STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495241	A. BUILDING _____ B. WING _____	C 05/04/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CONCORDIA TRANSITIONAL CARE AND REHAB-RIVER POINTE	4142 BONNEY ROAD VIRGINIA BEACH, VA 23452

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 5/1/18 through 5/4/18. Corrections are required for compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities.	E 000		
E 004 SS=C	Develop EP Plan, Review and Update Annually CFR(s): 483.73(a) [The [facility] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility] must develop establish and maintain a comprehensive emergency preparedness program that meets the requirements of this section.] * [For hospitals at §482.15 and CAHs at §485.625(a):] The [hospital or CAH] must comply with all applicable Federal, State, and local emergency preparedness requirements. The [hospital or CAH] must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach. The emergency preparedness program must include, but not be limited to, the following elements:] (a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be [reviewed], and updated at least annually. * [For ESRD Facilities at §494.62(a):] Emergency Plan. The ESRD facility must develop and maintain an emergency preparedness plan that must be [evaluated], and updated at least annually.	E 004		5/22/18

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

Electronically Signed | 05/24/2018

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E 004	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on record review, and staff interview, the facility staff failed to have documentation of the facilities Emergency Preparedness Plan identified risk assessment. The findings included: During an interview on 5/4/18 at 10:40 A.M. with the Administrator, he was asked for documentation of the facilities community -based risk assessments that will assist the facility in addressing the needs of their patients. The administrator stated the facility had not conducted a risk assessment of it's emergency preparedness plan. The facility staff failed to have documentation of identified risk assessments of the emergency preparedness plan.	E 004	1. Facility Emergency Preparedness plan and risk assessment is documented. 2. All residents have the potential to be affected. 3. Emergency Preparedness plan and risk assessment will be reviewed and updated by Emergency response team quarterly and/or as needed. Facility will be working with the Eastern Virginia Healthcare Coalition to review facilities Emergency Preparedness Plan. 4. Updates to the Emergency Preparedness Plan and risk assessment will be reviewed at facility monthly QAPI meeting and/or as needed for 3 months to ensure facility meets compliance requirements.	
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.	E 006		5/22/18

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E 006	Continued From page 2 *[For ICF/IIDs at §483.475(a)(1):] (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing clients. (2) Include strategies for addressing emergency events identified by the risk assessment. * [For Hospices at §418.113(a)(2):] (2) Include strategies for addressing emergency events identified by the risk assessment, including the management of the consequences of power failures, natural disasters, and other emergencies that would affect the hospice's ability to provide care. This REQUIREMENT is not met as evidenced by: Based on record review, and staff interview, the facility staff failed to have documentation of the facilities Emergency Preparedness Plan identified risk assessment and associated strategies. The findings included: During an interview on 5/4/18 at 10:45 A.M. with the Administrator, he was asked for documentation of the facilities community -based risk assessments and strategies that will assist the facility in addressing the needs of their patients. The administrator stated the facility had not conducted a risk assessment of it's emergency preparedness plan. The facility staff failed to have documentation of identified risk assessments and strategies of the emergency preparedness plan.	E 006	1. Facilities Emergency Preparedness plan has identified risk assessment and assessment and associated strategies. 2. All residents have the potential to be affected. 3. Emergency Preparedness Plan risk assessment and associated strategies will be reviewed and updated by emergency response team quarterly and/or as needed Eastern Virginia healthcare coalition will be working with facility quarterly to review the emergency preparedness plan. Results will be reviewed and presented to the QAPI committee for recommendations. 4. Updates to facility's risk assessment and associated strategies will be reviewed at facility's monthly QAPI meeting and/or as needed for three months to ensure facility meets and sustains compliance.	
E 007	EP Program Patient Population	E 007		5/22/18

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E 007 SS=C	Continued From page 3 CFR(s): 483.73(a)(3) [(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do the following:] (3) Address patient/client population, including, but not limited to, persons at-risk; the type of services the [facility] has the ability to provide in an emergency; and continuity of operations, including delegations of authority and succession plans.** *Note: ["Persons at risk" does not apply to: ASC, hospice, PACE, HHA, CORF, CMCH, RHC, FQHC, or ESRD facilities.] This REQUIREMENT is not met as evidenced by: Based on record review, and staff interview, the facility staff failed to have documentation of the facilities identified population at risk during an emergency and delegation of authority during an emergency. The findings included: During an interview on 5/4/18 at 10:50 A.M. with the Administrator, he was asked for documentation of the facilities identified population at risk during an emergency and delegation of authority during an emergency. The administrator stated the facility had not conducted a risk assessment of it's resident population at risk during an emergency. Nor did the facility have documentation of delegation of authority during an emergency. The facility staff failed to have documentation of	E 007	1. Facility has documented it's identified population at risk during an emergency and delegation of authority during an emergency. 2. All residents have the potential to be affected. 3. Facility will review and update it's identified population at risk during an emergency and delegation of authority during an emergency quarterly. Staff were educated by ED/SDC on residents order of evacuation during an emergency. Education was based on resident acuity levels identified in the Facility tools assessment section of Special Treatments and conditions. Results of review will be presented at QAPI committee for recommendations. 4. QAPI committee will review results for 3 months to ensure facility meets and sustains compliance.	

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E 007	Continued From page 4 the facilities identified population at risk and documentation of delegation of authority during an emergency.	E 007		
E 015 SS=C	Subsistence Needs for Staff and Patients CFR(s): 483.73(b)(1) [(b) Policies and procedures. [Facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk 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:	E 015		5/22/18

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E 015	Continued From page 5 (iii) The provision of subsistence needs for hospice employees and patients, whether they evacuate or shelter in place, include, but are not limited to the following: (A) Food, water, medical, and pharmaceutical supplies. (B) Alternate sources of energy to maintain the following: (1) Temperatures to protect patient health and safety and for the safe and sanitary storage 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 record review and staff interview, the facility staff failed to provide documentation that the emergency preparedness plan address vendor contract agreements to provide provision of subsistence including food and water. The facility also failed to have vendor contracts for sewage disposal services and a fire watch process. The findings included: The facility emergency preparedness plan failed to have documentation of contract agreements for the provision of food, water, and fuel during an emergency. The facility also failed to have vendor contracts for sewage disposal services and a fire watch process during an emergency. During a review of the emergency preparedness plan with the administrator on 05/03/18 at 11:01 A.M. he was asked for documentation for vendor contracts for food, water, fuel, sewage disposal	E 015	Facility's Emergency Preparedness plan has documentation addressing vendor contract agreements to provide provisions of subsistence including food, water as well as contract of sewage disposal services and a fire watch process. 2. All residents have the potential to be affected. 3. Emergency response team will review contracts and/or renew change/amend and acquired new one quarterly. Staff were educated by ED and Maintenance Director on current facility contracted vendors. New Facility vendor contracts will be communicated to staff by ED and Maintenance Director. 4. Results of review will be resented to QAPI committee for recommendations. QAPI committee will review results for 3 months to ensure facility meets and sustains compliance.	

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E 015	Continued From page 6 services and the facilities fire watch process. The administrator provided contracts of a former ownership group that was dated 10/13/10. The administrator stated "He did not have documentation of the facility having a fire watch process or sewage disposal services." The facility staff failed to provide documentation of vendor contracts for food, water, fuel sewage disposal services and a fire watch process.	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 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	E 018		5/22/18

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E 018	Continued From page 7	E 018		

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 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

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E 018	Continued From page 8 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 provide documentation for the location of residents at alternate sites. The facility failed to provide documentation that staff have been trained on the system to track the location of on-duty staff and sheltered patients who may be relocated during an emergency. The findings included: The facility failed to provide documentation that staff have been trained on the facilities tracking system. During review of the facilities emergency preparedness plan on 05/03/18 at 11:09 a.m. the administrator was asked to provide documentation that facility staff have been trained on the facilities system to track the location of on-duty staff and sheltered resident who are relocated during an emergency. The administrator stated, "We have not trained our staff on the tracking system." The facility staff failed to train staff on the system to track the location of on-duty staff and sheltered residents who are relocated during an emergency.	E 018	1. Facility has documentation that staff have been trained on the system to track the location of on-duty staff and sheltered patients who may be relocated during emergency. 2. All residents have the potential to be affected. 3. Staff Development Coordinator or designee will train staff on facilities tracking system for the location of residents at alternate site as well as location of on-duty staff ad sheltered patients who may be located during an emergency. Executive Director or designee will audit training weekly x 1 month, then monthly x 2 months, then quarterly x 3 months. Audits will be presented to the facility's QAPI committee. 4. Results of the audit will be reviewed by the QAPI committee for further recommendations and to ensure facility meets and sustains compliance.	
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	E 020		5/22/18

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E 020	Continued From page 9 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. (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.	E 020		

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E 020	Continued From page 10 * [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 failed to have documentation that the emergency preparedness plan included policy and procedures for the safe evacuation from the facility. The findings included: During an interview on 5/3/18 at 11:15 A.M. with the administrator, he was asked for documentation for the safe evacuation from the facility including care for the residents, transportation, identification of evacuation location and alternate means of communication with external resources and staff responsibilities. The administrator stated, he did not have documentation for the safe evacuation from the facility which included care for residents, transportation needs, communication with external resources and staff responsibilities. The facility staff failed to have documentation that the emergency preparedness plan included policy and procedures for the safe evacuation from the facility.	E 020	1. Facility has documentation of it's Emergency Preparedness plan that includes a policy and procedure for the safe evacuation of residents, staff and volunteers from the facility. 2. All residents have the potential to be affected. 3. Facility's emergency response team will be in-serviced on the emergency preparedness plan by Staff Development Coordinator or designee. Facility's emergency preparedness plan includes safe evacuation of patients, volunteers and staff. The emergency response team will review and update policy and procedure quarterly x 3 months. 4. Results of review will be presented to QAPI committee for recommendations.	
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	E 022		5/22/18

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E 022	Continued From page 11 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 have documentation for sheltering in place. The findings included: During an interview with the administrator on 5/3/18 at 11: 27 A.M. the administrator was asked for documentation for sheltering in place for staff, volunteers and visitors. The administrator stated, he did not have documentation for sheltering in place for staff, volunteers and visitors. The facility staff failed to have documentation for sheltering in place for staff, volunteers and	E 022	1. Facility has documentation for sheltering in place. 2. All residents have the potential to be affected. 3. Facility staff was in-service by the Executive Director or designee on Emergency Preparedness plan to include policy for sheltering in place for staff, volunteers, and visitors. Policy will be reviewed and updated annually as needed. 4. Results of review will be presented to facility QAPI committee for further recommendations and to ensure facility compliance.	

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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
E 022	Continued From page 12 visitors.	E 022		
E 023 SS=C	Policies/Procedures for Medical Documentation CFR(s): 483.73(b)(5) [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. At a minimum, the policies and procedures must address the following:] (5) A system of medical documentation that preserves patient information, protects confidentiality of patient information, and secures and maintains availability of records. [(5) or (3),(4),(6)] A system of medical documentation that preserves patient information, protects confidentiality of patient information, and secures and maintains availability of records. *[For RNHCIs at §403.748(b):] Policies and procedures. (5) A system of care documentation that does the following: (i) Preserves patient information. (ii) Protects confidentiality of patient information. (iii) Secures and maintains the availability of records. *[For OPOs at §486.360(b):] Policies and 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.	E 023		5/22/18

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	495241	A. BUILDING _____ B. WING _____	C 05/04/2018

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E 023	Continued From page 13 This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility staff failed to have verification for preserving patient information. The findings included: During an interview on 5/3/18 at 11:30 A.M. with the administrator, he was asked for documentation the emergency preparedness plan to protect confidentiality of patient information and maintain the availability of of resident records. The administrator stated, he did not have documentation to ensure patient records were secure and readily available to support the continuity of care for residents during an emergency. The facility staff failed to have verification for preserving resident information.	E 023	1. The facility's emergency preparedness plan has a documented policy to ensure patient records are secure and readily available to support the continuity of care for resident during an emergency. 2. All Residents have the potential to be affected. 3. ED or designee will in-service staff on protecting the confidentiality of patients, ensure records are secure and readily available to support continuity of care for residents during and emergency. 4. QAPI committee for 3 months will review emergency preparedness plan regarding securing patient and records are readily available to support the continuity of care for resident during an emergency.	
E 024 SS=C	Policies/Procedures-Volunteers and Staffing CFR(s): 483.73(b)(6) [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. At a minimum, the policies and procedures must address the following:] (6) [or (4), (5), or (7) as noted above] The use of volunteers in an emergency or other emergency	E 024		5/22/18

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E 024	Continued From page 14 staffing strategies, including the process and role for integration of State and Federally designated health care professionals to address surge needs during an emergency. *[For RNHCIs at §403.748(b):] Policies and procedures. (6) The use of volunteers in an emergency and other emergency staffing strategies to address surge needs during an emergency. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility staff failed to develop policies and procedures for the use or non use of volunteers during an emergency. The findings included: During an interview on 05/03/18 at 11:35 A.M. with the Administrator he stated, the facility have volunteers who assist residents daily, however, the facility had not developed policies and procedures for the use of volunteers during emergency preparedness activities. The facility failed to develop policies and procedures for the use or non use of volunteers during an emergency.	E 024	1. Facility emergency preparedness plan includes policy and procedures for use of volunteers in an emergency. 2. All residents have the potential to be affected. 3. ED or designee will review policy and procedure quarterly for any needed updates. Facility volunteers are trained on emergency preparedness by ED and SPC focusing on overall preparedness for emergency. New volunteers will be trained and documented. Results of review will be presented to the facility's QAPI committee for recommendations. 4. QAPI committee will review results for 3 months to ensure facility meets and sustains compliance.	
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	E 026		5/22/18

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E 026	Continued From page 15 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. *[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 have documentation describing the facilities role in providing care in an alternate care site. The findings included: During an interview with the administrator on 5/3/18 at 11:37 a.m. the administrator was asked for documentation describing the facilities role in providing care in an alternate care site. The administrator stated, he did not have any documentation describing the facilities role or the care that would be provided at an alternate care site. The facility staff failed to have documentation describing the facilities role in providing care in an	E 026	1. Facility has documentation describing the facilities role in providing care in an alternate care site. 2. Al residents have the potential to be affected. 3. ED or designee will in-service staff on emergency preparedness plan, facilities role in providing care in an alternative care site. Review of plan will be quarterly, results will be resented to facility QAPI committee for recommendations. 4. QAPI committee will review results for 3 months to ensure facility meets and sustains compliance.	

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E 026	Continued From page 16 alternate care site.	E 026		
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:] (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.	E 030		5/22/18

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E 030	Continued From page 17 (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. *[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 have all facility contact information in the communication plan. The findings included: During an interview on 5/3/18 at 11: 43 a.m. with the administrator, he was asked for names and contact information for all facility staff, as well as entities providing services under agreement during an emergency. A review of the communications plan did not include the name of all staff and their contact information. Nor did the plan include vendors providing services to the facility during an emergency.	E 030	1. Emergency preparedness plan for facility updated to include all staff and their contact information. Vendors providing services to the facility during an emergency contact numbers were included in the emergency preparedness binder. 2. All residents have the potential to be affected. 3. Emergency contact numbers in emergency preparedness pan will be reviewed and updated quarterly by the emergency response team. Results of review will be presented to facility's QAPI committee.	

