.All current staff will be inserviced by the Maintenance Director on the operational plan during and emergency and the delegation of authority during an emergency. 4.The EPP will be reviewed annually and as needed.	6/10/18
E 015	Subsistence Needs for Staff and Patients	E 015		

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E 015 SS=C	Continued From page 3 CFR(s): 483.73(b)(1) [(b) Policies and procedures. [Facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually.] At a minimum, the policies and procedures must address the following: (1) The provision of subsistence needs for staff and patients whether they evacuate or shelter in place, include, but are not limited to the following: (i) Food, water, medical and pharmaceutical supplies (ii) Alternate sources of energy to maintain the following: (A) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions. (B) Emergency lighting. (C) Fire detection, extinguishing, and alarm systems. (D) Sewage and waste disposal. *[For Inpatient Hospice at §418.113(b)(6)(iii):] Policies and procedures. (6) The following are additional requirements for hospice-operated inpatient care facilities only. The policies and procedures must address the following: (iii) The provision of subsistence needs for hospice employees and patients, whether they evacuate or shelter in place, include, but are not limited to the following:	E 015	E015- Subsistence needs for staff and patients 1.The EPP will be updated to include a fire watch program. The facility will obtain provisions for sewage disposal during an emergency and make that part of the EPP. 2.All residents have the potential to be affected by this deficient practice. 3. All current staff will be inserviced by the maintenance director on the fire watch program. 4. The EPP will be reviewed annually and as needed.	6/10/18

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E 015	Continued From page 4 (A) Food, water, medical, and pharmaceutical supplies. (B) Alternate sources of energy to maintain the following: (1) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions. (2) Emergency lighting. (3) Fire detection, extinguishing, and alarm systems. (C) Sewage and waste disposal. This REQUIREMENT is not met as evidenced by: Based on documentation, record review and staff interview, the facility staff failed to have documentation that the emergency preparedness plan provided for sewage disposal and fire watch detection. The findings included: During an interview with the administrator and director of maintenance on 4/26/18 at 10:46 A.M. the maintenance director stated, the emergency preparedness plan did not have a documented fire watch process. During an interview with the administrator she was asked if the facility had procedures to provide sewage disposal. The administrator stated , "no." The facility staff failed to have documentation for fire watch process and provisions for sewage disposal.	E 015		
E 018 SS=C	Procedures for Tracking of Staff and Patients CFR(s): 483.73(b)(2) [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness	E 018		

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E 018	Continued From page 5 policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually.] At a minimum, the policies and procedures must address the following:] (2) A system to track the location of on-duty staff and sheltered patients in the [facility's] care during an emergency. If on-duty staff and sheltered patients are relocated during the emergency, the [facility] must document the specific name and location of the receiving facility or other location. *[For PRTFs at §441.184(b), LTC at §483.73(b), ICF/IIDs at §483.475(b), PACE at §460.84(b):] Policies and procedures. (2) A system to track the location of on-duty staff and sheltered residents in the [PRTF's, LTC, ICF/IID or PACE] care during and after an emergency. If on-duty staff and sheltered residents are relocated during the emergency, the [PRTF's, LTC, ICF/IID or PACE] must document the specific name and location of the receiving facility or other location. *[For Inpatient Hospice at §418.113(b)(6):] Policies and procedures. (ii) Safe evacuation from the hospice, which includes consideration of care and treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s) and primary and alternate means of communication with external sources of assistance. (v) A system to track the location of hospice employees' on-duty and sheltered patients in the	E 018	E018- Procedure for tracking of staff and patients 1. The EPP will be updated to include the procedure for tracking residents and staff locations during an emergency. 2.All resident have the potential to be affected by this deficient practice. 3.All current staff will be inserviced by the maintenance director on the procedure for tracking residents and staff locations during an emergency. 4. EPP training will be done annually and as needed.	6/10/18

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E 018	Continued From page 6 hospice's care during an emergency. If the on-duty employees or sheltered patients are relocated during the emergency, the hospice must document the specific name and location of the receiving facility or other location. *[For CMHCs at §485.920(b):] Policies and procedures. (2) Safe evacuation from the CMHC, which includes consideration of care and treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s); and primary and alternate means of communication with external sources of assistance. *[For OPOs at § 486.360(b):] Policies and procedures. (2) A system of medical documentation that preserves potential and actual donor information, protects confidentiality of potential and actual donor information, and secures and maintains the availability of records. *[For ESRD at § 494.62(b):] Policies and procedures. (2) Safe evacuation from the dialysis facility, which includes staff responsibilities, and needs of the patients. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility staff failed to include policy and procedures to include emergency preparedness training for staff in tracking residents' and staff location. The findings included: During an interview on 4/26/18 at 10:52 A.M. with the administrator and the maintenance director, they were asked for policy and procedures to	E 018		

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E 018	Continued From page 7 document the location and of residents and staff during an emergency. The administrator stated, they did not have any policy and procedures for tracking residents during an emergency nor had staff been trained. The facility staff failed to include policies and procedures for tracking resident location during an emergency and training staff on the tracking system.	E 018		
E 020 SS=C	Policies for Evac. and Primary/Alt. Comm. CFR(s): 483.73(b)(3) [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. At a minimum, the policies and procedures must address the following:] Safe evacuation from the [facility], which includes consideration of care and treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s); and primary and alternate means of communication with external sources of assistance. *[For RNHCs at §403.748(b)(3) and ASCs at §416.54(b)(2):] Safe evacuation from the [RNHCI or ASC] which includes the following: (i) Consideration of care needs of evacuees. (ii) Staff responsibilities. (iii) Transportation.	E 020		

