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

PRINTED: 04/16/2018
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495194	A. BUILDING ______ B. WING ______	C 04/09/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF PORTSMOUTH	**3610 WINCHESTER DR PORTSMOUTH, VA 23707**

(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 04/03/18 through 04/09/18. Corrections are required for compliance with the Emergency Preparedness requirements and with 42 CFR Part 483 Federal Long Term requirements. Two complaints were investigated during this survey. The Life Safety Code report will follow. The census in this 108 bed facility at the time of the survey was 97. The survey sample consisted of 37 current and closed records.	E 000	Preparation and submission of this POC is required by state and federal law. This POC does not constitute an admission for purposes of general liability, professional malpractice or any other court proceeding.	
E 007 SS=C	EP Program Patient Population CFR(s): 483.73(a)(3) [(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do the following:] (3) Address patient/client population, including, but not limited to, persons at-risk; the type of services the [facility] has the ability to provide in an emergency; and continuity of operations, including delegations of authority and succession plans.** *Note: ["Persons at risk" does not apply to: ASC, hospice, PACE, HHA, CORF, CMCH, RHC, FQHC, or ESRD facilities.] This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility staff failed to provide documentation that the facility's Emergency Preparedness Plan included delegation of authority.	E 007	RECEIVED MAY 10 2018 VDH/OLC 1. EPP has been updated to reflect delegation of authority around the clock. 2. All residents at risk. 3. All current staff will be educated and new staff upon hire. 4. Random weekly audit of staff will be done x3 months by Administrator or designee on the understanding of the delegation of authority during an activation of the EPP. Audit results will be taken to QAPI meetings for discussion and revision as needed. 5. 5/23/18	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Kevin Reynolds | TITLE: Administrator | (X6) DATE: 4/24/18

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

program participation.

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E 007	Continued From page 1 The findings included: During an interview on 4/9/18 at 11:24 a.m. with the Administrator, he was asked to provide the facility's continuity of operations, including delegation of authority. The administrator stated, "The facilities Emergency Preparedness Plan did not include a delegation of authority for continuity of operations."	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.	E 015	1. A. EPP has been updated to ensure continuity of services for medication and pharmaceutical supplies during activation of the EPP. B. Plan has been updated to provide guidance during a sewage interruption in the facility. 2. All residents are at risk. 3. All current staff will be educated and new staff upon hire. 4. Random weekly audit of staff by Administrator or designee on their understanding of the EPP sewage backup plan and pharmacy continuity plan x 3months. Audit results will be taken to QAPI meetings for discussion and revision as needed. 5. 5/23/18 RECEIVED MAY 10 2018 VDH/OLC	

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E 015	Continued From page 2 *[For Inpatient Hospice at §418.113(b)(6)(iii):] Policies and procedures. (6) The following are additional requirements for hospice-operated inpatient care facilities only. The policies and procedures must address the following: (iii) The provision of subsistence needs for hospice employees and patients, whether they evacuate or shelter in place, include, but are not limited to the following: (A) Food, water, medical, and pharmaceutical supplies. (B) Alternate sources of energy to maintain the following: (1) Temperatures to protect patient health and safety and for the safe and sanitary storage 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 failed to include the provision of pharmaceutical supply services and sewage disposal services, in the emergency preparedness plan. The findings included: During a review of the emergency preparedness plan the administrator was asked for documentation for pharmaceutical supplies and sewage disposal services. The administrator after looking in various locations, stated he did not have documentation of the facility being provided with pharmaceutical supplies or sewage disposal services.	E 015		

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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 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	E 018	1. Staff has been educated on the procedure for tracking residents and staff location should evacuation or sheltering of residents become necessary. 2. All residents at risk. 3. All current staff educated and education and test added to staff orientation upon being hired. 4. Random weekly audit of staff by Administrator or designee on their understanding of the procedure for tracking residents and staff location x 3 months. Audit results will be taken to QAPI meetings for discussion and revision as needed. 5. 5/23/18	

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E 018	Continued From page 4 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 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 that staff have been trained on the facility's tracking system. There was no documentation that the staff had been trained on the system to track the location of on-duty staff and sheltered patients, who may	E 018	RECEIVED MAY 10 2018 VDH/OLC	