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E 030	Continued From page 18 The facility staff failed to have all facility contact information in the communication plan.	E 030	4. QAPI committee will review results x 3 months to ensure facility meets and sustains compliance.	
E 032 SS=C	Primary/Alternate Means for Communication CFR(s): 483.73(c)(3) [(c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least annually.] The communication plan must include all of the following: (3) Primary and alternate means for communicating with the following: (i) [Facility] staff. (ii) Federal, State, tribal, regional, and local emergency management agencies. *[For ICF/IIDs at §483.475(c):] (3) Primary and alternate means for communicating with the ICF/IID's staff, Federal, State, tribal, regional, and local emergency management agencies. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility staff failed to develop an emergency preparedness communication plan which included alternate means of communication in an emergency. The findings included: During an interview with the administrator on 5/3/18 at 11:53 A.M. the administrator was asked to see the facilities alternate communication equipment. The administrator stated, the facility had not purchased alternate communication	E 032	1. The facility has purchased walkie talkies as well as battery cell phone chargers (to charge phones)as alternate communication devices for use during an emergency. 2. All residents have the potential to be affected. 3. ED and Maintenance Director has trained staff and volunteers on how to use of Emergency Preparedness tools contained in the Emergency Preparedness kit. Emergency preparedness kit is in the ED office. The	5/22/18

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E 032	Continued From page 19 devices. The facility staff failed to have alternate communication equipment.	E 032	Emergency response team will review the type of communication devices quarterly and/or as needed and the results presented to QAPI committee for recommendations. 4. QAPI committee will review results for 3 months to ensure facility meets compliance.	
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: (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,	E 033		5/22/18

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E 033	Continued From page 20 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 have documentation that the communication plan included a method for sharing information and medical documentation to maintain continuity of care. The findings included: During an interview on 5/3/18 at 11:58 a.m. with the administrator, he was asked for evidence that the facility had a method for sharing information and medical care for residents with other health care providers to maintain continuity of care. The administrator stated, he did not have documentation for sharing information and medical care needs for residents in an alternate care site. The facility staff failed to have documentation that the communication plan included methods for sharing information and medical care with other health care providers.	E 033	1. the facility has both a communication plan and medical records policy that included the method for sharing information and medical care with other health care providers. Face sheets will be maintained on each resident and send in the case of an evacuation along with a tracking form. 2. Al residents have the potential to be affected. 3. Medical records will update the resident face sheet with each admission/discharge to ensure information is current. The Ed, Medical Records Coordinator and SDC has trained staff on the resident information and location of a secured tote containing residents information for use during evacuation. Tote is stored in the Medical record office. 4. The emergency response team will review the Emergency Preparedness Plan binders quarterly to ensure resident information is current and report findings to the QAPI committee.	
E 034	Information on Occupancy/Needs	E 034		5/22/18

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E 034 SS=C	Continued From page 21 CFR(s): 483.73(c)(7) [(c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least annually.] The communication plan must include all of the following: (7) [(5) or (6)] A means of providing information about the [facility's] occupancy, needs, and its ability to provide assistance, to the authority having jurisdiction, the Incident Command Center, or designee. *[For ASCs at 416.54(c)]: (7) A means of providing information about the ASC's needs, and its ability to provide assistance, to the authority having jurisdiction, the Incident Command Center, or designee. *[For Inpatient Hospice at §418.113:] (7) A means of providing information about the hospice's inpatient occupancy, needs, and its ability to provide assistance, to the authority having jurisdiction, the Incident Command Center, or designee. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility staff failed to have documentation about the facility's occupancy needs and its ability to provide assistance. The findings included: During an interview on 05/03/18 at 12:06 P.M. with the administrator, he was asked for	E 034	1. The facility Emergency Preparedness Plan has documentation about the facilities occupancy, needs and it's ability to provide assistance. 2. All residents have the potential to be affected. 3. Facility will update the occupancy needs and its ability to provide assistance quarterly and or/as needed. 4. Updates to the Emergency	

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E 034	Continued From page 22 documentation for identifying the needs of the facility, including the residents as well as the facilities ability to provide assistance to the Incident Command Center. The administrator stated, the facility had not identified the needs of the residents nor had the facility identified how the facility could provide assistance. The facility staff failed to provide documentation and have means of providing information about the facility's needs and its ability to provide assistance.	E 034	Preparedness Plan occupancy needs and ability to provide assistance will be reviewed in the facilities monthly QAPI meeting and/or as needed for 3 months to ensure facility sustains compliance.	
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 have a method for sharing information of the Emergency Preparedness Plan with residents and families. The findings included: During an interview on 05/03/18 at 12:11 P.M. with the administrator, he was asked how did the	E 035	1. A letter was sent to the resident /families explaining the facility emergency preparedness plan. 2. All residents have the potential to be affected. 3. New residents admitted and their families will be given information about the facility emergency preparedness plan by the admission coordinator. The ED or	5/22/18

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E 035	Continued From page 23 facility share information with residents and families. The administrator stated, the facility had not informed residents nor families about the emergency preparedness plan. The facility staff failed to have a method to share information of the emergency preparedness plan with residents and families.	E 035	designee will audit admissions monthly x 3 months for compliance. 4. Results of the admission audits will be reviewed by QAPI committee monthly to ensure facility meets and sustains compliance.	
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). *[For ESRD Facilities at §494.62(d):] Training,	E 036		5/22/18

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E 036	Continued From page 24 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 an emergency preparedness training and testing program. The findings included: During an interview on 05/03/18 at 12: 17 a.m. with the administrator, he was asked for documentation of the facilities training and testing program. The administrator stated, the facility had not developed a training and testing program. The facility staff failed to have a training and testing program.	E 036	1. Facility has documentation that staff have been trained on the Emergency Preparedness plan and testing. Hazard Vulnerability and associated risks were communicated to staff and formed the bases for Emergency Preparedness training and testing. Safety committee monthly meetings will focus on issues associated with Emergency preparedness and life safety. Members of Safe Committee meeting is the Interdisciplinary team (IDT). Quarterly updates on tools for Facility Assessment quarterly updates by ED. Facility is a member of Eastern Virginia coalition on Emergency preparedness and participated in VHASS (Virginia Healthcare Alerting and Status System exercises and document After Action Report/improvement plan. Ed/designee attends the scheduled meetings and conference calls on Emergency Preparedness. 2. All residents have the potential to be affected. 3. The Hazardous Vulnerability	

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E 036	Continued From page 25	E 036	Assessment was updated and strategies identified in the assessment and are the bases for training strategies for staff. Staff were informed and trained by ED/SDC on facility Hazard Vulnerability as identified in the assessment considering past or future Hazards. Results of the training will be reviewed at the monthly QAPI committee meeting. 4. QAPI committee will review the training and testing results quarterly to ensure facility meets and sustains compliance.	
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 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	E 037		5/22/18

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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 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

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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.
(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,

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E 037	Continued From page 28 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 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 have an initial emergency preparedness training program. The findings included: During an interview on 05/03/18 at 12: 22 P.M. with the administrator, he was asked for documentation for an initial training program in emergency preparedness policies and	E 037	1. All current staff were trained in the Emergency Preparedness Plan. New Staff will be trained on the EPP upon hire and annually by the Staff Development Coordinator. 2. All residents have the potential to be affected. 3. The Staff Development Coordinator or designee will train new staff on the Emergency Preparedness Plan. ED or designee will audit training weekly x 1 month, then monthly x 2 months, then	

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E 037	Continued From page 29 procedures for all new new and existing staff. The administrator stated, the facility had not conducted an initial training program for emergency preparedness. The facility staff failed to have an initial emergency preparedness training program.	E 037	quarterly x 3 months. Audits will be reviewed at facilities QAPI meeting. 4. Results of audit will be reviewed by QAPI committee for compliance.	
E 039 SS=C	EP Testing Requirements CFR(s): 483.73(d)(2) (2) Testing. The [facility, except for LTC facilities, RNHCIs and OPOs] must conduct exercises to test the emergency plan at least annually. The [facility, except for RNHCIs and OPOs] must do all of the following: *[For LTC Facilities at §483.73(d):] (2) Testing. The LTC facility must conduct exercises to test the emergency plan at least annually, including unannounced staff drills using the emergency procedures. The LTC facility must do all of the following:] (i) Participate in a full-scale exercise that is community-based or when a community-based exercise is not accessible, an individual, facility-based. If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in a community-based or individual, facility-based full-scale exercise for 1 year following the onset of 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.	E 039		5/22/18

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E 039	Continued From page 30 (B) A tabletop exercise that includes a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed. *[For RNHCIs at §403.748 and OPOs at §486.360] (d)(2) Testing. The [RNHCI and OPO] must conduct exercises to test the emergency plan. The [RNHCI and OPO] must do the following: (i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group discussion led by a facilitator, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (ii) Analyze the [RNHCI's and OPO's] response to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCI's and OPO's] emergency plan, as needed. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility staff failed to have documentation of the facilities emergency preparedness excise analysis and response. The findings include: During an interview on 05/03/18 at 12:25 P.M.	E 039	1. The facility participated in an Eastern Virginia Healthcare Coalition Emergency exercise on 4/30/2018. An after action report and analysis was done to evaluate. 2. All residents have the potential to be affected. 3. Facility will participate in Emergency Preparedness exercises provide by the Eastern Virginia Healthcare Coalition,	

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E 039	Continued From page 31 with the administrator, he was asked for documentation of the facilities table top exercise analyses and the revised emergency plan. The administrator stated, the facility staff did not conduct an analyzes of the table top exercise nor did the facility staff revise the emergency preparedness plan as a result. The facility staff failed to have documentation of the facilities exercise analysis and response.	E 039	complete the after action response and update the Emergency Preparedness Plan as necessary going forward and review in the facility QAPI meeting for updates and recommendations. 4. QAPI committee will review the results quarterly to ensure facility meets and sustains compliance.	
E 041 SS=C	Hospital CAH and LTC Emergency Power CFR(s): 483.73(e) (e) Emergency and standby power systems. The hospital must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section and in the policies and procedures plan set forth in paragraphs (b)(1)(i) and (ii) of this section. §483.73(e), §485.625(e) (e) Emergency and standby power systems. The [LTC facility and the CAH] must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section. §482.15(e)(1), §483.73(e)(1), §485.625(e)(1) Emergency generator location. The generator must be located in accordance with the location requirements found in the Health Care Facilities Code (NFPA 99 and Tentative Interim Amendments TIA 12-2, TIA 12-3, TIA 12-4, TIA 12-5, and TIA 12-6), Life Safety Code (NFPA 101 and Tentative Interim Amendments TIA 12-1, TIA 12-2, TIA 12-3, and TIA 12-4), and NFPA 110, when a new structure is built or when an existing	E 041		5/22/18

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E 041	Continued From page 32 structure or building is renovated. 482.15(e)(2), §483.73(e)(2), §485.625(e)(2) Emergency generator inspection and testing. The [hospital, CAH and LTC facility] must implement the emergency power system inspection, testing, and maintenance requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code. 482.15(e)(3), §483.73(e)(3), §485.625(e)(3) Emergency generator fuel. [Hospitals, CAHs and LTC facilities] that maintain an onsite fuel source to power emergency generators must have a plan for how it will keep emergency power systems operational during the emergency, unless it evacuates. *[For hospitals at §482.15(h), LTC at §483.73(g), and CAHs §485.625(g):] The standards incorporated by reference in this section are approved for incorporation by reference by the Director of the Office of the Federal Register in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. You may obtain the material from the sources listed below. You may inspect a copy at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html. If any changes in this edition of the Code are incorporated by reference, CMS will publish a document in the Federal Register to announce the changes.	E 041		

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E 041	Continued From page 33 (1) National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02169, www.nfpa.org, 1.617.770.3000. (i) NFPA 99, Health Care Facilities Code, 2012 edition, issued August 11, 2011. (ii) Technical interim amendment (TIA) 12-2 to NFPA 99, issued August 11, 2011. (iii) TIA 12-3 to NFPA 99, issued August 9, 2012. (iv) TIA 12-4 to NFPA 99, issued March 7, 2013. (v) TIA 12-5 to NFPA 99, issued August 1, 2013. (vi) TIA 12-6 to NFPA 99, issued March 3, 2014. (vii) NFPA 101, Life Safety Code, 2012 edition, issued August 11, 2011. (viii) TIA 12-1 to NFPA 101, issued August 11, 2011. (ix) TIA 12-2 to NFPA 101, issued October 30, 2012. (x) TIA 12-3 to NFPA 101, issued October 22, 2013. (xi) TIA 12-4 to NFPA 101, issued October 22, 2013. (xiii) NFPA 110, Standard for Emergency and Standby Power Systems, 2010 edition, including TIAs to chapter 7, issued August 6, 2009. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility staff failed to have documentation and written agreement with an outside fuel source vendor. The findings included: During an interview on 05/03/18 at 12:33 P.M. with the administrator he was asked for documentation for written agreement with an	E 041	1. the facility has a contract with PAPCO for a back up fuel source for its generator. 2. All residents have the potential to be affected. 3. The contract for the outside fuel vendor is in place and will be renewed on an annual basis to ensure a back up fuel source in case of an emergency. 4. The contract will be reviewed in the facility QAPI meeting to ensure compliance.	

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E 041	Continued From page 34 outside fuel vendor for emergencies. The administrator was not able to provide a written contract for an outside fuel vendor. The facility staff failed to have an written agreement for an outside fuel source vendor.	E 041		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard and complaint survey was conducted 5/01/18 through 5/04/18. Significant corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. Two complaints were investigated during the survey The census in this 138 certified bed facility was 125 at the time of the survey. The survey sample consisted of 41 current resident reviews and 5 closed record reviews.	F 000		
F 553 SS=D	Right to Participate in Planning Care CFR(s): 483.10(c)(2)(3) §483.10(c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to: (i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care. (ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care.	F 553		5/22/18

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F 553	Continued From page 35 (iii) The right to be informed, in advance, of changes to the plan of care. (iv) The right to receive the services and/or items included in the plan of care. (v) The right to see the care plan, including the right to sign after significant changes to the plan of care. §483.10(c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must- (i) Facilitate the inclusion of the resident and/or resident representative. (ii) Include an assessment of the resident's strengths and needs. (iii) Incorporate the resident's personal and cultural preferences in developing goals of care. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interviews, clinical record review, and review of the facility's policy the facility staff failed to ensure the resident was involved in the person centered care plan meeting for 1 of 46 residents (Resident #57), in the survey sample. The facility's staff failed to afford Resident #57 the opportunity to actively participate in revising and exploring ongoing care alternatives of the person centered care plan. The findings included; Resident #57 was originally admitted to the facility 7/25/15 and was discharged from the facility to a local acute care facility 12/31/17, returning 1/2/18. The resident's diagnoses include; high blood pressure, reflux disease, heart failure, diabetes	F 553	Resident Affected: A care plan invitation was delivered to resident #57 by the Social Worker on 5/7/2018 allowing resident opportunity to participate in POC for the development of person centered care. The resident attended the Plan of Care meeting on 5/11/2018 as scheduled. Residents having potential to be affected: All residents have the potential to be affected. Review of the care plan schedule has been completed and invitations to participate have been distributed out to resident and/or responsible party/family with the date and time of the care plan meeting thru June 30, 2018. This will also allow for a change in appointment to be made to	

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anemia, an anxiety disorder, bipolar disease, arthritis, coronary artery disease, hip fracture and a thyroid disorder.

The Brief Interview for Mental Status (BIMS) interview dated 2/25/18 revealed the resident scored 9 out of a possible 15. This indicated Resident #57's cognitive abilities for daily decision making were moderately impaired.

The quarterly Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 2/25/18 coded the resident as requiring total care of two with transfers, toileting and bathing, extensive assistance of two persons with bed mobility and dressing, extensive assistance of one with personal hygiene and locomotion on unit and independent after set-up with eating.

During an interview with Resident #57 on 5/2/18 at approximately 11:00 a.m., the resident was fully alert and oriented and was asked if she participated in meetings; meetings in-which the staff assists her to plan her activities, medical/nursing care and any other activities which she or the team deemed important to her life. Resident #57 stated she was not aware of such a meeting and she couldn't imagine why someone other than herself would address such concerns on her behalf. The resident then stated she would like to talk with the team about getting her out of bed more often for she had experienced too may falls attempting to self-transfer and to let them know she would like to attend musical activities because she enjoys singing is not out of bed to attend the activities.

An interview was conducted with the Social Service Director (SSD) on 5/3/18 at

accommodate needs of residents and RP/family as well as participation in developing person centered care plan. The Interdisciplinary team which included the Executive Director, Director of Nursing, Unit Managers, Social Worker, MDS. Activities Director, and Medical Records were in-serviced by the Staff Development coordinator using the care plan invitation and the monthly care plan process.

Systemic Changes:
MDS Coordinator will update the Care Plan calendar each month and the Social Worker will distribute invitations to participate in care plan meeting to resident and/or responsible party/family with the date and time of the care plan meeting. the social Worker will make copies of the invitations and place them in a binder. The Director of Nursing and/or the Assistant Director of Nursing will complete a monthly audit of the Plan of Care calendar and the distributed Plan of Care invitations to assure process is being maintained. The Care Plan process audit was completed on 5/21/2018, then monthly x 3 months, then bi-monthly x 3 months.