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E 020	Continued From page 8 (iv) Identification of evacuation location(s). (v) Primary and alternate means of communication with external sources of assistance. * [For CORFs at §485.68(b)(1), Clinics, Rehabilitation Agencies, OPT/Speech at §485.727(b)(1), and ESRD Facilities at §494.62(b)(2):] Safe evacuation from the [CORF; Clinics, Rehabilitation Agencies, and Public Health Agencies as Providers of Outpatient Physical Therapy and Speech-Language Pathology Services; and ESRD Facilities], which includes staff responsibilities, and needs of the patients. * [For RHCs/FQHCs at §491.12(b)(1):] Safe evacuation from the RHC/FQHC, which includes appropriate placement of exit signs; staff responsibilities and needs of the patients. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility staff emergency preparedness plan failed to include policies and procedures for the safe evacuation from the facility. The findings included: During an interview on 4/26/18 at 11:00 A.M. with the administrator and maintenance director, they were asked for documentation that the emergency preparedness plan included policies and procedures for safe evacuation from the facility. The administrator stated the emergency preparedness plan did not include policies and procedures for the safe evacuation from the	E 020	E20-Policies for evacuation and primary/alt. communication 1.The EPP will be updated to include the procedure for safe evacuation from the facility for all residents and staff 2. All residents have the potential to be affected by this deficient practice. 3.All current staff will be inserviced by the maintenance director on procedure for safe evacuation from the facility. 4. The EPP will be reviewed annually and as needed.	6/10/18 3

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E 020	Continued From page 9 facility. The facility staff failed to develop policies and procedures for the safe evacuation from the facility.	E 020		
E 022 SS=C	Policies/Procedures for Sheltering in Place CFR(s): 483.73(b)(4) [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. At a minimum, the policies and procedures must address the following:] (4) A means to shelter in place for patients, staff, and volunteers who remain in the [facility]. [(4) or (2),(3),(5),(6)] A means to shelter in place for patients, staff, and volunteers who remain in the [facility]. *[For Inpatient Hospices at §418.113(b):] Policies and procedures. (6) The following are additional requirements for hospice-operated inpatient care facilities only. The policies and procedures must address the following: (i) A means to shelter in place for patients, hospice employees who remain in the hospice. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility staff failed to develop policies and procedures for how the facility will provide a	E 022	E022-Policy and procedure for sheltering in place 1.The EPP was updated to include the procedure for use of volunteers who remain in the facility while sheltering in place. 2.All volunteers have the potential to be affected by this deficient practice. 3.All current staff will be inserviced by the maintenance director on the procedure for sheltering in place and the use of volunteers. 4.The EPP will reviewed annually and as needed.	6/10/18

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E 022	Continued From page 10 means to shelter in place for volunteers who remain in the facility. The findings include: During an interview on 4/26/18 at 11:08 A.M. with the administrator and the maintenance director they were asked for documentation that the facility's emergency preparedness plan included policies and procedures for the use of volunteers who remain in the facility while sheltering in place. The administrator stated, the facility had not developed any policies and procedures for the use of volunteers who remain in the facility during shelter in place. The facility failed to develop policies and procedures for volunteers during shelter in place.	E 022		
E 026 SS=C	Roles Under a Waiver Declared by Secretary CFR(s): 483.73(b)(8) [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. At a minimum, the policies and procedures must address the following:] (8) [(6), (6)(C)(iv), (7), or (9)] The role of the [facility] under a waiver declared by the Secretary, in accordance with section 1135 of the Act, in the provision of care and treatment at an alternate care site identified by emergency management officials.	E 026	E026- Rules under a waiver declared by the secretary 1. The EPP will be updated to include the Procedure for providing care at an alternate site during an emergency. 2.All residents have the potential to be affected by this deficient practice . 3.All current staff will be inserviced by the	6/10/18

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E 026	Continued From page 11 *[For RNHCIs at §403.748(b):] Policies and procedures. (8) The role of the RNHCI under a waiver declared by the Secretary, in accordance with section 1135 of Act, in the provision of care at an alternative care site identified by emergency management officials. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility staff failed to develop policies and procedures for proving care at alternate sites. The findings included: During an interview on 4/26/18 at 11:18 A.M. with the administrator and maintenance director, the administrator was asked for documentation that policies and procedures had been developed for providing care at alternate sites during an emergency. The administrator stated the facility did not have policies and procedures for providing care and treatment at alternate care sites. The facility staff failed to develop policies and procedures for providing care and treatment at alternate care site.	E 026	maintenance director on the procedure for providing care at an alternate site during an emergency. 4.EPP will be reviewed annually and as needed.	
E 030 SS=C	Names and Contact Information CFR(s): 483.73(c)(1) [(c) The [facility, except RNHCIs, hospices, transplant centers, and HHAs] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least annually. The communication plan must include all of the following:]	E 030	E030-Names and contact information 1 The EPP was updated to include the names and contact information of all staff and volunteers.	