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E 018	Continued From page 5 be relocated during an emergency. The findings included: During review of the facility's emergency preparedness plan on 4/9/18 at 11:55 a.m. the administrator was asked to provide documentation that facility staff had been trained on the system to track the location of on-duty staff and sheltered residents who are relocated during an emergency. The administrator stated, "We have not trained our staff on the tracking system."	E 018		
E 026 SS=C	Roles Under a Waiver Declared by Secretary CFR(s): 483.73(b)(8) [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. At a minimum, the policies and procedures must address the following:] (8) [(6), (6)(C)(iv), (7), or (9)] The role of the [facility] under a waiver declared by the Secretary, in accordance with section 1135 of the Act, in the provision of care and treatment at an alternate care site identified by emergency management officials. *[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	E 026	1. EPP has been updated to include the facilities role in providing care at alternate sites. 2. All residents at risk. 3. All current staff educated and education and test added to staff orientation upon being hired. 4. Random weekly audit of staff by Administrator or designee of understanding of what is expected of them while providing care/service at other facilities x3 months. Audit results will be taken to QAPI meetings for discussion and revision as needed. 5. 5/23/18	

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E 026	Continued From page 6 management officials. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility staff failed to develop emergency preparedness policy and procedures for providing care and services at alternate care sites during emergencies. The findings included: During a review of the facilities emergency preparedness plan on 4/9/18 at 11:58 a.m. the administrator was asked for the emergency preparedness policy and procedure that address specifically the facility's role in providing care at an alternate site. The administrator stated, "The facility does not have a policy and procedure that addresses the care and services that would be provided at an alternate care site."	E 026		
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	E 033	1. EPP has been updated to address the sharing of resident's information to other health providers to maintain continuity of care. 2. All residents at risk. 3. All current staff educated and education and test added to staff orientation upon being hired. 4. Random weekly audit of staff by Administrator or designee on their understanding of how information will be shared x3 months. Audit results will be taken to QAPI meetings for discussion and revision as needed. 5. 5/23/18	

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E 033	Continued From page 7 required for HHAs under §484.22(c), CORFs under §485.68(c), and RHCs/FQHCs under §491.12(c).] (6) [(4) or (5)]A means of providing information about the general condition and location of patients under the [facility's] care as permitted under 45 CFR 164.510(b)(4). *[For RNHCIs at §403.748(c):] (4) A method for sharing information and care documentation for patients under the RNHCI's care, as necessary, with care providers to maintain the continuity of care, based on the written election statement made by the patient or his or her legal representative. *[For RHCs/FQHCs at §491.12(c):] (4) A means of providing information about the general condition and location of patients under the facility's care as permitted under 45 CFR 164.510(b)(4). This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility staff failed develop emergency preparedness plans for sharing resident information. The findings included: During the emergency preparedness plan review on 4/9/18 at 12:12 P.M. with the administrator, he was asked for a policy and procedure for how the facility shares resident information under the facility's care with other health providers, to maintain continuity care. The administrator stated, "The facility does not have a policy and procedure to share information of residents under	E 033		

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E 033	Continued From page 8 its care during an emergency."	E 033		
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, 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	E 036	1. EPP has been updated to include a training and testing program based on the plan. 2. All residents at risk. 3. Staff education will occur at least annually on types of disasters and emergency preparedness. Annual disaster drills will occur and have written documentation of results. Results will be used to identify opportunities to improve staff performance via in service training. 4. Administrator will audit all new hires weekly to ensure they were trained on EPP and testing was done x3 months. Administrator will audit current employee's files annually to ensure review of EPP and competency test was completed. Audit results will be taken to QAPI meetings for discussion and revision as needed. 5. 5/23/18	

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E 036	Continued From page 9 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 develop emergency preparedness written training and testing program that was based on the emergency preparedness plan. The findings included: During review of the facility's emergency preparedness plan on 4/9/18 at 12:20 p.m. the administrator was asked for a training and testing program that was based on the facility's emergency preparedness plan. The administrator stated he did not have a training and testing program based on the emergency plan.	E 036		
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)	E 041	1. Facility has a quick connect installed and arrangements with a company to provide emergency generator power if facilities generator fails. 2. All residents at risk. 3. Quick Connect system will be tested semi-annually to ensure proper operation. Contract with generator Rental Company will be reviewed annually. 4. Administrator will do a quarterly review in QAPI to ensure semi-annual test of system and review of rental contract is conducted. 5. 5/23/18	