Monitoring:
The Director of Nursing will immediately initiate intervention if needed. The Director of Nursing or Assistant Director of Nursing will bring the Care Plan audit to be reviewed and discussed by the Monthly Performance Improvement Committee consisting of the Executive Director,

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approximately 1:50 p.m. The SSD stated he takes letters to each resident informing them of their care plan meeting but he doesn't document information such as; attendance, what was discussed in the care plan meeting or if a resident representative participated.

The SSD presented a copy of the resident invitation letter he stated Resident #57 received. It was a typed letter with a "sent" date handwritten in the top right corner. The SSD was asked if the facility utilizes a sign-in form for participants in the care plan meeting; he stated they did and returned later stating the resident had not signed in as a participant for the 4/23/18 or 1/22/18 care plan meetings.

An interview was also conducted with the Director of Nursing (DON) on 5/3/18 at approximately 3:40 p.m. The DON stated if a resident doesn't come to the care plan meeting then the interdisciplinary team should go to the resident.

On 5/4/18 at approximately 11:45 a.m., the resident invitation to participate in your care plan meeting was shown to Resident #57; the resident denied receiving the letter and stated the facility staff had not met with her in a room or at bedside for a care plan meeting.

The above information was shared with the Administrator and Director of Nursing during the pre-exit meeting at 3:00 p.m., on 5/4/18. No additional information was provided.

The facility's policy titled Comprehensive Plan of Care with a revision date of 11/28/17 stated, Under Procedure ... notify the resident and or family of the scheduled date and time for the care

Director of Nursing, Assistant Director of Nursing, Registered Dietician, Social Worker, MDS Coordinator, and the Medical Director to ensure compliance is ongoing and determine the need for further audits/in-serviced.

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F 553	Continued From page 38 plan conference. Resident and family invitations to care plan conferences are made in writing, in the form of a letter or card. It is recommended that invitation letters be sent out a month in advance. Document the notification in the patients' active medical record.	F 553		
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, medical record review and facility documents the facility staff failed to provide for the accommodation of needs to maintain independence and to ensure the safety for 1 of 46 residents in the survey sample, Resident #29. The facility staff failed to ensure the call bell was placed within reach of Resident #29 to maintain some independence and ensure her safety. The findings included: Resident #29 was a 83 year old admitted to the facility on 1/29/18 with diagnoses to include Diabetes Mellitus, Seizures, Congestive Heart Failure, Anxiety and Transient Alteration of Awareness. The most recent Minimum Data Set (MDS) was a Quarterly Assessment with an Assessment	F 558	Resident Affected: Director of Nursing immediately went and placed Resident #29 call light within reach. Resident with Potential to be Affected: All residents have the potential to be affected. Unit Managers immediately completed room rounds 5/4/2108 to assure all residents call lights were within reach. Staff were in-serviced on or prior to 5/12/2018 by the Assistant Director of Nursing of the importance of placing a call light within reach of the resident and to ensure proper placement for resident use. Staff that did not receive in-service will not be allowed to work until in-service complete by Staff Development Coordinator or designee. Systemic Changes:	5/22/18

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F 558	Continued From page 39 Reference Date (ARD) of 2/4/18. The Brief Interview for Mental Status (BIMS) for Resident #29 was a 7 out of 15 which indicated that the resident mild to moderate cognitive deficits. Also on the MDS under Section B Self Hearing, Speech, and Vision, B0700 Making Self Understood (Ability to express ideas and wants) Resident #29 was coded as a 1(Usually understood). Resident #29's current Comprehensive Patient-Centered Care Plan was reviewed and is documented in part, as follows: Focus: Name (Resident #29) has an ADL (Activities of Daily Living) Self Care Performance Deficit related to Confusion, Impaired balance. Date Initiated: 01/12/18 Revision on: 1/12/18 Interventions: *Encourage Name (Resident #29) to complete tasks and provide positive reinforcement for activities attempted and/or partially achieved. Date Initiated: 01/12/18 *Place personal items and assistive devices within reach. Date Initiated: 01/12/18 Focus: Gait Balance problems. Date Initiated: 01/12/18 Revision on: 1/12/18 Interventions: *Be sure the call light is within reach and encourage Name (Resident #29) to use it for assistance as needed. Date Initiated: 01/12/18 Revision on: 1/12/18 During the survey the following observations were made:	F 558	Staff Development Coordinator will educate new employees on importance of placing call light within reach and proper placement during orientation. Call light clip audit completed 5/19/2018 by the Assistant Director of Nursing to securing call light is within reach if clip needed. all staff will verify call light is in reach and placed properly with each patient interaction. The Unit Manager or Manager on Duty will complete call light audit daily for 2 weeks, then 3 times weekly x 4 weeks, then weekly times 4 weeks, then monthly x 3 months. The Director of Nursing and/or Assistant Director of Nursing will review the weekly audits of the call lights at he Standards of Care meeting. Monitoring: The call light audits will be given to the Director of Nursing on the day of the audits for review and immediate interventions if needed. The Executive Director will report the call light audit findings to the Performance Improvement committee consisting of the Executive director, Director of Nursing, Assistant Director of Nursing, Registered Dietician, social Worker, MDS Coordinator, and Medical Director will review the audits and ensure compliance is ongoing and determine the need for further audit/in-services.	

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On 05/01/18 01:18 PM Call bell was observed on the floor behind Resident #29's bed.

On 05/02/18 11:29 AM In to see resident in room, call bell remains on floor behind bed. Resident lying on left side and alert to person, able to squeeze surveyors hand with her right hand. Left hand contracted.

On 05/02/18 05:28 PM Resident lying in bed answers to name being called. Resident's call bell remains on floor behind bed.

On 05/03/18 03:34 PM Into residents room call bell remains on the floor behind bed.

On 05/04/18 9:45 AM Entered residents room, Resident #29 was lying on her back dressed and well groomed. Call bell noted lying across residents abdomen within her reach.

On 05/04/18 9:50 AM an interview was conducted with CNA (Certified Nursing Assistant) #1. CNA #1 was asked if she had been the caregiver for the Resident #29 any this week. CNA #1 stated, "No I haven't had her this week today is my first day having her." CNA #1 was asked if she was the one that placed the resident's call bell within her reach this morning and if so where did she fine the resident's call bell when she assumed care of the resident this morning. CNA #1 stated, "Yes, I put her call bell across her this morning and it was on the floor behind the bed this morning when I got here this morning." The surveyor asked where should the call bell be placed. CNA #1 stated, "The call bell should be in her reach." The surveyor made CNA #1 aware the call bell had been observed on the floor behind the resident's bed for the past 3 days and

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F 558	Continued From page 41 CNA #1 stated, "That makes me so sad just knowing she hasn't had it all week , it upsets me." (CNA #1 teared up) The Administrator acknowledged to this surveyor that the facility did not have a written policy for the placement of call bells in regards to the residents. However, the Administrator provided the surveyor with a CNA Tips sheet that was given to the CNA during orientation and was to be attached to their badges. The CNA Tips sheet was reviewed and is documented in part, as follows: 3. Call light within reach and clipped in place. On 5/4/18 at 2:58 PM a pre-exit interview was conducted with the Administrator and the Director of Nursing where the above information was shared. The Administrator was asked what he would have expected his staff to do with Resident #29's call bell. The Administrator stated, "They should have picked it up and clipped it to the resident within her reach." Prior to exit no further information was shared.	F 558		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events	F 609		5/22/18

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F 609	Continued From page 42 that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on an Adult Protective Services Report dated 11/ 7/17, staff interviews, medical record review, and facility document review the facility staff failed to complete and submit a Facility Reported Incident regarding an allegation of abuse within 24 to the appropriate State Agencies for 1 of 46 resident in the survey sample, Resident #20. The facility failed to complete and submit a Facility Reported Incident regarding an allegation of abuse within 24 to the appropriate State Agencies for Resident #20 after being informed by Adult Protective Services on 11/7/17. The findings included: Resident #20 was a 61 year old admitted to the facility on 8/22/16 with diagnoses to include Right	F 609	Resident Affected: It was determined from the APS investigation, and facility investigation that the allegation regarding Resident #20 was unsubstantiated, no negative outcome was identified. Residents with Potential to be Affected: All residents have the potential to be affected, Staff Development Coordinator completed in-service with 100% of staff that has worked regarding abuse reporting. Staff that will not be allowed to work a shift until in-service has been completed by the Staff Development Coordinator. District Director of Operations in-serviced the Executive Director on reporting all allegations per regulations.	

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F 609	Continued From page 43 Above the Knee Amputation, Aphasia (difficulty speaking or no speech) and a Right Hand Contracture. The most recent Minimum Data Set (MDS) was an Annual Assessment with an Assessment Reference Date (ARD) of 1/26/18. The Brief Interview for Mental Status (BIMS) was coded as 0, not attempted because the resident is rarely/never understood. Under Section C Cognitive Patterns Resident #20 was coded to have long and short term memory deficits and was severely impaired in cognition for daily decision making. An Adult Protective Services Report Investigation dated 11/7/17 regarding Resident #20 that was sent to the Office of Licensure and Certification was reviewed and is documented in part, as follows: REFERRAL FOR INVESTIGATION FROM ADULT PROTECTIVE SERVICES (APS) Virginia Beach Department of Social Services Date 11/7/17 An APS report received by this local department alleges that adult abuse, neglect, or exploitation occurred/occurring or there is risk of abuse, neglect, or exploitation. The investigation status is: FROM: Virginia Beach Department of Health Services received an adult protective services report on 11/6/17 concerning: The individual who was the subject of the APS investigation: Name (Resident #20)	F 609	Systemic Changes: Executive Director to complete audit on all Facility Reported Incidents to assure it was reported timely and reported to all agencies per regulation. Executive Director, Director of Nursing, Assistant Director of Nursing, Staff Development Coordinator, social Worker, Activities Director, and Unit Managers completed the ADS-5055- Recognizing and Reporting Abuse, Neglect, and Exploitation of Adults. The Staff Development Coordinator will educated all new employee during orientation on Abuse/Reporting. Angel rounds are conducted weekly. Monitoring: The Executive Director will take immediate action if audit results indicate all regulations have not been followed. The Executive Director, will discuss the audit results with the Interdisciplinary team during the monthly Performance Improvement committee meeting consisting of the Executive Director, Director of Nursing, Assistant Director of Nursing, Registered Dietitian, social Worker, MDS Coordinator, and Medical Director to ensure compliance is ongoing and determine the need for further audits/in-services.	

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The individual who was the alleged perpetrator is: Unknown male attendant.

Description of the Incident of Abuse, Neglect or Exploitation:
Caller reported on 11/6/17 client was seen with a black eye. Name (Resident #20) told caller that a male attendant was drunk at work and punched client in the eye and kicked client in the ribs. Caller reported that client was in her mid-50's and right leg amputated and little use of right arm. Caller reported client has limitation with speech. Caller reported taking a picture of client's black eye. Intake worker contacted Domestic Violence Unit. Detective (Name) agreed to meet assigned worker. The case is being assigned as Emergency due to alleged unknown prep. (perpetrator) has access to client. PLEASE NOTE THAT REPORT WAS NOT RECEIVED FROM THE FACILITY.

On 5/2/18 at approximately 11:00 A.M. the Director of Nursing (DON) was asked if she was aware of the APS Investigation regarding Resident #20 on 11/7/17. The Director of Nursing stated, "Yes, APS came in and made me aware because I started an investigation as well." The Director of Nursing handed the surveyor four different documents that she acknowledged as her investigation regarding the allegation of abuse for Resident #20. Surveyor then asked the DON for a copy of the Facility Reported Incident (FRI) that she submitted to the Office of Licensure and Certification regarding the allegation of abuse reported to her by APS on 11/7/17 for Resident #20. The DON stated, "I didn't submit a FRI because by the time I was notified by APS it was already past the 24 hours for reporting and APS

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had already began an investigation and I didn't think I needed to report it. I also did an investigation and there was no abuse." Surveyor responded by telling DON that her 24 hour clock began to submit a FRI to the Office of Licensure and Certification as soon as she was alerted by APS on 11/7/17 that there was an allegation of abuse for Resident #20.

A blank copy of a "Facility Reported Incident (FRI)" by the Virginia Department of Health(VDH) Office of Licensure and Certification was reviewed and is documented in part, as follows:

Use of this form is optional. Reporting as required is not optional.
Failure to provide credible protective/preventive measures at the time of an initial report or failure to provide evidence of a thorough investigation with corrective measures in the final report may result in VDH conducting an on-site investigation to determine if acceptable practices are in place to protect residents.

Incident Type:
Allegation of abuse/mistreat

Describe incident, including location, and action taken:

If applicable, date notification provided to:
Responsible Party:
Physician:
APS:
DHP (Department Health Professions):
Law Enforcement:

Facility internal investigation:
Completed on:

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Will be conducted/Report forwarded to VDH/OLC (Office of Licensure and Certification)
For 5-working day and final reports, include a summary of the investigation and corrective measures implemented to prevent recurrence.

The following facility documents of the DON's investigation regarding the allegation of abuse for Resident #20 reported by APS were reviewed and are documented in part, as follows:

1. Facility Fax Cover Sheet dated 11/8/17 that was sent to the APS worked that was conducting the investigation sent by the DON:

I checked her leg and her=right stump along with (Name) RN (Registered Nurse), ADON(Assistant Director of Nursing) and (Name) CNA (Certified Nursing Assistant) no bruising, discoloration, or swelling noted. Thanks (Name) DON.

2. Physician Progress Note for Resident #20 dated 11/7/17:

Pt.(patient) seen for DNS (Director Nursing Service)-
Another resident stated she had been assaulted with unk (unknown) person and had broken ribs and black eye. No evidence of any trauma to face and bilateral X-rays of her ribs negative for fracture. No contusions seen. Pt. nonverbal-can shake head yes and no-denies pain by No-head shake, right AKA (above the knee amputation) .
Impression: No evidence of trauma
Plan" Continue to monitor
Name (Medical Doctor)

3. Hand-written note by DON:

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11/7/17-APS came to building and stated they rec'd (received) a call alleging abuse against (Name) Resident #20. Stated caller reported that resident had 2 black eyes and was kicked in the shin and had a bruise. Stated an employee had abused the resident. APS worker and 2 Detectives went to courtyard and observed (Name) Resident #20 sitting up in W/C (wheelchair)-resident did not have any bruising around her eyes. Writer took resident to room and checked ribs for bruises none noted. APS and detectives spoke to (Name) Resident who made the allegation, and she then stated another resident did it. (Name) Resident who made the allegation has a history of fabricating events.

Radiology Report for Resident #20 dated 11/7/17 at 8:06 P.M.

Examination: RIBS Bi-Lateral
Conclusion: No displaced acute fracture is visualized.
MD (Medical Doctor) notified 11/7/17.

The facility policy titled "Detecting Abuse, Neglect, Misappropriation and Injuries of Unknown Origin" revised 11/28/17 was reviewed and is documented in part, as follows:

POLICY: Concordia Care facilities have processes in place to assist in prohibiting, preventing, detecting and investigating allegations of abuse, neglect, exploitation, misappropriation and injuries of unknown origin.

PROCEDURE:
Identification of Events and Occurrences that may Constitute or Contribute to Abuse and Neglect:

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 609	Continued From page 48	F 609		

1. Review reports of grievances, complaints, and allegations of abuse, neglect, exploitation, injuries of unknown injury, and misappropriation for patterns or isolated incidents of unexplained functional regression, or other evidence of physical, verbal, sexual or psychological abuse or punishment posing a serious and immediate threat to individuals.

INVESTIGATE:
15. Upon the conclusion of the investigation, prepare a summary report of the findings and conclusions.

16. Submit the findings to the State Survey Agency within 5 working days of the initial incident or per state regulations, if applicable.

Report/Response:

1. The center staff reports any alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property, immediately to:

d. Other officials in accordance with State regulations through established procedures (including to the State survey and certification agency, Adult Protective Services and local law enforcement).

7. Per the Elder Justice Act, if the reportable event does not result in serous bodily injury, report the suspicion not later than 24 hours after forming the suspicion.