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E 030	Continued From page 12 (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians (iv) Other [facilities]. (v) Volunteers. *[For RNHCIs at §403.748(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Next of kin, guardian, or custodian. (iv) Other RNHCIs. (v) Volunteers. *[For ASCs at §416.45(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians. (iv) Volunteers. *[For Hospices at §418.113(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Hospice employees. (ii) Entities providing services under arrangement. (iii) Patients' physicians. (iv) Other hospices.	E 030	2.All residents have the potential to be affected by this deficient practice. 3.All staff contact information will be reviewed monthly for accuracy by the Administrator/designee this practice will be ongoing 4. The EPP will be reviewed annually and as needed.	6/10/18

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E 030	Continued From page 13 *[For OPOs at §486.360(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Volunteers. (iv) Other OPOs. (v) Transplant and donor hospitals in the OPO's Donation Service Area (DSA). This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility staff failed to provide documentation that all facility contact information was included in the emergency communication plan. The findings included: During an interview on 4/26/18 at 11: 24 A.M. with the administrator and the maintenance director, they were asked to provide documentation of the communication plan with the names and contact information of volunteers and staff. The facility staff failed to provide documentation that the communication plan provided documentation of the names and contact information of volunteers and staff.	E 030		
E 033 SS=C	Methods for Sharing Information CFR(s): 483.73(c)(4)-(6) [(c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least annually.] The communication plan must include all of the following:	E 033		

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E 033	Continued From page 14 (4) A method for sharing information and medical documentation for patients under the [facility's] care, as necessary, with other health providers to maintain the continuity of care. (5) A means, in the event of an evacuation, to release patient information as permitted under 45 CFR 164.510(b)(1)(ii). [This provision is not required for HHAs under §484.22(c), CORFs under §485.68(c), and RHCs/FQHCs under §491.12(c).] (6) [(4) or (5)]A means of providing information about the general condition and location of patients under the [facility's] care as permitted under 45 CFR 164.510(b)(4). *[For RNHCIs at §403.748(c):] (4) A method for sharing information and care documentation for patients under the RNHCI's care, as necessary, with care providers to maintain the continuity of care, based on the written election statement made by the patient or his or her legal representative. *[For RHCs/FQHCs at §491.12(c):] (4) A means of providing information about the general condition and location of patients under the facility's care as permitted under 45 CFR 164.510(b)(4). This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility staff failed to develop policies and procedures that the facility will use to release resident information. The findings included:	E 033	E033- Methods of sharing information 1.The EPP was updated to include the procedure for the release of resident information including general condition and location of the residents during an emergency. 2.All residents have the potential to be affected by this deficient practice. 3.All current staff will be inserviced and all new employees on hire and at least annually. 4. The EPP will be reviewed annually and as needed.	6/10/18

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E 033	Continued From page 15 During an interview on 4/26/18 at 11:27 A.M. with the administrator and maintenance director, they were asked for documentation that the communication plan included policies and procedures for the release of resident information including general condition, and location of residents. The administrator stated, they had not developed policies and procedures for the release of resident information. The facility staff failed to develop policies and procedures for the release of resident information.	E 033		
E 035 SS=C	LTC and ICF/IID Sharing Plan with Patients CFR(s): 483.73(c)(8) [(c) The [LTC facility and ICF/IID] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least annually.] The communication plan must include all of the following: (8) A method for sharing information from the emergency plan, that the facility has determined is appropriate, with residents [or clients] and their families or representatives. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility staff failed to provide documentation that staff had reviewed the emergency preparedness plan. The findings included: During an interview on 4/26/18 at 11:33 A.M. with	E 035	E035- Sharing Plan with Patients 1.The EPP will be updated to include documentation that all staff has been inserviced on the plan. 2.All residents have the potential to be affected by the deficient practice. 3.All staff will be inserviced on the EPP annually. 4.The EPP will be reviewed annually.	6/10/18

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E 035	Continued From page 16 the administrator and maintenance director they were asked for documentation that staff had reviewed the emergency preparedness plan. The maintenance director and administrator stated, "staff had not review the emergency preparedness plan." The facility staff failed to provide documentation that staff had reviewed the emergency preparedness plan.	E 035		
E 036 SS=C	EP Training and Testing CFR(s): 483.73(d) (d) Training and testing. The [facility] must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least annually. *[For ICF/IIDs at §483.475(d):] Training and testing. The ICF/IID must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least annually. The ICF/IID must meet the requirements for evacuation drills and training at §483.470(h).	E 036	E036-EP Training and Testing 1.The EPP will be updated to include a training and testing program that is based on the emergency plan. 2.All residents have the potential to be affected by this deficient practice. 3.All staff will be inserviced on the EPP annually. 4.The EPP will be reviewed annually and as needed.	6/10/18

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E 036	Continued From page 17 *[For ESRD Facilities at §494.62(d):] Training, testing, and orientation. The dialysis facility must develop and maintain an emergency preparedness training, testing and patient orientation program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training, testing and orientation program must be reviewed and updated at least annually. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility staff failed to have a written training and testing emergency preparedness program. The findings included: During an interview on 4/26/18 at 11:37 A.M. with the administrator and the maintenance director, they were asked for documentation of the facilities written training and testing program. The administrator stated, "The facility did not develop a training and testing program." The facility staff failed to develop a written training and testing program.	E 036		
E 037 SS=C	EP Training Program CFR(s): 483.73(d)(1) (1) Training program. The [facility, except CAHs, ASCs, PACE organizations, PRTFs, Hospices, and dialysis facilities] must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing	E 037	E037- EP training program 1.The EPP will be updated to include an initial emergency preparedness training program.	6/10/18