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E 041	Continued From page 10 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 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	E 041		

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E 041	Continued From page 11 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. (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 failed to develop emergency plans to keep the emergency stand-by power system	E 041		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495194	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED C 04/09/2018

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED
CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF PORTSMOUTH	**3610 WINCHESTER DR PORTSMOUTH, VA 23707**

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E 041	Continued From page 12 operational during an emergency. The findings included: During the emergency preparedness plan review on 4/9/18 at 12:25 p.m. with the administrator he was asked how the facility could maintain power during an emergency. The administrator stated that the facility had a generator for back- up power. When asked what system was in place if the generator failed. The administrator stated there were no other plans. When asked if the facility had a means of obtaining a portable generator, the administrator stated the facility is not equipped with a quick connect for electrical power service. The administrator stated the facility was in the process of obtaining quotes for a quick connect system to be installed.	E 041		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 4/3/18 through 4/9/18. Two complaints were investigated during the survey. Corrections are required to the following 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code Report to follow. The census in this 108 certified bed facility was 97 at the time of the survey. The survey sample consisted of 37 resident reviews: 32 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:	F 553		

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F 553	Continued From page 13 (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. (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 facility documentation review, the facility failed to invite 1 of 37 residents to attend her person centered care plan meeting (Resident #79) in the survey sample. The findings included: Resident #79 was admitted to the facility on	F 553	1. Res #79 was discharged home on 4/19/18 prior to next scheduled care plan meeting. 2. Residents with care plans scheduled for April where audited to identify any residents who were not invited and invitation not documented. 3. Inservice by administrator or designee for social worker on inviting residents to their care plan meeting both in writing and verbally. 4. Administrator or designee will audit care plan schedules to ensure residents have been invited to care plan meeting weekly x 3 months. Audit results will be taken to QAPI meetings for discussion and revision as needed. 5. 5/23/18	

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F 553	Continued From page 14 03/01/18. Diagnosis for Resident #79 included but not limited to *Diabetes. *Diabetes is a complex disorder of carbohydrates, fat, and protein metabolism that is primarily a result off a deficiency or complete lack of insulin secretion (Mosby's Dictionary of Medicine, Nursing & Health Professions 7th Edition). The current Minimum Data Set (MDS), a quarterly assessment with an Assessment Reference Date (ARD) of 2/26/18 coded the resident with a 15 out of a possible score of 15 on the Brief Interview for Mental Status (BIMS) indicating no cognitive impairment. During the initial tour on 04/03/18 at approximately 3:19 p.m., an interview was conducted with Resident #79 who stated, "I was never invited to attend a care plan meeting nor did I received a letter to attend a care plan meeting." An interview was conducted with the Social Worker (SW) on 4/5/18 at approximately 1:00 p.m., who stated, "I invited Resident #79 to attend her care plan verbally but I did send a letter to her representative." The surveyor requested documentation that the resident was verbally invited to attend her person centered care plan meeting, she replied, "I can't; it was never documented." The SW stated," Resident #79's care plan was actually held today; she did not attend but I can update her on what was discussed during the care plan meeting." The above information was shared with Administration staff during a pre-exit meeting on 4/09/18 at 4:00 p.m. No additional information	F 553		

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F 553	Continued From page 15 was provided. The facility's policy titled Care Plan (Revision: April 6, 2017). Policy: -An interdisciplinary plan of care will be established for every resident and updated in accordance with state and federal regulatory requirements and on an as needed basis. In states where pre-admission screening applies, this will be coordinated with the facility assessment. Goals must be measurable and objective. Procedure include but not limited to, -The facility designee is responsible for delivering to each resident who is scheduled for conference an invitation to attend the meeting. The letter of requested participation (original) is presented t the resident at least five (5) days prior to the date of conference. A designated time of meeting is given to each resident. A copy of the letter is maintained for reference.	F 553		
F 582 SS=D	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be	F 582		