9. Report the alleged crime to the appropriate state agencies in accordance with state law.

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F 609	Continued From page 49 The DON also provided the surveyor with the following facility document algorithm which was reviewed and is documented in part, as follows: "MISCONDUCT AND INJURIES OF UNKNOWN ORIGIN FACILITY INVESTIGATION AND REPORTING REQUIREMENTS" EVENT: INCIDENT Facility learns of an incident of possible misconduct (mistreatment, abuse or neglect of a resident, or misappropriation of a resident's property) or any injury of unknown origin. ACTION: Facility protects resident(s) from further possible misconduct or injury. (Arrow Down to next box) ACTION: Facility files an initial written report with the OLC (Office of Licensure and Certification) (Arrow Down to next box) ACTION: Facility thoroughly investigates incident. After investigating, facility must make the following decisions. Algorithm now branches off into multiple questions. On 5/4/18 at 2:58 PM a pre-exit interview was conducted with the Administrator and the Director of Nursing where the above information was shared. The Director of Nursing was asked if allegations of abuse should be report to the State Agency and if so when. The Director of Nursing stated, "Yes they should be and within 24 hours. In the future I will report and do my FRI." Prior to exit no further information was shared.	F 609		
F 623 SS=E	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8)	F 623		5/22/18

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§483.15(c)(3) Notice before transfer.
Before a facility transfers or discharges a resident, the facility must-
(i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman.
(ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and
(iii) Include in the notice the items described in paragraph (c)(5) of this section.

§483.15(c)(4) Timing of the notice.
(i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged.
(ii) Notice must be made as soon as practicable before transfer or discharge when-
(A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section;
(B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;
(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;
(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or

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F 623	Continued From page 51 (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. §483.15(c)(6) Changes to the notice.	F 623		

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F 623	Continued From page 52 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,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 4 of 46 residents (Resident #475, #474, #110 and #57) in the survey sample. 1. The facility staff failed to notify the Office of the State Long-Term Care Ombudsman of Resident #475's discharge to the hospital on 3/11/18. 2. The facility staff failed to notify the Office of the State Long-Term Care Ombudsman of Resident #474's discharge home on 3/31/18. 3. The facility staff failed to notify the Office of the State Long-Term Care Ombudsman of Resident #110's discharge to the hospital. 4. The facility staff failed to notify the Office of the	F 623	Residents Affected: Social Services sent notification to the Office of Long Term Care Ombudsman for residents #475, #474, #110, #57 on Friday May 11,2018. Residents with Potential to be Affected: All residents have the potential to be affected. Staff Development Coordinator in-serviced Social Worker and Activities Director on the CMS requirement to send all resident discharges to the Office of Long Term Care Ombudsman. On May 11,2018 all resident discharges from November 1,2017 thru May 1o, 2018 and on May 18,2018 discharges for the week of May 11- 17, 2018 were sent to the Office of Long Term Care Ombudsman. Systemic Changes: The Social Worker/ designee will send a	

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F 623	Continued From page 53 State Long-Term Care Ombudsman of Resident #57's discharge to the hospital. The finding include: 1. The facility staff failed to notify the Office of the State Long-Term Care Ombudsman of Resident #475's discharge to the hospital on 3/11/18. Resident #475 was initially admitted to the nursing facility on 9/17/17 with diagnoses that included Alzheimer's disease and status post fall with left hip fracture repair. The resident was transferred and admitted to the local hospital on 3/11/18 after a fall in the facility. The entry tracking Minimum Data Set (MDS) assessment was dated 9/17/17. The Admission MDS assessment dated 9/24/17 coded the resident on the Brief Interview for Mental Status (BIMS) with a score of 01 out of a possible score of 15 which indicated the resident was severely impaired in the cognitive skills for daily decision making. The discharge tracking MDS assessment was dated 3/11/18. The nurse's notes dated 3/11/18 at 7:21 p.m., indicated the resident was discharged to the local hospital. On 5/2/18 at 3:15 p.m., an interview was conducted with the facility's social worker. He stated he was not aware of the mandate dated 11/28/17 to report applicable discharges to the Ombudsman, thus he had not reported any of them.	F 623	list of all discharged resident from the week prior every Friday. Activities Director will complete a weekly audit x 4 weeks, then monthly x 3 months to assure that all discharged residents were reported to the Office of Long Term Care Ombudsman per CMS regulation. Monitoring: The Executive Director will discuss the audit results with the Interdisciplinary team during the monthly Performance Improvement committee meeting consisting of the Executive Director , Director of Nursing, Assistant Director of Nursing, Registered Dietician, social Worker, MDS Coordinator, and Medical Director will review the audits and ensure compliance is ongoing and determine the need for further audits/in-services.	

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A debriefing was conducted with the Administrator and Director of Nursing (DON) on 5/4/18 at 2:50 p.m. The Administrator stated he was not aware of the criteria used to report any of the facility's discharges to Ombudsman office. He stated it would be the Social Worker's responsibility to send the notices to the Ombudsman and they would set up a process to start reporting the required discharges as soon as possible.

2. The facility staff failed to notify the Office of the State Long-Term Care Ombudsman of Resident #474's discharge home on 3/31/18.

Resident #474 was admitted to the nursing facility on 2/21/18 with diagnoses that included weakness and difficulty walking.

The entry tracking Minimum Data Set (MDS) assessment was dated 2/21/18.

The Admission MDS assessment dated 2/28/18 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 necessary for daily decision making.

The discharge tracking MDS assessment was dated 3/31/18.

The nurse's notes dated 3/31/18 p.m., indicated the resident was discharged home.

On 5/2/18 at 3:15 p.m., an interview was conducted with the facility's social worker. He stated he was not aware of the mandate dated 11/28/17 to report applicable discharges to the

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Ombudsman, thus he had not reported any of them.

A debriefing was conducted with the Administrator and Director of Nursing (DON) on 5/4/18 at 2:50 p.m. The Administrator stated he was not aware of the criteria used to report any of the facility's discharges to Ombudsman office. He stated it would be the Social Worker's responsibility to send the notices to the Ombudsman and they would set up a process to start reporting the required discharges as soon as possible.

3. The facility staff failed to notify the State Ombudsman's office after Resident #110 was discharged to the hospital on 3/25/18.

Resident #110 was initially admitted to the facility on 11/14/2017, diagnoses included but were not limited to cardiovascular accident, non-Alzheimer's dementia, cognitive communication deficit, visual impairment, encephalopathy, muscle wasting and atrophy, renal insufficiency, and Diabetes Mellitus.

Clinical record review for Resident #110 noted a quarterly MDS (Minimum Data Set 3.0) was completed on 3/1/18 was completed. The assessment indicates resident #110 has a BIMS (Brief Interview for Mental Status) assessment score of 5, indicating severe cognitive impairment. Resident #110's ADL (Activities of Daily Living) status was coded as limited assistance needed for self-performance and staff assistance of one staff member for bed mobility, transfers, locomotion on and off the unit, dressing, toilet use, and personal hygiene. He

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needed supervision and set up assistance for eating.

On 5/1/18 at 1:00 PM the clinical record was reviewed and revealed documentation that resident #110 sustained a fall on 3/25/18 and was discharged to the hospital.

An interview with the Social Service Director #4 on 5/4/18 at 1:15 PM regarding notice issuance to the Ombudsman's office for resident #110 after facility initiated discharge the hospital on 3/25/18. When asked if the Ombudsman's office had been notified of the discharge of resident #110 the Social Service Director stated he "did not know he was supposed to do that". (Provide notice of discharge).

A request was made for the facility policy for Ombudsman notice for discharged residents and surveyor was told there was no policy.

Pre-Exit review with Administrator, Regional nurse consultant, and DON was held on 5/4/18 at approximately 4:00 p.m. and they were informed of the lack of notice to the Ombudsman's office for resident #110's discharge. No additional information was provided by the facility.

4. The facility staff failed to notify the Office of the State Long-Term Care Ombudsman of Resident #57's discharge to an acute care hospital 12/31/17.

Resident #57 was originally admitted to the facility 7/25/15 and was discharged from the facility to a local acute care facility 12/31/17, returning 1/2/18. The resident's diagnoses include; high blood

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pressure, reflux disease, heart failure, diabetes anemia, an anxiety disorder, bipolar disease, arthritis, coronary artery disease, hip fracture and a thyroid disorder.

The Brief Interview for Mental Status (BIMS) interview dated 2/25/18 revealed the resident scored 9 out of a possible 15. This indicated Resident #57's cognitive abilities for daily decision making were moderately impaired.

The quarterly Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 2/25/18 coded the resident as requiring total care of two with transfers, toileting and bathing, extensive assistance of two persons with bed mobility and dressing, extensive assistance of one with personal hygiene and locomotion on unit and independent after set-up with eating.

Review of the clinical record revealed Resident #57 was transferred to the hospital on 12/31/17 for an acute illness but; there was no documentation the ombudsman was notified.

During the interview with the Social Service Director (SSD) on 5/3/18 at approximately 10:55 a.m., information was obtained to determine how Resident #57's transfer to the acute care hospital was managed in relation to notification of the Ombudsman. Consideration was given that the notification may have been sent when practicable, such as in a list of residents on a monthly basis. The SSD stated he was not aware such notifications were necessary and he had not been notifying the Office of the State Long-Term Care Ombudsman of any types of transfers/discharges and neither did he have knowledge that any personnel in the facility was fulfilling the mandate.

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F 623	Continued From page 58 An interview was also conducted with the Admissions Director to ascertain if possibly she may be fulfilling the regulation. The Admissions Director stated on 5/4/18 at approximately 1:20 p.m., that she had been employed by the facility for two weeks and she only notified the resident/resident representative of the bed hold policy after a transfer to an acute care facility and she was not aware documentation of the notifications was necessary. The above information was shared with the Administrator and Director of Nursing during the pre-exit meeting at 3:00 p.m., on 5/4/18. No additional information was provided.	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)	F 625		5/22/18

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F 625	Continued From page 59 of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on staff interviews and clinical record review the facility staff failed to provide notice of bed hold information to the resident or responsible party after a facility initiated discharge to the hospital on 3/25/18 for one (resident #110) in the survey sample of 46. Findings included: Resident #110 was initially admitted to the facility on 11/14/2017, diagnoses included but were not limited to cardiovascular accident, non-Alzheimer's dementia, cognitive communication deficit, visual impairment, encephalopathy, muscle wasting and atrophy, renal insufficiency, and Diabetes Mellitus. Resident #110 was readmitted to the facility on 3/28/18. Resident #110's quarterly MDS (Minimum Data Set 3.0) was completed on 3/1/18. The assessment coded resident #110 with a BIMS (Brief Interview for Mental Status) score of 5, indicating severe cognitive impairment. Resident #110's ADL (Activities of Daily Living) status was coded as limited assistance needed for self-performance and staff assistance of one staff member for bed mobility, transfers, locomotion on and off the unit, dressing, toilet use, and personal	F 625	Resident Affected: Resident #110 did return to the facility once discharged from the hospital Residents with Potential to be Affected: All residents have the potential to be affected. All residents that were in the hospital at the time of notification were notified of the bed hold policy. All residents that were in the hospital a bed was available for their return to the facility. Systemic Changes: Staff Development Coordinator in-serviced the licensed nurses and Admission Coordinator regarding Discharge packets containing a bed hold policy. Packets with bed hold policy in it were distributed to nursing units on the hall by Medical Records; Licensed Nurses will give the packet to the resident and/or to the responsible party/family; if the resident is admitted then the Admission Coordinator will call the resident or responsible party/family and offer a bed hold as per policy. Bed hold audit will be completed by the Social Worker weekly x 4 weeks, then monthly x 3 months.	

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F 625	Continued From page 60 hygiene. He needed supervision and set up assistance for eating. On 5/1/18 at 1:00 PM Resident #110's clinical record was reviewed and revealed documentation that resident #110 sustained a fall on 3/25/18, was discharged to the hospital and was admitted with a fractured left femur. An interview with the Social Service Director #4 was conducted on 5/4/18 at 1:15 PM regarding a bed hold notice issuance for Resident #110 when discharged to the hospital on 3/25/18. When asked if a bed hold notice was issued the Social Service Director stated he "did not know he was supposed to do that". (Provide bed hold information). Review of the facility policy, titled "Bed Hold Policy" had no policy number nor date. The policy did not include a provision of written notice which was to be given to a resident or representative at the time of discharge. Pre-Exit review with Administrator, Regional nurse consultant, and DON was held on 5/4/18 at approximately 4:00 p.m. they were informed of the lack of notice of bed hold for resident #110. No additional information was provided by the facility.	F 625	Monitoring Bed Hold audit will be given to the Executive Director for review; immediate corrective action will be initiated if required. The Executive Director will discuss the audit results with the Interdisciplinary team during the monthly Performance Improvement committee meeting consisting of the Executive Director, Director of Nursing, Assistant Director of Nursing, Registered Dietician, Social Worker, MDS Coordinator, and Medical Director who will review the audits and ensure compliance is ongoing and determine the need for further audits/in-service.	
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by:	F 641		5/22/18

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F 641	Continued From page 61 Based on clinical record review, staff interviews and facility documentation review, the facility staff failed to accurately code Minimum Data Set assessments to reflect the resident's status for 2 of 46 residents (Residents #475 and #103) in the survey sample. 1. Resident #475's falls were not accurately coded in sections J1800 and J1900 on MDS assessment dated. 2. The facility staff failed to accurately code Resident #103's, 4/4/18 quarterly (MDS) assessment to reflect the resident's status at "I4500" and "K0300". The findings include: 1. Resident #475 was initially admitted to the nursing facility on 9/17/17 with diagnoses that included Alzheimer's disease and status post fall with left hip fracture repair. The resident was transferred to the local hospital on 3/11/18 after a fall in the facility and was admitted with a diagnosis of *acute (recent onset) subpial intracranial hemorrhage with a left periorbital (around the eye) and left frontal hematoma. Resident #475 was readmitted to the nursing facility on 3/13/18 and expired on 3/23/18, thus a closed record review was conducted. *Subpial tissue is situated beneath the pia mater (https://www.merriam-webster.com/medical/subpial). Pia mater is the delicate and highly vascular membrane of connective tissue investing the brain and spinal cord (https://www.merriam-webster.com/dictionary/pia%20mater). Intracranial hemorrhage is a type of bleeding that occurs inside the skull (cranium)	F 641	Residents Affected: Modification completed on Resident #475 by MDS Coordinator; MDS quarterly completed 4/4/2018 was coded "0" (No or unknown) weight loss for K0300, modified on 5/21/2018 to show K0300 changed to a 2 (yes, not on physician prescribed weight loss regimen). Resident coded on MDS 4/4/2018 I4500 Cardiovascular Accident (CVA), Transient Ischemic Attack (TIA), Or Stroke it was modified to remove active diagnosis I4500, under I8000 MDS Coordinator remove G. Hemiplga following unsp Cerebvasc Disease AFF Unsp Side. Modification completed on Resident #103 by the MDS Coordinator on MDS on 10/1/2017 was coded under J1800 as No Falls, Modification completed on 5/21/2018 on J1800 changed to 1=Yes (to show there was a fall), J1900 modified to show 2 falls with no injury. 3/11/2018 MDS Assessment J1900 1 fall with minor injury and 0 falls with major injury, this MDS was modified on 5/21/2018 to show J1900 0 falls with minor injury, and 1 fall with major injury. Residents with Potential to be Affected: All residents have the potential to be affected. 5 random residents will be audited for MDS coding accuracy by the Assistant Director of Nursing or designee. MDS Regional Director in-serviced the facility MDS Coordinators 5/21/2018. Systemic Changes: The Assistant Director of Nursing or	

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F 641	Continued From page 62 (https://my.clevelandclinic.org/.../14480-intracranial-hemorrhage-cerebral-hemorrhage). A hematoma is a mass of clotted or coagulated blood. It differs from a simple bruise or contusion because the area becomes swollen, raised, or painful. Hematomas may occur after an injury or impact to the skin (https://my.clevelandclinic.org/health/diseases/15235-bruises). The Admission Minimum Data Set (MDS) assessment dated 9/27/17 in section J1800 failed to code the resident for falls prior to the OBRA assessment. Under J1900, this assessment also failed to code the resident for the recent hip fracture (major injury) she sustained prior to admission to the facility. The MDS assessment dated 12/15/17 instrumental at the time of the 3/11/18 fall was a quarterly and coded the resident with a score of 1 out of a possible score of 15 on the Brief Interview for Mental Status (BIMS) which indicated the resident was severely impaired in the cognitive skills necessary for daily decision making. The MDS coded the resident to have fallen, without injury, once since admission. The nurse's notes indicated the resident had at least five falls that should have been coded on this assessment in section J1900: 9/27/17, two on 9/28/17, 10/20/17 and 11/13/17. The MDS assessment dated 3/11/18 was a discharge and coded the resident to have fallen two or more times since admission with one of the falls resulting in non-major injury. The MDS assessment dated 3/13/18 was an entry and failed to code the resident in section	F 641	designee will audit 5 random residents for MDS accuracy weekly x 4 weeks, then monthly x 3 months to ensure that all items are correctly coded. If in-accuracy identified the MDS will be modified and the Regional MDS Director will in-service the MDS Coordinators. Monitoring: All findings will be reviewed with the Regional MDS Director and the Director of Nursing. The audit reports will be discussed at the monthly Performance Improvement committee meeting consisting of the Executive Director, Director of Nursing, Assistant Director of Nursing, Registered Dietitian, Social worker, MDS Coordinator, and Medical Director who will review the audits to ensure compliance is ongoing and determine the need for further audits/in-services.	