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E 037	Continued From page 18 staff, individuals providing services under arrangement, and volunteers, consistent with their expected role. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. *[For Hospitals at §482.15(d) and RHCs/FQHCs at §491.12:] (1) Training program. The [Hospital or RHC/FQHC] must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing on-site services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. *[For Hospices at §418.113(d):] (1) Training. The hospice must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing hospice employees, and individuals providing services under arrangement, consistent with their expected roles. (ii) Demonstrate staff knowledge of emergency procedures. (iii) Provide emergency preparedness training at least annually. (iv) Periodically review and rehearse its emergency preparedness plan with hospice employees (including nonemployee staff), with special emphasis placed on carrying out the procedures necessary to protect patients and	E 037	2.All residents have the potential to be affected by this deficient practice. 3. All staff will be inserviced on the EPP annually. 4. The EPP will be reviewed annually and as needed.	6/10/18

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E 037	Continued From page 19 others. *[For PRTFs at §441.184(d):] (1) Training program. The PRTF must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) After initial training, provide emergency preparedness training at least annually. (iii) Demonstrate staff knowledge of emergency procedures. (iv) Maintain documentation of all emergency preparedness training. *[For PACE at §460.84(d):] (1) The PACE organization must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing on-site services under arrangement, contractors, participants, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least annually. (iii) Demonstrate staff knowledge of emergency procedures, including informing participants of what to do, where to go, and whom to contact in case of an emergency. (iv) Maintain documentation of all training. *[For CORFs at §485.68(d):](1) Training. The CORF must do all of the following: (i) Provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles.	E 037		

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E 037	Continued From page 20 (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. All new personnel must be oriented and assigned specific responsibilities regarding the CORF's emergency plan within 2 weeks of their first workday. The training program must include instruction in the location and use of alarm systems and signals and firefighting equipment. *[For CAHs at §485.625(d):] (1) Training program. The CAH must do all of the following: (i) Initial training in emergency preparedness policies and procedures, including prompt reporting and extinguishing of fires, protection, and where necessary, evacuation of patients, personnel, and guests, fire prevention, and cooperation with firefighting and disaster authorities, to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. *[For CMHCs at §485.920(d):] (1) Training. The CMHC must provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles, and maintain documentation of the training. The CMHC must demonstrate staff knowledge of emergency	E 037		

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E 037	Continued From page 21 procedures. Thereafter, the CMHC must provide emergency preparedness training at least annually. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility staff failed to develop an initial emergency preparedness training program. The findings included: During an interview on 4/26/18 at 11:42 A.M. with the administrator and maintenance director were asked for documentation of an initial emergency preparedness program. The administrator stated, 'The facility did not develop an initial emergency preparedness training program." The facility staff failed to develop an initial emergency preparedness training program.	E 037		
E 039 SS=C	EP Testing Requirements CFR(s): 483.73(d)(2) (2) Testing. The [facility, except for LTC facilities, RNHCIs and OPOs] must conduct exercises to test the emergency plan at least annually. The [facility, except for RNHCIs and OPOs] must do all of the following: *[For LTC Facilities at §483.73(d):] (2) Testing. The LTC facility must conduct exercises to test the emergency plan at least annually, including unannounced staff drills using the emergency procedures. The LTC facility must do all of the following:] (i) Participate in a full-scale exercise that is	E 039	E039-Testing Requirements 1.The EPP will be updated to include a full scale community based exercise for emergency predaredness. 2.All residents have the potential to be affected by this deficient practice.	6/10/18

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E 039	Continued From page 22 community-based or when a community-based exercise is not accessible, an individual, facility-based. If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in a community-based or individual, facility-based full-scale exercise for 1 year following the onset of the actual event. (ii) Conduct an additional exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, facility-based. (B) A tabletop exercise that includes a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed. *[For RNHCIs at §403.748 and OPOs at §486.360] (d)(2) Testing. The [RNHCI and OPO] must conduct exercises to test the emergency plan. The [RNHCI and OPO] must do the following: (i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group discussion led by a facilitator, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (ii) Analyze the [RNHCI's and OPO's] response to and maintain documentation of all tabletop	E 039	3.All staff will be inserviecd on the EPP annually. Local officails will be contacted by the Maintenance Director and the facility will request a full scale community based exercise. 4.The EPP will be reviewed annually and as needed.	6/10/18

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E 039	Continued From page 23 exercises, and emergency events, and revise the [RNHCI's and OPO's] emergency plan, as needed. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility staff failed to develop a full scale community based exercise for emergency preparedness. The findings included: During an interview on 4/26/18 at 11:47 A.M. with the administrator an the maintenance director, they were asked for documentation of the facility's participation in a full scale community based emergency preparedness exercise. The administrator stated, 'The facility had not developed an exercise nor had it participated in one." The facility staff failed to develop a full scale community based emergency preparedness exercise.	E 039		
F 000	INITIAL COMMENTS An unannounced (Medicare/Medicaid) standard survey was conducted 4/24/18 through 4/27/18. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. No complaints were investigated during the survey. The census in this 136 certified bed facility was 75 at the time of the survey. The survey sample consisted of 31 current Resident reviews.	F 000		
F 623	Notice Requirements Before Transfer/Discharge	F 623		