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F 582	Continued From page 16 charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section. §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the	F 582	1. Res #74 89 are both LTC residents and the ABN has been reviewed with RP. 2. 100% audit of residents discharged since April 1, 2018 to identify those with the potential for this deficiency. 3. Inservice by Administrator or designee for social worker on regulation regarding ABN's. 4. Administrator or designee will audit weekly, residents for discharge to ensure ABN's are issued. X 3 months. Audit results will be taken to QAPI meetings for discussion and revision as needed. 5. 5/23/18 RECEIVED MAY 10 [illegible] VDH/OLC	

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F 582	Continued From page 17 facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by: Based on clinical record review, staff interviews, and facility documentation review, the facility failed to ensure Medicare Beneficiary Notices in accordance with applicable Federal regulations, were issued to 2 of 37 residents (Residents #74 and #89) in the survey sample. The findings included: 1. Resident #74 was admitted to the nursing facility on 1/23/18 with a diagnosis of dementia and severe arthritis. The Minimum Data Set (MDS) Admission assessment dated 2/23/18 coded the resident with a score of 8 out of a possible score of 15 on the Brief Interview for Mental Status (BIMS) which indicated the resident was moderately impaired in the skills needed for daily decision making. On review of the Beneficiary Notification Checklists provided by the facility to surveyors it was noted that Resident #74 was not listed for having been issued the SNF ABN (Skilled Nursing Facility-Advanced Beneficiary Notice, form CMS-10055). The resident had received a NOMNC (Notice of Medicare Provider Non-Coverage- form CMS-10123), however no copies of the SNF ABN(CMS-10055) were provided. Resident #74 started a Medicare Part A stay on 1/23/18, and the last covered day of this stay was 2/24/18. Resident #74 was discharged from Medicare Part A services when benefit days were	F 582		

F 582 | F 582

Continued From page 18

not exhausted and should have been issued a SNF ABN (CMS-10055) and an NOMNC (CMS-10123). Resident #74 had only used 31 days of her Medicare Part A services. Only an NOMNC was issued, with verbal notification to the resident on 2/21/18.

2. Resident #89 was admitted to the nursing facility on 2/15/18 with a diagnosis of falling and post operative left hip fracture.

The Minimum Data Set (MDS) assessment dated 3/17/18 coded the resident with an 15 out of a possible score of 15 on the Brief Interview for Mental Status (BIMS) which indicated the resident was cognitively intact with the necessary skills for daily decision making.

On review of the Beneficiary Notification Checklists provided by the facility to surveyors it was noted that Resident #89 was not listed for having been issued the SNF ABN (Skilled Nursing Facility-Advanced Beneficiary Notice, form CMS-10055). The resident had received a NOMNC (Notice of Medicare Provider Non-Coverage- form CMS-10123), however no copies of the SNF ABN(CMS-10055) were provided.

Resident #89 started a Medicare Part A stay on 11/1/17, and the last covered day of this stay was 11/21/17. Resident #89 was discharged from Medicare Part A services when benefit days were not exhausted and should have been issued a SNF ABN (CMS-10055) and an NOMNC (CMS-10123). Resident #89 only used 21 days of his Medicare Part A services. Only an NOMNC was issued, with verbal notification to the resident on 11/17/17.

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F 582	Continued From page 19 On 4/5/18 at 10:30 a.m., the facility Administrator and the social worker stated they were not aware of the issuance of a SNF ABN when Medicare Part A is discontinued by the provider. They only issued the NOMNC to the residents. No additional information was provided prior to exit. The facility's policy and procedures titled Medicare Cut Letter Policy dated 3/2/18 for residents who will remain in the facility for any length of time following their last Medicare covered day and have days remaining in their benefit period, the Social Worker, or Designees , will notify the Resident/ Authoried Representative when the resident is approaching the end of coverage but no later than 2 days prior to the last covered Medicare Part A day, and issue both the follwoing notices in the order indicated: -Notice of Medicare Provider Non-Coverage CMS-10123 notified the resident and /or person acting on their behalf of their immediate appeal rights. -Skilled Nursing Facility Advance Beneficiary Notice CMS-10055 identifiying the specific reason the facility believes their care and services will no longer be covered by Medicare and of the resident's financial liability.	F 582		
F 600 SS=D	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This	F 600		