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F 641	Continued From page 63	F 641		

J1800 with falls prior to the readmission, nor were there any falls recorded in section J1900 in light of the most recent fall on 3/11/18 with major injury.

The MDS assessment dated 3/17/18 was a quarterly and did not code the resident for any falls. A curser symbol was in the blocks for falls with no injury, non major falls and falls with major injury. The resident had been in the facility four days at the time of this assessment and there were no MDS corrections made to this assessment.

An interview was conducted with the Director of Nursing (DON) on 5/3/18 at 9:30 a.m. The DON stated the falls should have been accurately coded on the MDS and they used the Resident Assessment Instrument as their guidance to complete MDS assessments.

The RAI 3.0 manual guidance indicated in section J1800 report of falls should be captured in this section. Available sources to code accurately in this section could come from medical records, resident and or family. Code 0 (no) if the resident had no falls since last assessment or prior to the OBRA or PPS, whichever is more recent. Code 1 (yes) if the resident had falls since last assessment or prior to the OBRA or PPS, whichever is more recent.

The RAI 3.0 manual guidance indicated in section J1900 report of falls should be captured in this section. Available sources to code accurately in this section could come from medical records, resident and or family.

CMS's RAI Version 3.0 Manual dated 5/2010 (the

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F 641	Continued From page 64 facility's guidance/policy for completing MDS assessments) Coding Instructions for J1900A, No injury: Code 0, none: if the resident had no injurious fall since the admission or prior assessment. Code 1, one: if the resident had one injurious fall since admission or prior assessment. Code 2, two or more: if the resident had two or more injurious falls since admission or prior assessment. Coding Instructions for J1900B, Injury (Except Major): Code 0, none: if the resident had no injurious fall (except major) since admission orprior assessment. Code 1, one: if the resident had one injurious fall (except major) since admission or prior assessment. Code 2, two or more: if the resident had two or more injurious falls (except major) since admission or prior assessment. Coding Instructions for J1900C, Major Injury: Code 0, none: if the resident had no major injurious fall since admission or prior assessment. Code 1, one: if the resident had one major injurious fall since admission or prior assessment. Code 2, two or more: if the resident had two or more major injurious falls since On 5/4/18 at 2:50 p.m., a debriefing was conducted with the Administrator and the DON. No further information was brought forth prior to exit. 2. Resident #103 was originally admitted to the	F 641		

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F 641	Continued From page 65	F 641		

facility 7/9/13 and was discharged to a local acute care hospital on 4/27/18 but had not return to the nursing facility at the time of the survey. The resident's diagnoses in the nursing facility included; dementia, cerebrovascular accident (stroke), hemiparesis, a seizure disorder, hypothyroidism, contractures, adult failure to thrive and dysphagia.

The quarterly MDS assessment with an assessment reference date (ARD) of 4/4/18 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 2 out of a possible 15. This indicated Resident #103's cognitive abilities for daily decision making were severely impaired. The resident was coded for no mood or behavior problems.

In section "G"(Physical functioning) the resident was coded as requiring extensive assistance of 2 people with bed mobility and transfers, total care of 1 person with locomotion, personal hygiene, bathing, dressing and eating and total care of 2 people with toileting.

Review of the clinical record also revealed a physician's progress note dated 4/18/18 revealing Resident #103 had a diagnosis of "stroke" which resulted in hemiparesis. The MDS was not coded for CVA in (Active Diagnoses) at "I4500" on the 4/4/18 quarterly MDS assessment.

Rationale: The physician note within the last 30 days indicates stroke. (Resident Assessment Instrument; Chapter 3 page I-10.

In section "K" (Swallowing/Nutritional Status) of the 4/4/18 MDS assessment the resident was coded at K0200B weight, 86 pounds (lbs). K0300;

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F 641	Continued From page 66 resident coded for no weight loss of 5% or more in the last month or loss of 10% or more in 6 months. Review of Resident #103's weight revealed the following; 10/2/17 (98.5 lbs), 10/13/17 (100.5 lbs), 10/20/17 (100.1 lbs), 10/27/17 (101.2 lbs), 12/7/17 (94.2 lbs), 12/9/17 (97.2 lbs), 2/20/18 (92 lbs), 2/27/18 (90.0 lbs), 3/6/18 (91.0 lbs), 3/12/18 (86.0 lbs), 3/19/18 (87.2 lbs), 3/26/18 (86.5 lbs), 4/2/18 (86.0 lbs). The high weight of 10/27/17 of 101.2 lbs and the low weight of 4/2/18 (86.0 lbs) results in a significant weight loss of 10.1% over 180 days for a total of loss of 15.2 lbs over 180 days therefore K0300 wasn't coded, yes for weight loss, not on a physician-prescribed weight-loss regimen on the 4/4/18 quarterly MDS assessment. 10% WEIGHT LOSS IN 180 DAYS: Start with the resident's weight closest to 180 days, go and multiply it by .90 (or 90%). The resulting figure represents a 10% loss from the weight 180 days ago. If the resident's current weight is equal to or less than the resulting figure, the resident has lost 10% or more body weight. (Resident Assessment Instrument; Chapter 3 pages K 4-5). The facility has policy for the completion of the MDS assessments. They follow the instructions as outlined in the MDS 3.0 RAI manual.	F 641		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans	F 657		5/22/18

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F 657	Continued From page 67 §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 observation, staff interview, facility documentation review and clinical record review, the facility staff failed for one (Resident #86) of 46 residents in the survey sample to revise the comprehensive care plan. The facility staff failed to revise Resident #86's Person-Centered Comprehensive Care Plan when his condition changed. Resident #86 was admitted on 02/19/2018 with	F 657	Resident Affected: Resident #86 BIM's was reviewed and new assessment of BIM's was completed. Resident care plan was updated on 5/2/2018 to reflect resident choice of dressing preference with door and curtain open while in resident room. Resident's responsible party was notified of resident choice. Medical Director was notified of dressing preference.	

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F 657	Continued From page 68 diagnosis to include but not limited to * Malignant Neoplasm of tongue, difficulty in walking and weakness. The most recent Minimum Data Set (MDS) for Resident #86 was an End of Therapy Comprehensive Assessment with Assessment Reference Date (ARD) of 4/7/2018. The Brief Interview for Mental Status (BIMS) was an 11 out of a possible 15, which indicated that resident #86 has moderate cognitive impairment. Initial review of Resident #86's Person-Centered Comprehensive Care Plan was conducted on 5/2/18 at approximately 8:40 a.m. The Care Plan was dated as initiated on 2/24/2018 and listed the focus as Activities of Daily Living (ADL) Self-care Performance deficit related to Activity intolerance. Goal for Resident #86, will improve level of function in Bed Mobility, Transfers, Eating, Dressing, Toilet use and Personal Hygiene, ADL score through the review date. On 5/2/2018 at approximately 8:30 a.m. two surveyors observed Resident #86 seated in a wheelchair in front of the closet and only wearing a tee shirt. Resident #86 was naked from the waist down. On 5/2/2018 at 8:36 a.m. the surveyor observed Activities Director and Registered Dietitian walking into Resident #86's room and talking to the Resident in first bed. The door was open, privacy curtain was not pulled between two beds and Resident #86 was naked from waist down. There was no interaction with Resident #86. On 5/2/2018 at 8:43 a.m. observation was of Resident #86's room. The door was wide open, privacy curtain not pulled and Resident #86 still naked from the waist down. On 5/2/2018 at approximately 8:44 a.m. an interview was conducted with the Activities	F 657	Residents with Potential to be Affected: All residents have the potential to be affected. Resident with BIM's below 12 were assessed for behaviors or choices that would require updated care plans to be updated. There were no residents that required care plans to be updated at this time. Systemic Changes: Residents with change of condition will be reviewed in the Clinical Morning Meeting to assure their care plan has been updated. If care plan was not updated appropriately it will be documented on the Clinical Morning Meeting follow up form and reviewed for completion in the daily Stand up meeting by the Director of Nursing. Education and training was provide on Resident Rights and Dignity by the Ombudsman on 5/16/2018. the Staff Development Coordinator will educate new hires on resident rights and dignity during orientation. Monitoring: the Director of Nursing will review the Clinical follow up log and determine if additional items need to be added to the process. The Executive Director will discuss care palm updates with the Interdisciplinary team during the monthly Performance Improvement committee meeting consisting of the Executive Director, Director of Nursing, Assistant Director of Nursing, Registered Dietitian, Social Worker, MDS Coordinator, and Medical Director who will review the audits to ensure compliance is ongoing and	

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F 657	Continued From page 69 Director. The surveyor asked, "I observed you and another person going into Resident #86's room, the door was open and the privacy curtain was not drawn. The surveyor asked, "Did you notice Resident #86 in the corner wearing a tee shirt and naked from the waist down. Activities Director stated, "No, We were not focused on Resident #86". Surveyor asked," Is that an issue for a resident to be naked from the waist down and the door open and the privacy curtain not pulled?" Activities director stated, "Yes". On 5/2/2018 at approximately 8:45 a.m. Surveyor walked down to nursing station and informed License Practical Nurse #2 that Resident # 86 was observed for approximately 20 minutes, naked from waist down and needing assistance with ADL's. Observation was made of Licensed Practical Nurse #2 and CNA #3 going into Resident # 86's room. On 5/2/18 at approximately 9:00 a.m. Resident #86's care plan had the following information added: Interventions/Tasks: Resident chooses to dress and wash with curtain/door to be open as is his right to do so. (Date initiated 5/2/2018). On 5/2/2018 at approximately 9:05 a.m. surveyor was approached by LPN #2. LPN #2 stated, "what is your name?' Surveyor stated name. LPN #2 stated, "Resident #86, will not let us close the door or pull the curtain for privacy while dressing". Surveyor stated, Is it appropriate for Resident #86 to be exposed and naked for anyone to see while dressing?" LPN #2 walked away without responding to surveyor's question. On 5/2/2018 at 9:12 a.m. an interviewed was conducted with registered dietitian. The Surveyor asked, did you notice Resident #86 seated in the corner, wearing a tee shirt and naked from the waist down". The registered dietitian stated,	F 657	determine the need for further audits/in-services.	

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F 657	Continued From page 70 "What did you do about it?" Surveyor stated, "I am here to observe". Registered dietitian stated, "On one hand you have dignity and on the other hand you have resident rights, how can you balance them out". The Surveyor stated, "Resident have their rights, but is it not a dignity issue for someone to be naked and exposed to anyone walking past their open door?" The registered dietitian had no additional response The Facilities policy and Procedures titled "Care Plan" with a revision date of 11/28/2017, documented the following: A comprehensive care plan is developed consistent with the resident's specific conditions, risks, needs, behaviors, preferences and with standards of practice including measurable objectives, interventions/services, and timetables to meet the resident's needs as identified in the resident's assessment or as identified in relation to the resident's response to the interventions or changes in the resident's condition. 6. (c). Change in resident condition, ability to make decisions, cognition, medications, behavioral symptoms or visual changes. On 5/4/2018 at 2:58 p.m. a pre-exit was conducted with the Administrator, and the DON. The above findings were shared. Surveyor asked, "what are the expectations for updating or revising person-centered comprehensive care plans?' Director of Nursing stated, "I would expect my staff to update the care plans as needed. The facility did not present any further information about the findings.	F 657		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary	F 677		5/22/18

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F 677	Continued From page 71 services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews and clinical record review the facility staff failed to ensure 2 of 46 residents (Resident #115 and 29) in the survey sample who were unable to carry out activities of daily living receives the necessary services to maintain fingernail care. 1. The facility staff failed to ensure that fingernail care was provided to Resident #115. 2. The facility staff failed to ensure the necessary care and services of nail care were provided for Resident #29. The findings include: 1. Resident #115 was admitted to the facility on 02/25/16. Diagnosis for Resident #115 included but not limited to *Dementia and right hand *contracture. *Dementia is the name for a group of symptoms caused by disorders that affect the brain. 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 (https://medlineplus.gov/ency/article/007365.htm). *Contracture is an abnormal, usually permanent condition of a joint, characterized by flexion and fixation (Mosby's Dictionary of Medicine, Nursing & Health Professions 7th edition).	F 677	Residents Affected: Residents #115 and #29 had nail care rendered to include cleaning and cutting of fingernails and toenails. Residents with Potential to be Affected: All residents have the potential to be affected. Unit Managers observed all residents finger nails and toenails and compiled a list of residents that were in need of finger nail and toenail care. Residents that were in need of finger nail care had nails cleaned and cut by nursing staff. Residents that required toenail care were scheduled with the Podiatrist. Systemic Changes: Staff Development Coordinator or designee in-serviced all licensed nurses and certified nursing assistants on providing nail care for resident using Concordia Nail Procedure. Staff that have not received in-service will not be allowed to work a shift until the in-service has been completed by the Staff Development Coordinator or designee. Residents will be monitored using the Care Observation Audit Tool, the Unit Managers or designee will complete the Care Observation audit tool of 2 rooms daily x 5 days x 4 weeks, then 2 rooms 3 days a week x 4 weeks, then 2 rooms 2 day a week x 4 weeks. the Staff Development Coordinator will educate new clinical staff on nail care using Concordia Nail Procedure during	

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F 677	Continued From page 72 The current Minimum Data Set (MDS) a quarterly assessment with an Assessment Reference Date (ARD) of 04/07/18 coded the resident with short and long term memory problems. Resident was also coded under cognitive skill for daily decision making as severely impaired - never/rarely made decision. In addition, the MDS coded Resident #115 requiring total dependence of one personal hygiene. Resident #115's comprehensive care plan indicated alteration in musculoskeletal status and ADL self care performance deficit r/t hx. of bilateral hip fractures with hip contractures, right hand contracture and dementia. The goals the facility staff set for the resident will remain free from complications related to right hand fracture and daily needs will be anticipated and met by staff through the next review. Some of the interventions included but not limited to: anticipate and meet needs, apply right hand wash cloth and or kling roll to hand, provide hand hygiene as ordered, resident is total care in all areas and keep residents nail cut short. On 05/01/18 at 11:35 a.m., doing the initial tour resident was observed lying bed with both hands on top of his covers. His fingernails were observed to be long, thick with jagged edges and a dark substance under them. On 05/02/18 at approximately 8:00 a.m., and 5:10 p.m., the resident's fingernails remained unchanged. On the same day at 5:25 p.m., License Practical Nurse (LPN) #9 and this surveyor went into Resident #115's room. LPN #9 stated, "Yes, his fingernails need to be cut, I will get them cleaned and cut tonight."	F 677	orientation. Monitoring: the audits will be give to the Director of Nursing day they are completed for review and corrective action if needed. The Executive Director will discuss the audit results with the Interdisciplinary team during the monthly Performance Improvement committee meeting consisting of the Executive Director, Director of Nursing, Assistant Director of Nursing, Registered Dietician, social Worker, MDS Coordinator, and Medical Director who will review the audits to ensure compliance is ongoing and determine the need for further audits/in-services.	