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F 657	Continued From page 39 visiting the scheduled resident prior to developing the plan of care. -The MDS Coordinator develops the current care plan prior to conference by addressing all unresolved problems from the previous care plan and/or noting on the care plan all new problems, approaches and target dates as they are identified.	F 657		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and resident and staff interviews, the facility staff failed to administer oxygen consistent with professional standards for 1 (Resident #128) of 31 residents in the survey sample. For Resident #128, the facility staff failed to obtain physician orders prior to administering oxygen therapy. The findings included: Resident #128 was admitted to the facility on 4/21/18, diagnoses included, but were not limited to, heart failure, muscle weakness (generalized), hyperlipidemia, Type II diabetes, aphasia,	F 695	F-695-D- Respiratory/tracheostmy care and suctioning 1.Resident #128 use of oxygen was clarified with physician and order was obtained. 2.Any resident receiving oxygen has the potential to be affected by this deficient practice. 3.Licensed nurses inserviced on obtaining oxygen orders by Don/designee.	6/10/18

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F 695	Continued From page 40 unspecified dementia with behavioral disturbance, cerebral infarct, primary insomnia, unspecified atrial fibrillation. Resident #128 was a new admission and therefore no MDS (Minimum Data Set) assessment was due to be completed. On 04/24/18 at 1:00 PM Resident #128 was observed resting in bed eating her lunch meal with the speech therapist present. Resident #128 had an oxygen concentrator in use administering oxygen at 3L (liters per minute) via nasal cannula. On 4/24/18 Resident #128's medical record was reviewed and revealed initial Physician's orders dated 4/21/18. The orders included, but were not limited to: Diet as Cardiac with regular texture and thin consistency for heart healthy, blood sugar checks at bed time, PT and OT evaluate and treat, weekly blood pressure on Mondays. There were no orders for oxygen use included on the initial orders. During the medical record review a nursing admission note written on 4/21/18 at 1:00 PM read that Resident #128's LOC (level of consciousness) was AAOx3. (Alert, and Oriented to person, place, and time). Follow up record review on 04/24/18 at 03:25 PM revealed no physician's order for the use of oxygen. On 04/25/18 at 10:57 AM during review of Resident #128's clinical record, a physician's order dated 4/25/18 at 09:59 AM for "O2 (Oxygen) at 2L via nasal cannula as needed for SOB (shortness of breath) and comfort" was observed in the record.	F 695	4.Audits of 5 residents receiving oxygen per week by unit manager/designee for 12 weeks to ensure order present. Results of audits will be taken to QAPI committee monthly x 3 for review and revision as needed.	

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	495334	A. BUILDING _____ B. WING _____	04/26/2018

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F 623 SS=E	Continued From page 24 CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would 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,	F 623	Plan of correction F 623-E- Transfer and discharge 1.Ombudsman was notified of resident #76 discharge to hospital on 3/1/18, resident #77 discharge home on 1/24/18, resident #66 discharge to hospital 2/1/18 and 3/25/18, resident #58 discharge to hospital 1/27/18 and 2/12/18, resident #47 discharged to hospital 3/1/18 2.Any resident being discharged has the potential to be affected by this deficient practice.	6/10/18

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F 623	Continued From page 25 under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance 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.	F 623	3. Social service director inserviced on discharge and transfer policy by administrator. 4. Audits of 5 discharges per week for 12 weeks will be done by administrator/designee for ombudsman notification. Results of audits will be taken to QAPI committee monthly x3 for review and revision as needed.	

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F 623	Continued From page 26 §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 clinical record review, staff interviews, State Long-Term Care Ombudsman Interview, and facility document review the facility staff failed to notify the Office of the State Long-Term Care Ombudsman in writing of applicable discharges for 5 of 31 residents in the survey sample (Resident #76, #77, #66, #58 and #47). 1. The facility staff failed to notify the Office of the State Long-Term Care Ombudsman of Resident #76's discharge to the hospital on 3/1/18. 2. The facility staff failed to notify the Office of the State Long-Term Care Ombudsman of Resident #77's discharge home on 1/24/18. 3. The facility staff failed to notify the Office of the State Long-Term Care Ombudsman of Resident #66's discharges to the hospital on 2/1/18 and	F 623		

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F 623	Continued From page 27 3/25/18. 4. The facility staff failed to notify the Office of the State Long-Term Care Ombudsman of Resident #58's discharges to the hospital on 1/27/18 and 2/12/18. 5. The facility staff failed to notify the Office of the State Long-Term Care Ombudsman of Resident #47's discharge to the hospital on 3/14/18. The finding include: 1. The facility staff failed to notify the Office of the State Long-Term Care Ombudsman of Resident #76's discharge to the hospital on 3/1/18. Resident #Resident #76 was admitted to the nursing facility on 1/23/18 with diagnoses that included generalized muscle weakness, anemia and sepsis. The entry tracking Minimum Data Set (MDS) assessment was dated 1/23/18. The Admission MDS assessment was dated 1/28/18 coded the resident on the Brief Interview for Mental Status (BIMS) with a score of 15 out of a possible score of 15 which indicated the resident was intact in the cognitive skills for daily decision making. The discharge tracking MDS assessment was dated 3/1/18. The nurse's notes dated 3/1/18 at 3:48 p.m., indicated Emergency Medical Services (EMS)	F 623		