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F 600	Continued From page 20 includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on review of a Facility Reported Incident (FRI), observations, staff and resident interview, and review of facility documentation, the facility staff failed to ensure 1 of 37 residents (Resident #44) was free from abuse. The facility staff failed to ensure staff refrained from the use of insulting and ridiculing language towards Resident #44. The findings include: Resident #44 was admitted to the nursing facility on 1/15/18 with diagnoses that included post surgical gangrene of the right groin, chronic pain and muscle weakness. The most recent Minimum Data Set (MDS) assessment was a quarterly dated 3/4/18 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 with the necessary skills for daily decision making. The resident was assessed with clear speech, had the the ability to understand staff and was understood by them. The resident was not assessed to have any mood or behavioral	F 600	Past noncompliance: no plan of correction required.	

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F 600	Continued From page 21 symptoms. Resident #44 required extensive assistance from staff for transfers, bed mobility, dressing and toilet use. The resident was coded totally dependent on one staff for locomotion on and off the unit, and used a wheelchair as her primary mobility device. The resident was assessed to have an indwelling urinary catheter. Resident #44 was coded to have pain verbally described as very severe and horrible. The care plan dated as revised on 3/20/18, identified the right leg post surgical wound, as well as chronic pain related to the wound and obesity. The care plan also identified Resident #44 required assistance from nursing staff for Activities of Daily Living (ADL) and had an indwelling urinary catheter. The goal set for the resident indicated her ADLs would be met on a daily basis to include care of the indwelling urinary catheter. Review of the FRI dated 3/19/18, as received in the State Agency, indicated RN #3 (supervisor) allegedly verbally abused Resident #44 on 3/16/18, 3/11 shift. The incident was not reported to the Administrator until the morning of 3/19/18 by the resident. According to the five day follow-up investigation dated 3/23/18, as well as review of the staff statements, Resident #44 informed Certified Nursing Assistant (CNA) #2, who also worked on 3/16/18, that when the resident asked to have her catheter checked, RN #3 told her "Shut up, you are full of drama." It was documented in the CNA's written statement that she approached RN#3 to tell her what the resident said, after which the RN stated she only told the resident she would check the catheter when she got a chance because she was passing medications.	F 600		

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F 600	Continued From page 22 CNA #2 did not further report the allegation of verbal abuse to the Administrator or designee. The investigation revealed a resident across the hall from Resident #44 overheard RN#3 tell Resident #44 to "Shut up." RN#3's written statement dated 3/19/18 involving the incident read, "I accused her (Resident #44) of attention seeking and said 'Oh please Stop'". The Administrator documented that the resident stated she would not be spoken to "like a child." The investigation also identified a second CNA (#3), who worked the following day (3/17/18) on the 7/3 shift, and that the resident shared the same account of the incident, but also failed to report it to the Administrator. Additionally, RN#3 worked the entire weekend (3/16, 17, and18) which did not offer protection for the resident to prevent further potential from abuse. The aforementioned FRI follow-up investigation report indicated the Administrator was made aware of the incident the morning of 3/19/18 during rounds, by the resident. An interview was conducted on 4/5/18 at 3:55 p.m. with the Administrator about the incident. He stated the RN had been a nurse for many years and he was very disappointed to learn about her behavior. According to review of the original sign in sheets, RN#3 had attended the mandatory inservice on abuse conducted January 31, 2018. He stated, regardless he immediately suspended RN#3 until completion of his investigation, and substantiated that Resident #44 was verbally abused by the RN and it was intentional, based on his interview with the resident, as well as interviews with nursing	F 600		