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Review of the resident's medical record on 5/3/18 revealed that the podiatrist came in on 5/2/18 and provided fingernail care to Resident #115. On the same day at approximately 8:35 a.m., this surveyor observed Resident #115's fingernails were clean, cut and trimmed.

The facility administration was informed of the finding during a briefing on 5/04/18 at approximately 3:30 p.m. The Administrator stated he expect the staff to check nail care daily while providing care.

The facility's policy titled (Nail Care - Revision date: 11/28/17).
-Rationale: Nail care pertains to looking after fingernails and toenails, nail cuticles and the area surrounding the nails. Manicure and pedicure are procedures used to keep the finger and toe nails in good shape. The most common and mild nail problems are caused due to lack of proper care, cleanliness, and hygiene of the fingernails. Good nail care provides cleanliness, prevents the spread of infection such as fungal infections and preventions.

Procedure to include but not limited to:
-After the resident's shower or bath, use an orange stick or nail brush to remove any soil underneath the nails.
-Trim and clean nails; file smoothly

Responsible Disciplines
-Nursing

2. Resident #29 was a 83 year old admitted to the facility on 1/29/18 with diagnoses to include Diabetes Mellitus, Seizures, Congestive Heart

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Failure, Anxiety and Transient Alteration of Awareness.

The most recent Minimum Data Set (MDS) was a Quarterly Assessment with an Assessment Reference Date (ARD) of 2/4/18. The Brief Interview for Mental Status (BIMS) for Resident #29 was a 7 out of 15 which indicated that the resident mild to moderate cognitive deficits. Also on the MDS under Section G Functional Status G0110 Activities of Daily Living (ADL) Assistance J. Personal Hygiene Resident #29 was coded 4,2 indicating she was totally dependent and requiring 2 person physical assist.

Resident #29's current Comprehensive Patient-Centered Care Plan was reviewed and is documented in part, as follows:

Focus: Name (Resident #29) has an ADL (Activities of Daily Living) Self Care Performance Deficit related to Confusion, Impaired balance. Date Initiated: 01/12/18 Revision on: 1/12/18

Interventions:
*PERSONAL HYGIENE/ORAL CARE: Name (Resident #29) requires staff participation with personal hygiene and oral care. Date Initiated: 01/12/18 Revision on: 1/12/18

During the survey the following observations were made:

On 05/01/18 01:18 PM Resident's fingernails on both hands are long with debris noted under nail beds.

On 05/02/18 11:29 AM In to see resident in room. Resident lying on left side and alert to

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person, able to squeeze surveyors hand with her right hand. Left hand contracted. Fingernails on both hands remain long with continued debris noted under nail beds.

On 05/02/18 05:28 PM Resident lying in bed answers to name being called. Fingernails on both hands remain long with continued debris noted under nail beds.

On 05/03/18 03:34 PM Entered into residents room and resident's fingernails on both hands remain long with debris noted under nails.

On 05/04/18 9:45 AM In residents room, Resident lying on back dressed and well groomed. Fingernails remain long with noted debris under nails.

On 05/04/18 9:50 AM an interview was conducted with CNA (Certified Nursing Assistant) #1. CNA #1 was asked if she had been the caregiver for the Resident #29 any this week. CNA #1 stated, "No I haven't had her this week, today is my first day having her." CNA #1 was asked who was responsible for providing nail care fro the residents. CNA #1 stated, "The nurses, CNA's and the podiatrist do nail care. I will take care of her nails today."

On 05/04/18 10:30 AM CNA #1 came to surveyor and stated, "The resident's nails have been taken care of." Resident #29's nails were observed and have been cut and are clean.

The facility policy titled "Nail Care" revised 11/28/17 was reviewed and is documented in part, as follows:

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Rationale: Nail care pertains to looking after finger nails and toe nails, nail cuticles and the area surrounding the nails. Manicure and pedicure are procedures used to keep the finger and toe nails in good shape. The most common and mild nail problems are caused due to the lack of proper care, cleanliness, and hygiene of the fingernails. Good nail care provides cleanliness, prevents the spread of infection such as fungal infections and prevents skin problems.

Responsible Disciplines: Nursing

Procedure:
1. Perform hand hygiene and don gloves if there is a risk of contact with blood or body fluids.
2. Soak hands for five minutes in basin of warm water, temperature not to exceed 105 degrees Fahrenheit.
3. Use an orange stick or nail brush to remove any soil underneath the nails and remove hands from basin.
4. Put hands on towel. Trim and clean nails; file smoothly.
5. Discard water, clean equipment and wash hands.

or

9. After the resident's shower or bath, use an orange stick or nail brush to remove any soil underneath the nails.
10. Trim and clean nails; file smoothly.
11. Apply lotion to hands and feet.
12. Remove gloves, if applicable and perform hand hygiene.

On 5/4/18 at 2:58 PM a pre-exit interview was conducted with the Administrator and the Director of Nursing where the above information was shared. The Director of Nursing was asked what

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F 677	Continued From page 77 she would have expected her staff to do about Resident #29's fingernails. The Director of Nursing stated, "Fingernails should be done as needed." The Administrator stated, "The resident's nails should be checked daily during care." Prior to exit no further information was shared.	F 677		
F 686 SS=G	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on information obtained from the local Adult Protection Service (APS) representative, clinical record review, staff interviews and facility documentation, the facility staff failed to ensure the necessary care and services were provided to prevent pressure injury development for 1 of 46 residents in the survey sample, Resident #103. The facility staff failed to identify Resident #103 had developed a left buttock pressure injury until it had advanced to a stage 3 pressure injury and	F 686	Resident Affected: Resident #103 was transferred to the hospital on 4/27/2018. Resident with Potential to be Affected: All residents have the potential to be affected. Unit Manager completed audit on all residents that have a pressure ulcer (admitted with and in-house). Audit completed 5/20/2018, no negative outcome identified. Staff Development	5/22/18

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F 686	Continued From page 78 presented with non-viable tissue, which constitutes harm. The findings included: Resident #103 was originally admitted to the facility 7/9/13 and was discharged to a local acute care hospital on 4/27/18 but had not return to the nursing facility at the time of the survey. The resident's diagnoses in the nursing facility included; dementia, stroke, hemiparesis, a seizure disorder, hypothyroidism, contractures, adult failure to thrive and dysphagia. The quarterly Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 4/4/18 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 2 out of a possible 15. This indicated Resident #103's cognitive abilities for daily decision making were severely impaired. The resident was coded for no mood or behavior problems. In section "G"(Physical functioning) the resident was coded as requiring extensive assistance of 2 people with bed mobility and transfers, total care of 1 person with locomotion, personal hygiene, bathing, dressing and eating and total care of 2 people with toileting. In section "K" (Swallowing/Nutritional Status) of the 4/4/18 MDS assessment the resident was coded at K0200B weight, 86 pounds. K0300; resident coded for no weight loss of 5% or more	F 686	Coordinator in-serviced licensed nurses and certified nursing assistants on reporting skin issues that are identified immediately and treatment put in place as per Physician order. Staff that has not completed the in-service will not be allowed to work a shift until the Staff Development Coordinator or designee completes the in-service. Systemic Changes: Unit Managers completed skin sweep on all resident which was completed on 5/20/2018; newly identified skin changes were addressed immediately. The Unit Manager or designee will complete the pressure ulcer audit and review and discuss the finding and corrective action if required during the weekly Standards of Care meeting. All newly hired licensed nursing and certified nursing assistance will receive education on identifying and reporting any change in skin condition by the Staff Development Coordinator. Monitoring: The pressure ulcer audits will be given to the Director of Nursing when completed for review and additional interventions if indicated. the Director of Nursing will bring the Pressure Ulcer audit to the monthly Performance Improvement committee meeting to be reviewed and discussed by the Performance Improvement committee which consist of the Executive Director, Director of Nursing, Assistant Director of Nursing, Registered Dietician, Social Worker, MDS Coordinator, and Medical Director who will	

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in the last month or loss of 10% or more in 6 months.

An interview was conducted with the APS representative on 5/2/18 at approximately 3:30 p.m. The APS representative stated the daughter of Resident # 103 contacted their office on 4/30/17 concerning the resident's food and fluid consumption while in the nursing facility as well as the status of the resident's pressure injuries.

Review of the clinical record revealed a nurses' note dated 4/27/18 at 12:21 p.m. It stated; Resident #103 was observed with changes in her breathing, "sounding wet" and an elevated temperature of 100.5 axillary (under the armpit). The physician was notified and ordered a chest x-ray. The x-ray company was made aware and the daughter was in informed, for she was in the facility. Another nurses' note dated 4/27/18 at 13:30 p.m., stated the resident was transferred to a local hospital per request of the daughter.

Further review of the clinical record revealed Resident #103 had 2 pressure injuries present. Pressure injury #1, was to the right buttock was identified as shearing 3/29/18 and progressed by 4/12/18, to a stage 3 pressure injury, measuring 3.0 x 2.0 x 1 centimeters and presented with white/grey non-viable tissue.

During an interview with the new wound care nurse on 5/3/18 at approximately 10 a.m., the wound care nurse stated pressure injury #2, was identified 4/5/18, by herself and the wound care nurse who was training her. The new wound care nurse stated the two of then turned Resident #103 after completing the dressing change to the

review the audits to ensure compliance is ongoing and determine the need for further audits/in-service.

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right buttock, revealing the first observation of the pressure injury to the left buttock.

The newly identified left buttock pressure injury, upon initial observation and assessment measured 3.5 x 4.5 x 0.2 centimeters. It also presented with 10% white/grey non-viable tissue in the center of the wound bed and was surrounded by pink scar tissue from a previously healed pressure ulcer. The left buttock pressure injury was staged by the two wound care nurses as a stage 3 pressure injury. An order was obtained to treat the left buttock pressure injury with Calcium Alginate (a highly absorbent dressing), every other day.

During the 10 a.m., interview with the new wound care nurse 5/3/18, she stated it is the facility's expectation for pressure injuries to be identified at an early stage, not a stage 3 or 4. She further stated skin integrity education is ongoing to ensure the nursing staff is well informed. She also stated the first line of detecting skin impairment should be from direct care observations during daily care and skin checks/assessments.

On 5/4/18 at approximately 10:45 a.m., the Director of Nursing (DON) was asked if an investigation of the in-house acquired left buttock stage 3 pressure injury identified 4/5/18 was conducted and if she cared to share the findings. She stated it was investigated and presented the investigation document. The document stated the resident's risk status were impaired transfer or bed mobility only. Comatose, malnutrition and end stage disease were also options but not chosen as Resident #103's risk factors. Under clinical status the following were selected; chronic urinary incontinence, poor food/fluid intake. Under

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Lab Data no information was selected. The heading clinical signs of inadequate nutrition/hydration cachexia or muscle wasting was noted. The investigation also noted the following under facility interventions; preventive skin care - clean, protect and moisture, utilization of appropriate pressure reduction support surfaces, evidence of consistently monitoring skin/body, Registered Dietitian consult to address nutrition needs, prevention addressed on care plan to manage identified risk factors. The facility's determination stated facility interventions are checked- area unavoidable.

An interview was conducted with Registered Nurse (RN) #1 on 5/3/18 at approximately 11:00 a.m. RN #1 stated Resident #103 required total care with incontinence care, showers/bathing and dressing and meal consumption. RN #1 also stated the resident was out of bed daily in a recliner chair with a basic cushion and sometimes accepted meals in the dining room. RN #1 further stated Resident #103 was doing better with meal consumption up until the week prior to transferring to the hospital.

The most recent Braden Scale for Predicting Pressure Sore Risk dated 2/5/18 revealed Resident #103's score of 10. This indicated the resident had a high risk for pressure ulcer development because of a limited ability to feel pain over most of her body surface, constant moisture to the skin, chair-fastness, and complete immobility.

Resident #103 Nutrition Therapy Review dated 4/6/18 revealed there was a change in the diet order since the last nutritional review. The current diet consistency was pureed and fortified foods

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were ordered, all liquids were served spoon/pudding thick. The nutritional review read the resident averaged intake was more than 50% in the past 7 days. The resident's weight have ranged from 2/20/18 (92 pounds) to 4/16/18 (83.5 pounds) 4/23/18 (85.3 pounds).

The active care plan with a revision dated of 4/7/16 had a problem which read; potential for impaired skin integrity related to generalized weakness, muscle atrophy, poor appetite, weight loss, dementia, failure to thrive and incontinence. The goal read; skin will remain intact through next review. The interventions were; Assess resident's skin weekly and as needed. Dietary consult as needed. Encourage resident to get up and attend activities. Obtain rehab consult as needed. Offload heels as tolerated when in bed. Provide fortified cereal at breakfast. Provide house supplements as ordered. Provide skin care per physician's order. Resident is to be fed by staff. Stat two mattress as ordered. Turn and reposition as needed.

Another active care plan problem was initiated 4/5/18 and revised 4/25/18 to reflect Resident #103's newly identified pressure ulcer. The problem read (name of resident) has a pressure ulcer to the left buttock. The goals read; (name of resident) pressure ulcer will show signs of healing and remain free from infection through next review and (name of resident) will have interventions in place to prevent altered skin integrity through next review. The interventions were; Administer treatments as ordered and monitor for effectiveness. Assess/record/monitor wound healing per protocol. Measure length, width and depth where possible. Assess and document status of wound perimeter, wound bed

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and healing progress. Report improvements and declines to the physician. Monitor dressing per protocol to ensure it is intact and adhering. Report lose dressing to the treatment nurse. Monitor/document/report to physician as needed changes in skin status, appearance, color, wound healing, signs/symptoms of infection, wound size and stage. Offload heels while in bed. Treat pain as per orders prior to treatment/turning, etc., to ensure resident's comfort.

Also an active care plan problem dated 4/5/18 and revised 4/25/18. The problem read; (name of resident) has pressure ulcer to the right buttock. The goal read; (name of resident) pressure ulcer will show signs of healing and remain free from infection through review date. (name of resident) will have interventions in place to prevent altered skin integrity. (name of resident) will not develop any new skin breakdown through next review. The interventions were the same as in care plan problem above with a revision date of 4/25/18.

The above information was shared with the Administrator and Director of Nursing during the pre-exit meeting at 3:00 p.m., on 5/4/18. The Director of Nursing stated the facility staff had identified the above information also and a Quality Assurance Performance Improvement (QAPI) plan was developed and on 2/28/18 and assessment for compliance was ongoing.

The QAPI tool presented by the DON stated 20 residents were identified with a high risk for skin breakdown based on their Braden scores. The 20 identified residents would receive twice weekly skin assessments to ensure no new or worsen skin breakdown and to verify accuracy of weekly skin assessments. The QAPI plan stated during

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March 2018, three in-house wounds were acquired, 1 resident with a previously vascular wound reopened and 2 high risk residents developed wounds.

An interview was conducted with the Primary care physician 5/4/18 at approximately 5:35 p.m. The physician stated it was his expectation for pressure injuries to be identified at an early stage as 1 or 2 but he has known pressure injuries to develop within a few hours. The physician also stated a person in the emergency room has no one to turn and reposition them on a gurney and may be left for many hours without repositioning. The physician was reminded that we were reviewing Resident #103's care while she was a resident in the nursing facility for it was within the nursing facility she was identified with a stage 3 pressure ulcer of the left buttock on 4/5/18. The physician further stated the resident was with poor nutritional intake and a low weight and for her to develop a pressure injury within 2 hours was a possibility. The physician was asked if he felt since the resident was frail and could develop a pressure injury so quickly were every 1 hour turning and repositioning prudent interventions. The physician replied (name of physician) looked at the resident's pressure injuries and agreed with the treatment plan.

The National Pressure Ulcer Advisory Panel (NPUAP) NOTE: Based on current reported data,
Stage I PrU likely began 12-24 hours prior
Stage II PrU likely began 24 hours prior
Stage III - IV PrU likely began at least 72 hours prior
sDTI PrU purple tissue without epidermal loss likely began 48 hours prior
(file:///C:/Users/eyz54832/AppData/Local/Microso

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The facility policy with a revision date of 11/28/17 titled Prevention and Treatment of Pressure Ulcers and other Skin Alterations read; The facility has a system in place to promote skin integrity, prevent pressure ulcer development/other skin alterations, promote healing of existing wounds and prevent further development of additional skin alterations.