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F 623	Continued From page 28 was called at 3:35 p.m. due to a change in the resident's condition (i.e., sluggish and not eating). The Transfer Discharge Report indicated Resident #76 was discharged to the local hospital on 3/1/18. An interview was conducted with the Administrator on 4/26/18 at 12:00 p.m. She stated they had not been sending notifications of discharges to the local Ombudsman office. The Administrator said she would have to look up the requirements for discharges, but was aware of notifications sent to the resident representatives. She stated it would be the Social Workers responsibility to send the notices to the Ombudsman, but after checking various folders and binders she discovered there was only a system to notify families. No copies of discharges were sent to the Ombudsman. The local Ombudsman was in the facility on 4/26/18 at 12:30 p.m. and joined the interview with the Administrator. The Ombudsman stated she had not been receiving written notifications of resident discharges from the facility. On 4/26/18 at 1:40 p.m., a pre-exit debriefing was held with the Administrator. No further information was shared prior to survey exit. 2. The facility staff failed to notify the Office of the State Long-Term Care Ombudsman of Resident #77's discharge home on 1/24/18. Resident #Resident #77 was admitted to the nursing facility on 11/28/17 with diagnoses that included chronic obstructive pulmonary disease (COPD), dizzy spells and collapse.	F 623		

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F 623	Continued From page 29 The entry tracking Minimum Data Set (MDS) assessment was dated 11/28/17. The Admission MDS assessment dated 12/19/17 coded the resident on the Brief Interview for Mental Status (BIMS) with a score of 15 out of a possible score of 15 which indicated the resident was intact in the cognitive skills for daily decision making. The discharge tracking MDS assessment was dated 1/24/18. The nurse's notes dated 1/24/18 p.m. at 4:16 p.m., indicated the resident was discharged home with his resident representative. An interview was conducted with the Administrator on 4/26/18 at 12:00 p.m. She stated they had not been sending notifications of discharges to the local Ombudsman office. The Administrator said she would have to look up the requirements for discharges, but was aware of notifications sent to the resident representatives. She stated it would be the Social Workers responsibility to send the notices to the Ombudsman, but after checking various folders and binders she discovered there was only a system to notify families. No copies of discharges were sent to the Ombudsman. The local Ombudsman was in the facility on 4/26/18 at 12:30 p.m. and joined the interview with the Administrator. The Ombudsman stated she had not been receiving written notifications of resident discharges from the facility. On 4/26/18 at 1:40 p.m., a pre-exit debriefing was held with the Administrator. No further information was shared prior to survey exit.	F 623		

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F 623	Continued From page 30	F 623		

3. For Resident #66 the facility staff failed to notify the Ombudsman of two hospitalizations.

Resident #66 was admitted to the facility on 1/19/18 and Readmitted on 3/27/18. Diagnoses for Resident #66 included but are not limited to Dementia, Renal Insufficiency and Paralysis . Resident #66's Admission Minimum Data Set (an assessment protocol) with an Assessment Reference Date of 1/26/18 coded Resident #66 with a BIMS Score of 12 out of 15 indicating moderate cognitive impairment.

Resident #66 required extensive staff assistance for bathing and toileting.

Resident #66 was observed on 4/24/18 at approximately 1:10 PM, and was observed to be well groomed. Resident #66 was observed on 4/25/18 and was observed to be clean and well groomed.

Resident #66 was admitted to a local hospital on 2/1/18 and discharged on 2/3/18. The Hospital discharge summary documented the following:
Discharge Diagnosis:
Rhabdomyolysis
Paraparesis of both lower limbs
Stage 3 chronic kidney disease
Dementia

Resident #66 was admitted to a local hospital on 3/25/18 and discharged on 3/27/18. The Hospital discharge summary documented the following:

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F 623	Continued From page 31 Discharge diagnosis: Acute cystitis without hematuria as principal; problem Acute renal failure Dehydration Dementia An interview was conducted with Administrator #1 on 4/26/18 at approximately 12:00 PM. The Administrator stated that the letters to the Ombudsman are not being done on a regular basis. The Administrator added that the facility no longer has a Social Worker and may be part of the problem. The Administrator stated that was not an excuse and that the Ombudsman should be notified on hospitalizations. The Ombudsman stated on 04/26/18 at approximately 01:10 PM that she doesn't get notifications of hospitalizations from the facility. The facility administration was informed of the findings during a Pre-exit briefing on 4/26/18 at approximately 1:45 PM. The facility did not present any further information about the findings. 4. Resident #47 was originally admitted to the facility on 2/28/18. Diagnosis for Resident #47 included but not limited to *Acute Respiratory Failure. *Respiratory Failure occurs when fluid builds up in the air sacs in your lungs (https://www.healthline.com/health/acute-respiratory-failure).	F 623		