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F 600	Continued From page 23 staff, other residents, and RN#3. He stated the RN admitted to saying to the resident, she was attention seeking and basically phrased the same information as was told to him by the resident. He stated he proceeded with termination of RN #3 and she was permanently removed from the schedule. The Administrator presented a corrective action plan that addressed the following: -How the corrective action will be accomplished for those residents found to be affected by the deficient practice. All staff would be inservced on the abuse policy, mandated reporter status, immediate reporting requirements and who to report to if the supervisor is involved in the abuse; report to the Director of Nursing (DON) and the Administrator. If the DON and the Administrator is involved, inform the area Adult Protective Services (APS), local Ombudsman, as well as the State survey and certification agency via phone numbers with identified locations of these contact numbers. Completion date 3/21/18. -Address how the facility would identify other residents having the potential to be affected by the same deficient practice. All alert and oriented times 4 resident would be interviewed and asked if they had negative experiences with a nurse. All residents would have skin checked completed. Completion date 3/22/18. -Address what measures would be put in place or systemic changes made to ensure that the deficient practice would not reoccur. All orientation classes would include information on who to report allegations of abuse to if supervisor and or DON and Administrators are involved..	F 600		

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F 600	Continued From page 24 Completion date 3/26/18. -Indicated how the facility plans to monitor its performance to make sure that solutions are sustained. Random audits of personnel on abuse immediate reporting requirement times 90 days. Results to be reviewed in next QAPI meeting. Completion date 3/26/18 and ongoing. On 4/4/18 at 1:00 p.m., an interview was conducted with the Resident #44 regarding the incident with RN# 3. The resident stated the RN was tending to her roommate, when all she said was "When you have a chance can you check my catheter?" She said it was at that time that the RN told her to "Shut up, you are always complaining, I will get to you when I get to you." The resident stated if she had been able, she would have rose from her chair and snatched her hair out. She stated she told the RN that she would not be talked to like that and that she was not a child. The resident also stated she spoke to CNA #2 and told her the same day about the incident and was shocked because the perpetrator was the RN supervisor. She stated she also shared details of the incident with a second CNA (#3) the following morning on 3/17/18, as well as the Administrator on 3/19/18. Resident #44 stated she was humiliated, insulted and hurt that someone would demean her by the tone and language exhibited by RN #3. She stated she shared the incident with her niece. The resident stated she tried to lay low through the weekend in order not to experience the abuse again from RN#3, but "I made sure I told several people along the way until I could see (Administrator's name)." The resident said she has not had an abuse encounter since 3/16/18.	F 600		

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	495194	A. BUILDING ______ B. WING ______	C 04/09/2018

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F 600	Continued From page 25 Based on the corrective action plan, interviews with the resident, staff, review of the facility's investigation, as well as evidence that no additional abuse incidents had occurred since allegation of compliance dated 3/26/18, or during the current survey, Past Non-Compliance was granted for the deficient practice. The facility's policy and procedure titled "Resident Abuse" dated as revised on 7/28/17 indicated the facility would not tolerate abuse, neglect, mistreatment, exploitation of residents, and misappropriation of resident property by anyone. Verbal abuse included actions of oral, written or gestured language that wilfully includes disparaging and derogatory terms to residents within hearing distance, regardless of their age, ability to comprehend or their disability.	F 600		
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 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	F 609		

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F 609	Continued From page 26 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 review of a Facility Reported Incident (FRI), observations, staff and resident interview, and review of facility documentation, the facility failed to immediately report an allegation of abuse to the Administrator and to the State Agency, for 1 of 37 residents (Resident #44). The alleged abuse occurrence was 3/16/18 and the Administrator was not aware of the allegation until he was told by the resident on 3/19/18. This incident was not reported to the State survey and certification agency until 3/19/18. The findings include: Resident #44 was admitted to the nursing facility on 1/15/18 with diagnoses that included post surgical gangrene of the right groin, chronic pain and muscle weakness. The most recent Minimum Data Set (MDS) assessment was a quarterly dated 3/4/18 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 with the necessary skills for daily decision	F 609	Past noncompliance: no plan of correction required. RECEIVED MAY 10 2018 VDH/OLC	