Prevention steps:
1. A risk assessment is completed upon admission and at designated intervals throughout the resident's stay.
a. Residents at risk for developing pressure ulcers are identified by using the Braden scale.
b. Residents are identified as at risk for skin related issues such as;: moisture associated skin damage, skin tears, or other non-pressure skin related issues upon admission and at designated intervals throughout the resident's stay.
c. Pressure ulcer and other wound and skin related interventions are created in collaboration with the interdisciplinary team and implemented in other to identify, prevent or reduce the risk of acquiring pressure and/or non-pressure related wounds or skin issues:
2. Treatment of new or existing pressure and non-pressure related wounds are initiated following the principles of wound healing.
3. Nutritional status is addressed upon admission or when there is a change in the resident's skin status.
4. The interdisciplinary team, resident/family collaborates to establish goals and interventions to address resident specific risk factors for the

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prevention of skin alteration.
5. The Interdisciplinary team and resident/family collaborates to establish goals and interventions to promote the healing of wounds and/or prevent further breakdown.

Multiple request were make to the DON for the twice skin assessments or weekly skin assessments but they were not provided.

Pressure Injury:
A pressure injury is localized damage to the skin and underlying soft tissue usually over a bony prominence or related to a medical or other device. The injury can present as intact skin or an open ulcer and may be painful. The injury occurs as a result of intense and/or prolonged pressure or pressure in combination with shear. The tolerance of soft tissue for pressure and shear may also be affected by microclimate, nutrition, perfusion, co-morbidities and condition of the soft tissue.

Stage 3 Pressure Injury: Full-thickness skin loss
Full-thickness loss of skin, in which adipose (fat) is visible in the ulcer and granulation tissue and epibole (rolled wound edges) are often present. Slough and/or eschar may be visible. The depth of tissue damage varies by anatomical location; areas of significant adiposity can develop deep wounds. Undermining and tunneling may occur. Fascia, muscle, tendon, ligament, cartilage and/or bone are not exposed. If slough or eschar obscures the extent of tissue loss this is an Unstageable Pressure Injury.

Debridement - Debridement is the removal of

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F 686	Continued From page 87 devitalized/necrotic tissue and foreign matter from a wound to improve or facilitate the healing process.	F 686		
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on a complaint investigations, observations, clinical record review, staff and family interview, and facility documentation interview the facility staff failed to provide adequate supervision to prevent avoidable accidents for 1 of 46 residents (Resident #475) in the survey sample. The facility staff failed to adequately supervise Resident #475, leaving her alone at the nurse's station. The resident fell and sustained an acute subpial intracranial hemorrhage with a left periorbital and left frontal hematoma. The findings include: Resident #475 was initially admitted to the nursing facility on 9/17/17 with diagnoses that included Alzheimer's disease and status post fall with left hip fracture repair. The resident was transferred to the local hospital on 3/11/18 after a	F 689	Resident Affected: Resident #475 was discharged from the facility on 3/23/2018 Residents with Potential to be Affected: All residents have the potential to be affected. Director of Nursing completed an audit on all falls occurring in the last 30 days to assure appropriate intervention was in place and being followed. Staff Development Coordinator in-serviced clinical staff on appropriated person centered interventions and the implementation of interventions put in place. Staff that did not complete the in-service will not be allowed to work a shift until the Staff Development Coordinator or designee completes the in-service with the employee. Systemic Changes: Fall audit will be completed by the Director	5/22/18

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F 689	Continued From page 88 fall in the facility and was admitted with a diagnosis of *acute (recent onset) subpial intracranial hemorrhage with a left periorbital (around the eye) and left frontal hematoma. Resident #475 was readmitted to the nursing facility on 3/13/18 and expired on 3/23/18, thus a closed record review was conducted. *Subpial tissue is situated beneath the pia mater (https://www.merriam-webster.com/medical/subpial). Pia mater is the delicate and highly vascular membrane of connective tissue investing the brain and spinal cord (https://www.merriam-webster.com/dictionary/pia%20mater). Intracranial hemorrhage is a type of bleeding that occurs inside the skull (cranium) (https://my.clevelandclinic.org/.../14480-intracranial-hemorrhage-cerebral-hemorrhage). A hematoma is a mass of clotted or coagulated blood. It differs from a simple bruise or contusion because the area becomes swollen, raised, or painful. Hematomas may occur after an injury or impact to the skin (https://my.clevelandclinic.org/health/diseases/15235-bruises). The Minimum Data Set (MDS) assessment dated 12/15/17 instrumental at the time of the 3/11/18 fall was a quarterly and coded the resident with a score of 1 out of a possible score of 15 on the Brief Interview for Mental Status (BIMS) which indicated the resident was severely impaired in the cognitive skills necessary for daily decision making. The resident required extensive assistance from two staff for transfers and toileting. She was totally dependent on one staff for bathing. The resident required set up and supervision for eating. She was assessed to have balance problems and not steady without	F 689	of Nursing or designee weekly on all falls x 4 weeks, then monthly x 3 months. Falls will be reviewed in the Clinical Morning meeting to assure Post Fall and pain assessment has been completed appropriately, interventions are in place and being followed. Staff Development Coordinator educate all new clinical staff on care planning of fall interventions and that interventions are being followed. Monitoring: The weekly fall audit will be given to the Director of Nursing to review completion and will implement process interventions if appropriate. The Director of Nursing will review and discuss the fall audits during the monthly Performance Improvement committee meeting which consists of the Executive Director, Director of Nursing, Assistant Director of Nursing, Registered Dietitian, Social Worker, MDS Coordinator, and Medical Director will review the audit to ensure compliance is ongoing and determine the need for further audits/in-services.	

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the assistance of staff to move from a seated to a standing position, move on and off the toilet, and surface to surface transfers. Resident #475 was coded with range of motion limitations of the lower extremity on one side. The MDS coded the resident to have fallen, without injury, once since admission.

The MDS assessment dated 3/11/18 was a discharge and coded the resident to have fallen two or more times since admission with one of the falls resulting in non-major injury.

The MDS assessment dated 3/17/18 was a quarterly and did not code the resident for any falls. A curser symbol was in the blocks for falls with no injury, non major falls and falls with major injury. The resident had been in the facility four days at the time of this assessment and there were no MDS corrections made to this assessment.

The admission fall risk assessment dated 9/17/17 indicated Resident #475 was at high risk for falls based on fall history, functional status and dementia.

The care plan dated initiated on 9/18/17 and revised on 3/6/18 identified Resident #475 was at risk for falls related to confusion, gait/balance problems, history of falls and actual falls. The goals set by the staff for the resident remained the same, the resident would not sustain serious injury related to falls. Some of the approaches to accomplish this goal included continue to assess risk for falls, bring to nurse's station for short periods when restless, close observation and supervision while at nurse's station, use chair pressure pad alarm when in chair/wheelchair, and

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review information on past falls and attempt to determine cause of falls and follow fall protocol which is inherent in the facility's policy and procedures to prevent falls, fall response and management. Record possible root causes. After remove any potential causes if possible. Educate resident, family, caregivers and interdisciplinary team members as to causes.

Resident #475 had multiple falls since her admission to the nursing facility without injury where she was found either on the floor mat beside her bed or attempting to rise and walk while in her room sitting in the wheelchair. The care plan indicated when restless keep at the nurse's station for close supervision and observation to redirect when attempting to stand in order to prevent fall with subsequent injury. The resident also had a chair sensor pad that would alarm to alert staff of her movement, thus abort a fall that could subsequently result in injury.

The nurse's notes dated 3/11/18 at 7:21 p.m. indicated the following: "Resident fell from wheelchair at nurse's station, have a large hematoma on the left side of her head. Resident says she is in no pain. Area cleaned and dressing applied. She also has a skin tear to her left elbow. Area cleaned and bacitracin ointment applied and wrapped with dressing. POA (power of attorney) notified. (Attending physician's name) notified, ordered her to be sent out to ER to be evaluated and treated. 911 arrived at 6:20 p.m. and left at 6:30 p.m. Resident was alert and nonverbal, but confused when left the facility, was transported to (local hospital name).

The fall investigation report dated 3/11/18, filled

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out by Licensed Practical Nurse (LPN) #7 indicated the resident had a witnessed fall that occurred at 6:30 p.m. from the wheelchair at the nurse's station, but the circumstances of the fall were unknown. Injuries included a hematoma of the left side of the head. First aid was applied to the left side of the head and left eye. The documented measures implemented included to continue 1:1 care in that patient does not comprehend due to dementia. The post fall investigation dated 3/11/18 at 6:33 p.m., filled out by LPN #7, evidenced the same information as the fall investigation report with the addition that the resident was standing up and lost her balance and vital signs were obtained, all within normal range.

Neither the fall investigation report or the post fall investigation report indicated whether the chair sensory alarm sounded to alert the staff at the nurse's station of the resident's movement in the wheelchair in her attempts to stand.

The local hospital admission information dated 3/11/18 indicated the resident's primary diagnosis was a closed head injury after sustaining a fall out of her wheelchair and hitting her head which resulted in an intracranial hemorrhage as validated through CT. The resident also sustained a left periorbital and left frontal hematoma. Based on a follow-up CT, the resident was stable enough to transfer back to the nursing facility on 3/13/18.

The following interviews were conducted some of the facility's IDT members:

On 5/2/18 at 5:00 p.m., an interview was conducted with the Director of Rehabilitation

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(Rehab) department. He presented screening, evaluation and treatment records that were applicable to physical functioning status of the resident, Physical Therapy (PT) and Occupational Therapy (OT). He stated PT concentrated on gait/balance and therapeutic strengthening exercises and OT's concentration was on activity tolerance, strength and safety in order to maximize activities of daily living (ADL). He said the resident was screened and provided the aforementioned therapies based on her repeated falls and basically did not meet the long term goals, thus she was discharged from OT and PT. He stated the resident was picked up again for PT on 1/29/18 and discharged again on 2/2/18 for therapy exercises to improve strength, endurance and gait. He stated the resident was evaluated for therapies again after she returned from the hospital on 3/14/18. He further said, they provided a hip abductor pillow between her legs, but it irritated the resident and she frequently removed it. He also stated it was not traditional to implement a helmet to protect her from head injuries as a result of falls because that would be an added irritant to the resident. The Director of Rehab stated the best course of action for the resident was to closely supervise her when out of bed 1:1 with nursing staff and or to keep her in activities. He stated Dycem (a non-slip mat) was also placed in her seat to prevent sliding, as well as bed and chair alarms to alert staff of resident movement. He stated if the resident happened to fall out of bed, she was protected from injury due to the fall mat on the floor beside the bed, with the other side of the bed positioned against the wall.

On 5/2/18 at 5:20 p.m., an interview was conducted with LPN #8, who stated Resident

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#475 had to be closely supervised by nursing staff and was mostly kept at the nurse's station when out of bed so staff could provide 1:1 supervision otherwise she would try to stand. She added the chair alarm would sound when the resident attempted to stand, and by her positioned with staff at the nurse's station you would be able to reposition her back in the chair.

On 5/2/18 at 5:30 p.m., an interview was conducted with LPN #7 who filled out the investigation report as well as the post fall report related to the 3/11/18 fall. The LPN stated she left the resident with LPN #6 when she went around the corner to get a bag of potato chips and when she came back to the nurse's station LPN #6 was coming out of another patient's room and they met each other in the hallway. Once back at the nurse's station they found the resident in the floor, turned her over to see a large "goose egg" on the left side of her head. She said the alarm was not sounding. She stated she immediately called the physician and the resident was sent to the ER for evaluation. When asked why didn't she record this information on the incident report, she was silent, became tearful and asked, "Are we going to be in trouble for this?"

On 5/2/18 at 5:45 p.m., an interview was conducted with LPN #6 regarding Resident #475's fall on 3/11/18. He took this surveyor to the nurse's station where the fall occurred. This nurse's station floor area was not carpeted and was a concrete linoleum type floor. He stated he was sitting at the computer and the resident was sitting "sort of" behind him, when LPN #7 stated she was leaving the nurse's station to get a bag of potato chips. The LPN stated he stayed at the

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nurse's station with Resident #475. This surveyor asked since he was with her; how did she fall, did he hear the chair alarm sound, did he hear her moving, did he hear her hit the floor and did he see her hit the floor. LPN #7 responded to all the aforementioned questions, "I cannot recall."

On 5/2/18 at 5:55 p.m., an interview was conducted with both LPN#6 and #7. LPN #7 shared with LPN #6 that on her way back to the nurse's station they met each other in the hall and he was coming out of a resident's room. They looked over into the nurse's station and found Resident #475 on the floor. It was at this time LPN #6 stated he had left the resident unsupervised and did not have anyone replace him to provide the necessary supervision for Resident #475 when he left the nurse's station.

On 5/3/18 at 11:15 a.m., and interview was conducted with the Homer unit's Registered Nurse (RN) #1. RN#1 stated the resident resided on the Homer unit and was best supervised when out of bed at the nurse's station desk with staff at the desk. She stated, "I would call it 1:1, but other staff observed and supervised her. We needed to keep her in eyesight if she attempted to stand up we could intervene quickly before an accident could occur. We would see her get up or hear the alarm sound." The unit manager added they would give her magazines at the nurse's station or give her wash cloths to fold to keep her occupied. She stated from her understanding the resident fell at the nurse's station and hit her head, but she did not know the circumstances surrounding the fall. She stated all falls are discussed at the morning meeting and during the weekly standards of care meeting. She stated if there are any further

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recommendations to prevent falls they are discussed during those times and interventions updated on the care plan. She said the nurse who filled out the fall investigation should have thorough and complete information about the fall and that information would be brought forward to the aforementioned meetings.

On 5/4/18 at 10:57 p.m., interviews were conducted with the Director of Nursing and the Assistant Director of Nursing. They both stated although they did not hire a nurse or aide to be 1:1 with Resident #475 or had a policy for 1:1, the staff established 1:1 supervision for the resident among themselves in order to keep the resident safe. The DON stated different nursing staff provided 1:1 supervision for Resident #475 because she would try to rise from her wheelchair which could result in a fall. They stated the resident had a bed and chair sensor pad to alert staff of her movement in order to redirect and position her back in the chair. The DON also stated the staff would offer picture magazines and drinks as interventions to divert her from trying to stand. The DON stated she reviewed the fall investigation report and the post fall investigation report of the fall incident on 3/11/18 and concluded that the resident stood from her wheelchair and fell. Both the fall investigation report and post fall investigation report indicated the fall was unwitnessed. She stated she did not interview any of the staff on duty that night to include the ones at the desk when the resident fell, but took the information as documented by Licensed Practical Nurse (LPN) #7 and saw it as an unfortunate accident and everything had been done to avoid the fall. The DON stated she was aware that the resident had a closed head injury and an intracranial bleed as a result of the fall on

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3/11/18. She presented a Root Cause Analysis (RCA) of the fall and stated the information to generate the RCA came from the investigation report that was filled out by LPN #7 and saw no need to investigate further or conduct any further interviews.

The RCA (no date) that the DON referred to indicated the resident fell and sustained a hematoma and skin tear at the nurse's station on the evening shift and that the human factors relevant to the outcome involved supervision. The RCA indicated supervision was missing and the cause of the incident, and documented the staff had the resident in supervised area at the time of the incident and it was "questionable" as to how the incident happened. It was documented there were no uncontrollable external factors and her physical environment was appropriate. The RCA did not include whether the chair alarm sounded at the time of the fall or any interviews specific to who saw the fall and if it was questionable about the supervision aspect, why weren't further inquires and staff interviews conducted. This surveyor chose not go over the findings from the interviews that were conducted with LPN #6 and #7 at this time.

On 5/4/18 at 12:48 p.m., an interview was conducted with Certified Nursing Assistant (CNA) #4. The CNA stated the resident loved to coordinate her clothes everyday and would be excited every morning to pick her clothes out. She stated she and other CNAs would trade off to provide 1:1 supervision because she would try to stand from her wheelchair and walk. The CNA stated they also placed the resident at the nurse's station's desk to be 1:1 with them when they were

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at the desk. She added the sensor pad alarm in the resident's chair alerted the staff if she was trying to stand and they would catch her before she attempted to try to walk. The CNA stated, "When she came back after that last fall with the head injury, she no longer was her lively self and was not interested in coordinating her clothes. She was different."