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F 623	Continued From page 32 The current Minimum Data Set (MDS), a comprehensive assessment with an Assessment Reference Date (ARD) of 4/04/18 coded the resident with a 03 out of a possible score of 15 on the Brief Interview for Mental Status (BIMS) indicating severe cognitive impairment. The Discharge MDS assessment was dated 3/14/18. According to the facility's documentation, Resident #47 was found unresponsive on 3/14/18. The facility's staff was unable to obtain a blood pressure but resident was breathing. Resident #47 was transported to the local Emergency Room (ER) via Emergency Medical Services (EMS). An interview was conducted with the Administrator on 4/26/18 at 12:00 p.m. She stated they had not been sending notifications of discharges to the local Ombudsman office. The Administrator said she would have to look up the requirements for discharges, but was aware of notifications sent to the resident representatives. She stated it would be the Social Workers responsibility to send the notices to the Ombudsman, but after checking various folders and binders, she discovered there was only a system to notify families. No copies of discharges were sent to the Ombudsman. The local Ombudsman was in the facility on 4/26/18 at 12:30 p.m. and joined the interview with the Administrator. The Ombudsman stated she had not been receiving written notifications of resident discharges from the facility. On 4/26/18 at 1:40 p.m., a pre-exit debriefing was	F 623		

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F 623	Continued From page 33 held with the Administrator. No further information was shared prior to survey exit. 5. Resident #58 was originally admitted to the nursing facility on 10/19/16. Diagnosis for included but not limited to *Chronic Obstructive Pulmonary Disease (COPD). *COPD makes it hard for you to breathe. The two main types are chronic bronchitis and emphysema. The main cause of COPD is long-term exposure to substances that irritate and damage the lung (https://medlineplus.gov/ency/article/007365.htm). The current Minimum Data Set (MDS) a quarterly MDS with an Assessment Reference Date (ARD) of 03/20/18 coded the resident with a 15 of a total possible score of 15 on the Brief Interview for Mental Status (BIMS), indicating no cognitive impairment. The Discharge MDS assessments were dated for 1/27/18 and 2/12/18. On 1/27/18, According to the facility's documentation, Resident #58 was observed slumped down in her wheel chair with head down with increased lethargy: VS taken: (BP) 72/45, (P) 112, (T) 104.2, (R) 24, SPO2 @98% on 2 liters. Resident was transported to the local Emergency Room (ER) via EMS. On 2/12/18, According to the facility's documentation, Resident #58 was observed slouched in her wheelchair with her head resting on the bed and arms dangling bedside the wheelchair; Vital Signs (VS); (BP) 99/63, (P)96,	F 623		

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F 623	Continued From page 34 (T) 99.8, SPO2 @ 95% on room air. Resident was transported to the local Emergency Room (ER) via EMS. An interview was conducted with the Administrator on 4/26/18 at 12:00 p.m. She stated they had not been sending notifications of discharges to the local Ombudsman office. The Administrator said she would have to look up the requirements for discharges, but was aware of notifications sent to the resident representatives. She stated it would be the Social Workers responsibility to send the notices to the Ombudsman, but after checking various folders and binders, she discovered there was only a system to notify families. No copies of discharges were sent to the Ombudsman. The local Ombudsman was in the facility on 4/26/18 at 12:30 p.m. and joined the interview with the Administrator. The Ombudsman stated she had not been receiving written notifications of resident discharges from the facility. On 4/26/18 at 1:40 p.m., a pre-exit debriefing was held with the Administrator. No further information was shared prior to survey exit. The facility's policy titled Discharge/Transfer Letter Policy (Revised October 5, 2017). -Policy: The facility will complete discharge letters appropriately and according to all federal, state, and local regulations. Social Services or designee will assure the original discharge/transfer letter is given to resident or guardian/sponsor, if applicable. -Copies will be sent to Department of Health, Ombudsman Office and filed in the business file and/or scanned into PCC documents tab with	F 623		

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F 623	Continued From page 35 administrator/designee signature, with the certified receipt if applicable. -For emergency transfers, one list can be sent to the Ombudsman at the end of the month.	F 623		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on staff interviews, resident interview, clinical record review and facility documentation	F 657	F657-D- Care Plan 1.Resident #58 was reviewed and revised to reflect current status. 2.Any resident who smokes has the potential to be affected by this deficient practice. Current residents who smoke have had care plans reviewed for accuracy and completeness. 3. Inservice to MDS coordinator on development of comprehensive care plan done by Regional Director of Clinical Services. Inservie to interdisciplinary team by MDS coordinator on development of comprehensive care plan policy.	6/10/18