On 5/4/18 at 1:15 p.m., the activities assistant presented activity logs from October 2017 through March 2018, where the resident participated in many activities on a daily basis. The activities assistant stated the resident's sister visited everyday and came to activities with her. She stated when she was pulled up to the table participating in activities, especially Bingo, and was with her sister, she did not attempt to stand up from her wheelchair.

On 5/3/18 at 11:30 a.m., an interview was conducted with Resident #475's Resident Representative (RR). She stated, because she did not drive, she visited mostly on Sunday afternoons when a friend could offer transportation. She said she made telephone calls to the nurse's station and asked to talk to the resident. The RR stated although the resident had Alzheimer disease with confusion, the resident knew who she was and was full of lively chatter, and never left a conversation without calling her "little girl" and asking "where's your daddy, did you bring your daddy." She said when she went to the hospital on 3/11/18, she was shocked to see the huge bump on the resident's head and her left eye swollen shut. She continued to say, when she visited the following weekend after the fall, the resident did not participate in "lively chatter" nor did she call

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her "little girl" or "where's your daddy, did you bring your daddy."

During the debriefing with the Administrator and the DON on 5/4/18 at 2:50 p.m., the above information from LPN #6 and #7 was shared with them. The DON stated she expected the resident to have been supervised per the plan when she was up and out of bed with either CNA staff or licensed staff. She stated although it was not an ordered 1:1, the staff provided it in order to keep her safe. The DON said she thought there was only one nurse involvement in the incident of 3/11/18 and could not answer why the one nurse left the resident alone. Other unanswered questions, during this interview, were the same ones this surveyor posed to LPN #6 (if she was with a nurse), how did she fall, did you hear the chair alarm sound, did you hear her moving, did you hear her hit the floor and did you see her hit the floor?

On 5/4/18 at 6:00 p.m., the DON brought in the attending physician and asked the survey team if we had any questions. The attending physician asked, "I understand there may be concerns about (Resident #475's name) fall on 3/11/18." This survey shared the aforementioned details about the staff's failure to properly supervise the resident on 3/11/18. The attending physician was not aware of all of the circumstances surrounding the fall and was in agreement that the resident sustained an acute closed head injury with a intracranial bleed, left frontal hematoma and left periorbital hematoma as a result of the 3/11/18 fall.

No further information was brought forth prior to survey exit.

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F 758 SS=E	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended	F 758		5/22/18

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F 758	Continued From page 100 beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review the facility staff failed to ensure Residents did not receive unnecessary medications for 1 of 46 residents (Resident #57), in the survey sample. Facility staff failed to obtain an order to discontinue Heparin (an blood thinner) after Resident #57 was determined not have a blood clot to the right leg and once the right femur fracture healed. The findings included; Resident #57 was originally admitted to the facility 7/25/15 and was discharged from the facility to a local acute care facility 12/31/17, returning 1/2/18. The resident's diagnoses include; high blood pressure, reflux disease, heart failure, diabetes anemia, an anxiety disorder, bipolar disease, arthritis, coronary artery disease, hip fracture and a thyroid disorder. The Brief Interview for Mental Status (BIMS) interview dated 2/25/18 revealed the resident scored 9 out of a possible 15. This indicated Resident #57's cognitive abilities for daily decision	F 758	Resident Affected: Physician discontinued the Heparin on 5/2/2018. No negative outcome identified. Residents with Potential to be Affected: All residents have the potential to be affected. Director of Nursing completed audit of all resident with a physician order for an anti-coagulant for proper diagnosis and stop date if appropriate. Systemic Changes: Staff Development Coordinator in-serviced all licensed nurses regarding anti-coagulants and the importance of assuring stop date is on the physician order for Heparin. Licensed Nurses that have not completed the in-service will not be allowed to work a shift until in-service is completed.Heparin log has been initiated for all licensed nurses to complete when a resident is admitted with or has a new physician order for Heparin. Anti-Coagulant/Heparin audit will be completed weekly x 4 weeks, then monthly x 3 months by the Director of Nursing or designee. Staff Development Coordinator will educate all new licensed	

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F 758	Continued From page 101 making were moderately impaired. The quarterly Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 2/25/18 coded the resident as requiring total care of two with transfers, toileting and bathing, extensive assistance of two persons with bed mobility and dressing, extensive assistance of one with personal hygiene and locomotion on unit and independent after set-up with eating. The clinical record revealed on 12/9/17, Resident #57's right leg was with swelling and the resident complained of right leg pain therefore; the physician assessed the resident and ordered a Venous Duplex Ultrasound (a test which provides pictures of the veins) of the right leg, Ultram (a pain medication) extended release tablets 100 milligrams (mg) by mouth every 2 hours and Heparin (a medication used to treat and/or prevent blood clots) 5,000 units subcutaneously two times per day. Review of the physician's order summary for May 2018, the following orders were present; Order date 2/1/18; Aspirin tablet 81 milligrams- Give 1 tablet by mouth in the morning related to fracture of lower end of the right femur. Order date 1/12/18; Heparin Sodium solution 5000 units/5 milliliters- Inject 5000 units subcutaneously every 12 hours for non ambulatory. The results of the Venous Duplex Ultrasound were reported to the facility staff 12/10/17 at 2:22 p.m. The impression read; "no evidence of deep venous thrombosis within the right lower extremity". The nurse's note written on the Venous Duplex Ultrasound report stated the	F 758	nurses on anti-coagulation procedure and Heparin log completion during orientation. Monitoring: Director of Nursing will implement any intervention needed based on audit results. the Director of Nursing will review and discuss the anti-coagulant audits during the monthly Performance Improvement committee meetings which consist of the Executive Director, Director of Nursing, Assistant Director of Nursing, Registered Dietician, Social Worker, MDS Coordinator, and Medical Director who will review the audits to ensure compliance is ongoing and determine the need for further audits/in-services.	

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physician was notified 12/11/17 but it doesn't state the response from the physician.

The physician assessed the resident on 12/13/17 and stated to continue the Heparin for a right fracture of the distal femur. The physician again assessed Resident #57 on 12/16/17....

A physicians progress noted dated 12/13/17 read; right distal femur fracture, right DVT continue subcutaneous Heparin. The local hospital discharge summary dated 11/21/17 stated the resident fell while hospitalized 11/14/17, sustaining the right femur fracture. Another physician's progress note dated 12/16/17 didn't address the DVT or Heparin but addressed pain management of the right femur fracture. No further documentation on the fracture or use of the Heparin was observed or provided by the facility staff.

Registered Nurse (RN) #1 was interviewed on 5/2/18 at approximately 10:15 a.m. RN #1 stated three reasons were documented for Resident #57 to receive the Heparin. They included none ambulatory, a right femur fracture sustained in the hospital 11/14/17 and a deep vein thrombosis (DVT) of the right leg. As RN#1 reviewed each rationale by documented information the following was ascertained.

The 12/9/17 physician order for Heparin was written with a request for a Venous Duplex Ultrasound which revealed on 12/10/17, the resident was without a blood clot to the right leg.

RN #1 also stated the May 2018 physician's order summary read; Heparin Sodium 5,000 units/5

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milliliters. Inject 5,000 units subcutaneous every 12 hours for "none ambulatory".

RN #1 stated it was not a common practice to have a resident on Heparin because they were not ambulating, neither was it customary for a resident to continue Heparin after the fracture was healed. An orthopedic progress note dated 3/20/18 read; "Her fracture appears healed on x-ray and on exam".

The 3/2/18 orthopedic progress note also stated; "she was bed bound prior to this injury and at this point has been in bed for the last 4 months. She and her daughter are accepting to her staying wheelchair bound".

On 5/4/18, RN #1 presented a a nurses' note which stated the physician for Resident #57 was contacted regarding the Heparin order and if indeed it was still necessary to continue the medication. The physician gave an order to discontinue the Heparin. A rationale for discontinuation was not provided.

The above information was shared with the Administrator and Director of Nursing during the pre-exit meeting at 3:00 p.m., on 5/4/18. No additional information was provided.

Heparin and aspirin both increase anticoagulation. Modify Therapy/Monitor Closely.

aspirin, heparin. Either increases toxicity of the other by anticoagulation. Use Caution/Monitor. The need for simultaneous use of low-dose

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F 758	Continued From page 104 aspirin and anticoagulant or antiplatelet agents are common for patients with cardiovascular disease; monitor closely. (https://reference.medscape.com/drug/calciparine-monoparin-heparin-342169#3)	F 758		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on general observations of the nursing facility, staff interviews, the facility failed to ensure medications were labeled in accordance with	F 761	Resident Affected: The Lantus pen with the incorrect name was discarded and the correct Lantus pen	5/22/18

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F 761	Continued From page 105 currently accepted professional principles in 1 out of 6 facility medication carts and failed to follow the manufacturer's guidelines for a single use wound medication dressing for one (1) of 44 residents (Resident #27) in the survey sample. 1. The facility staff failed to ensure one (1) insulin Lantus pen was correctly labeled with the correct resident's name and located in the resident's original package on the Homer Unit -back hall medication cart. 2. The facility staff failed to follow the manufacture's guidelines for a single use wound medication dressing for one (1) resident (Resident #27) in the survey sample. The finding include: 1. On 05/03/18 at approximately 11:30 a.m., this surveyor inspected the back hall medication cart on Homer Unit with LPN #4. Doing the inspection of the Lantus pens located inside the medication cart; one Lantus pen did not have the original label to include the resident's name but had a hand written name on it; the Lantus pen located inside the medication package did not match and name on the outside label of the medication package. The LPN verified that the Lantus medication package and the hand written name on the Lantus pen that was located inside the medication package did not match. The nurse stated, "I checked the insulin's this morning for the open date but did not look at the insulin pens." The nurse proceeded to say, "The night nurse should be looking for the right patient and right dose before administering the insulin." The LPN also stated, "The medication should not be in the cart with someone's name on it if it does	F 761	was placed for resident #27. The partial Alginate dressing package was disposed of. There was no negative outcome identified for Resident #27. Resident with Potential to be Affected: All residents have the potential to be affected. Medication carts were audited using the Medication Cart audit tool. There were no other resident affected. Systemic Change: Staff Development Coordinator or designee in-serviced licensed nursing staff on medication storage using the medication storage policy and procedure and following manufacturer labeling for single use wound dressings. Licensed Nurses that have not completed the in-service will not be allowed to work as shift until the Staff Development Coordinator or designee completes the in-service with the employee. The Assistant Director of Nursing and Unit Mangers will audit the medication carts 3 times per week x 4 weeks, then 2 times a weeks x 4weeks, then weekly x 4 weeks. Staff Development Coordinator will educate all new nurses regarding labeling, and following manufacturer labeling. Monitoring: The audits will be given to the Director of Nursing for review and any immediate interventions needed. the Director of Nursing will review and discuss audit findings during the monthly Performance Improvement committee meeting which consist of the Executive Director, Director	

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F 761	Continued From page 106 not belong to them. The LPN removed the Lantus pen with the hand written name on it. An interview was conducted with Administrator and DON on 5/3/18 at approximately 3:25 p.m., who stated, "I expect for all nurses to administer medication according to the 5 rights of medication administration: Right patient, dose, time, route and medication." The facility administration was informed of the finding during a briefing on 5/04/18 at approximately 3:30 p.m. The facility did not present any further information about the findings. 2. Resident #27 was readmitted to the facility on 2/17/2018 with a diagnosis of *Urethro cutaneous fistula and penile ulcer. The most recent Minimum Data Set (MDS) was an Annual assessment with an Assessment Reference Date (ARD) date of 2/3/2018. The Brief Interview for Mental Status (BIMS) was a 15 out of a possible 15, which indicates that Resident #27 has no cognitive impairment. The Person-Centered Comprehensive Care Plan initiated on 02/12/2018 and revised on 2/24/2018 identified that Resident #27 has Actual impairment to skin integrity related to open area penile shaft, uretherocutaneous fistula and penis ulcer. Goal: The resident will have no complications related to the skin injury by the review date. Interventions/Tasks: Follow physician's orders for skin care and treatment. Observe location, size and treatment of skin injury. Report abnormalities, failure to heal, signs and symptoms, maceration etc., to MD.	F 761	of Nursing, Assistant Director of Nursing, Registered Dietician, Social Worker, MDS Coordinator, and Medical Director who will review the audit to ensure compliance is ongoing and determine the need for further audits/in-service.	

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Resident #27's Treatment Administration Record (TAR) was reviewed on 5/4/2018 and revealed an order was renewed on 2/27/2018. The treatment order for the penile wound read as follows: cleanse with Normal Saline and pack with Alginate AG packing rope. Cover with secondary dressing every other day, but may need to change as needed for drainage.

On 5/4/2018 at approximately 10:35 a.m. a wound dressing observation for Resident #27 was conducted with Registered Nurse (RN) #2. After the dressing change was completed RN #2 pulled open the treatment cart, placed the opened Alginate package in and sealed the gallon zip lock bag and placed it back into the cart. The surveyor asked RN #2, "are you done?' RN #2 stated, "Yes". .

On 5/4/2018 at approximately 11:15 a.m. the surveyor asked RN #2 to reopen the treatment cart and pull out the bag of supplies used to change Resident #27's dressing. Surveyor asked if the Alginate dressing for Resident # 27 was going to be used again. RN #2 stated, Yes, we pull out what we need and put the package back into the zip lock bag". Surveyor asked, "Would you turn over the package of Alginate. There are directions or symbol you recognized. RN #2 pointed to the symbol of two in circle with line through it. I never paid any attention to that symbol before. Surveyor stated, "The symbol indicates that the item is for single use only and must not be used more than once". The RN stated, "I did not know that".

On 5/4/2018 at approximately 11:25 a.m. an interview was conducted with the wound nurse

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495241	A. BUILDING _____ B. WING _____	C 05/04/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CONCORDIA TRANSITIONAL CARE AND REHAB-RIVER POINTE	4142 BONNEY ROAD VIRGINIA BEACH, VA 23452

(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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Licensed Practical Nurse #2. Surveyor showed LPN #2 the Alginate dressing package. Surveyor asked, "Do you know what this symbol it means?" LPN #2 (wound nurse) stated, "No". Surveyor informed LPN #2 (wound nurse), "This is a single use package". LPN #2 stated, "Our normal practice is to close the package and reuse them".

On 5/4/2018 at approximately 11:35 a.m. an interview was conducted with Director of Nursing. Surveyor showed the Alginate package to DON and asked, "Do you know what this symbol means?" DON stated, "I do not know what that means". Surveyor stated, "I asked RN #2 and LPN #2 and neither were made aware of what the symbol means". DON stated, "Let me check with LPN #1. LPN #1 knows better than those two". Surveyor stated, "Per manufactures instructions the Alginate packages used in this facility are for single use only and not to be reused". DON stated, "Someone needs to educate these nurses on that".

On 5/4/2018 at approximately 2:58 p.m. a pre-exit was conducted with the Administrator, and the Director of Nursing. The above findings were shared. The surveyor asked the Director of Nursing" What are your expectations concerning packaged dressing materials?" The Director of Nursing stated, "I would expect my staff to follow the manufactures recommendations and we will be educating the staff" The facility did not present any further information about the findings.

The facility's policy titled: 5.3 Storage and Expiration of Medications, Biologicals, Syringes and Needles (Last revision date: 12/01/17).

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495241	A. BUILDING _____ B. WING _____	C 05/04/2018

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F 761	Continued From page 109 5. Once any medication or biological package is opened, Facility should follow manufacture/supplier guidelines with respect to expiration dates for opened medications. Facility staff should record the date opened on the medication container when the medication has a shortened expiration date once opened. 6. Facility should destroy and reorder medications and biologicals with soiled, illegible, worn, makeshift, incomplete, damaged or missing labels or cautionary instructions. 10. Facility should ensure that the medications and biolgoicals for reach resident are stored in the containers in which they are originally received. Facility should ensure that no transfers between containers are performed by non-Pharmacy personnel.	F 761		