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F 657	Continued From page 36 review the facility staff failed to revise one (1) of 31 residents (Resident #58) comprehensive personal centered care plan in the survey sample. The facility staff failed to revise Resident #58's comprehensive person centered care plan to include smoking. The findings include: Resident #58 was originally admitted to the nursing facility on 10/19/16. Diagnosis for included but not limited to *Chronic Obstructive Pulmonary Disease (COPD). *COPD makes it hard for you to breathe. The two main types are chronic bronchitis and emphysema. The main cause of COPD is long-term exposure to substances that irritate and damage the lung (https://medlineplus.gov/ency/article/007365.htm). The current Minimum Data Set (MDS) a quarterly MDS with an Assessment Reference Date (ARD) of 03/20/18 coded the resident with a 15 of a total possible score of 15 on the Brief Interview for Mental Status (BIMS), indicating no cognitive impairment. During the initial tour on 4/24/18 at approximately 1:53 p.m., Resident #58 stated, "I've been smoking ever since I was admitted here." The Certified Nursing Assistant (CNA)'s or a nurse takes us out after each meal and again before, we go to bed. The resident said they are not allowed not keep their cigarettes or lighters; they are locked up on the unit. Resident #58 also stated she has to wear a smoking cover over	F 657	4.Audits of 5 care plans per week for 12 weeks for accuracy and completeness by DON/designee. Results of audits to QAPI committee monthly x 3 for review and revision as needed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495334	A. BUILDING _____ B. WING _____	04/26/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 657	Continued From page 37 when she smokes. The review of Resident #58 comprehensive person care plan did not include a care plan for smoking. An interview was conducted with the MDS Coordinator, RN #1 on 4/25/18 at approximately 12:45 p.m., who stated, "Yes, we should have done a smoking care plan because she does smoke; I will do one right now." An interview was conducted with LPN #3 on 4/25/18 at approximately 11:55 a.m., who stated, "Resident #58 is always supervised when she smokes." The License Practical Nurse (LPN) said a CNA or a nurse will take the smokers out after each meal and right before bedtime and everyone wears a smoking apron while smoking." On 4/25/8 at approximately 1:25 p.m., Resident #58 was observed in the designated smoking area with direct supervision and wearing a smoking apron. On 4/25/18 at approximately 3:35 p.m., the MDS Coordinator gave the surveyor a smoking care plan with a revision date of 4/25/18 for Resident #58. The review of resident's smoking care plan revised on 4/25/18 documented Resident #58 is a smoker. The goal: the resident will be able to smoke safely in accordance with policy. The intervention/tasks to manage goal included *cigarettes, lighters, and matches are to be kept by appropriate staff only, orient/review smoking policy, times and places to smoke and staff to keep lighters, matches etc. at the nurse's	F 657		

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F 657	Continued From page 38 station/activities department. On 4/26/18 at approximately 1:25 p.m., the surveyor received another revised smoking care plan dated 4/26/18 from MDS Coordinator LPN #2 to include but not limited to: The goal: the resident will be able to smoke safely in accordance with policy. The intervention/tasks to manage goal included *cigarettes, lighters, and matches are to be kept by appropriate staff only, orient/review smoking policy, times and places to smoke and staff to keep lighters, matches etc. at the nurse's station/activities department, resident to wear a smoking apron and resident to be provided with supervision for smoking. The above information was shared with Administration staff during a pre-exit meeting on 4/26/18 at 1:45 p.m. No additional information was provided. The facility's policy titled: Care Plan (Revision 4/6/17). -An interdisciplinary plan of care will be established for every resident and updated in accordance with state and federal regulatory requirements and on an as needed basis. In states where pre-admission screening applies, this will be coordinated with the facility assessment. Goals must be measurable and objective. Procedure -The MDS Coordinator is responsible for reviewing and updating the Resident Assessment (MDS) as well as the previous plan of care prior to the scheduled Resident Care Plan conference. -The MDS coordinator is responsible for reviewing the resident's Medical record and	F 657		

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F 695	Continued From page 41 On 04/25/18 at 11:20 AM an interview was conducted with Licensed Practical Nurse #1 (LPN #1). When asked about the oxygen order, she stated "the order for oxygen was obtained this morning". When asked when the order should have been obtained she stated "it should have been done when she was admitted". On 04/25/18 at 12:05 PM an interview was conducted with Resident #128. When the resident was asked how often she uses oxygen and she replied "Oh, I use oxygen all the time honey." On 04/26/18 at approximately 3:00 PM an exit review was conducted with the Administrator and DON; they were informed of the use of oxygen without an order. No other information was offered by the facility staff.	F 695		
F 850 SS=E	Qualifications of Social Worker >120 Beds CFR(s): 483.70(p)(1)(2) §483.70(p) Social worker. Any facility with more than 120 beds must employ a qualified social worker on a full-time basis. A qualified social worker is: §483.70(p)(1) An individual with a minimum of a bachelor's degree in social work or a bachelor's degree in a human services field including, but not limited to, sociology, gerontology, special education, rehabilitation counseling, and psychology; and §483.70(p)(2) One year of supervised social work experience in a health care setting working directly with individuals. This REQUIREMENT is not met as evidenced	F 850	F850-E-Qualifications of Social Worker 1.Full time social worker was in place May 14, 2018. 2.All residents have the potential to be affected by this deficient practice	06/10/18

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F 850	Continued From page 42 by: Based on staff interview, the facility staff failed to employ a full time social worker. The findings included: During an interview on 4/26/18 at 9:30 a.m. with the facilities social worker, he stated, "He is at the facility on a part- time bases." The social worker stated, "He only works at the facility for three days a week." During an interview on 4/26/18 at 1:30 P.M. with the administrator she confirmed that the facilities social worker was only part-time. The administrator was asked for a policy regarding the qualification and services provided by the social worker. The administrator stated the facility did not have a policy. The facility staff failed to employ a full time social worker in a 136 bed facility.	F 850	3.Administrator inserviced on requirements of full time social worker for facility of 120 beds or greater by Regional Director of Clinical Services. 4. Audit of social services position weekly by DON/Designee to ensure position in place. Results of audits to QAPI committee monthly x3 for review and revision as needed.	