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F 609	Continued From page 27 making. The resident was assessed with clear speech, had the the ability to understand staff and was understood by them. The resident was not assessed to have any mood or behavioral symptoms. Resident #44 required extensive assistance from staff for transfers, bed mobility, dressing and toilet use. The resident was coded totally dependent on one staff for locomotion on and off the unit, and used a wheelchair as her primary mobility device. The resident was assessed to have an indwelling urinary catheter. Resident #44 was coded to have pain verbally describe as very severe and horrible. The care plan dated as revised on 3/20/18 identified the right leg post surgical wound, as well as chronic pain related to the wound and obesity. The care plan also identified Resident #44 required assistance from nursing staff for Activities of Daily Living (ADL) and had an indwelling urinary urinary catheter. The goal the nursing staff set for the resident indicated her ADLs would be met on a daily basis to include care of the indwelling urinary catheter. Review of the FRI dated 3/19/18, as received in the State Agency, indicated RN #3 (supervisor) allegedly verbally abused Resident #44 on 3/16/18, 3/11 shift. The incident was not reported to the Administrator until the morning of 3/19/18 by the resident. According to the five day follow-up investigation dated 3/23/18, as well as review of the staff statements, Resident #44 informed Certified Nursing Assistant (CNA) #2, who also worked on 3/16/18, that when the resident asked to have her catheter checked, RN #3 told her "Shut up, you are full of drama." It was documented in the CNA's written statement that she approached RN#3 to tell her what the	F 609		

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F 609		F 609		

Continued From page 28 resident said, after which the RN stated she only told the resident she would check the catheter when she got a chance because she was passing medications.

CNA #2 did not further report the allegation of verbal abuse to the Administrator or designee. The investigation revealed a resident across the hall from Resident #44 overheard RN#3 tell Resident #44 to "Shut up." RN#3's written statement dated 3/19/18 involving the incident read, "I accused her (Resident #44) of attention seeking and said 'Oh please Stop'". The Administrator documented that the resident stated she would not be spoken to "like a child."

The investigation also identified a second CNA (#3), who worked the following day (3/17/18) on the 7/3 shift, and that the resident shared the same account of the incident, but also failed to report it to the Administrator.

Additionally, RN#3 worked the entire weekend (3/16, 17, and18) which did not offer protection for the resident to

The aforementioned FRI follow-up investigation report indicated the Administrator was made aware of the incident the morning of 3/19/18 during rounds, by the resident. An interview was conducted on 4/5/18 at 3:55 p.m. with the Administrator about the incident. He stated the RN had been a nurse for many years and he was very disappointed to learn about her behavior. According to review of the original sign in sheets, RN#3 had attended the mandatory inservice on abuse conducted January 31, 2018. He stated, regardless he immediately suspended RN#3 until completion of his investigation, and substantiated

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F 609	Continued From page 29 that Resident #44 was verbally abused by the RN and it was intentional, based on his interview with the resident, as well as interviews with nursing staff, other residents, and RN#3. He stated the RN admitted to saying to the resident, she was attention seeking and basically phrased the same information as was told to him by the resident. He stated he proceeded with termination of RN #3 and she was permanently removed from the schedule. The Administrator presented a corrective action plan that addressed the following: -How the corrective action will be accomplished for those residents found to be affected by the deficient practice. All staff would be inservced on the abuse policy, mandated reporter status, immediate reporting requirements and who to report to if the supervisor is involved in the abuse; report to the Director of Nursing (DON) and the Administrator. If the DON and the Administrator is involved, inform the area Adult Protective Services (APS), local Ombudsman, as well as the State survey and certification agency via phone numbers with identified locations of these contact numbers. Completion date 3/21/18. -Address how the facility would identify other residents having the potential to be affected by the same deficient practice. All alert and oriented times 4 resident would be interviewed and asked if they had negative experiences with a nurse. All residents would have skin checked completed. Completion date 3/22/18. -Address what measures would be put in place or systemic changes made to ensure that the deficient practice would not reoccur. All	F 609		

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F 609	Continued From page 30 orientation classes would include information on who to report allegations of abuse to if supervisor and or DON and Administrators are involved.. Completion date 3/26/18. -Indicated how the facility plans to monitor its performance to make sure that solutions are sustained. Random audits of personnel on abuse immediate reporting requirement times 90 days. Results to be reviewed in next QAPI meeting. Completion date 3/26/18 and ongoing. On 4/4/18 at 1:00 p.m., an interview was conducted with the Resident #44 regarding the incident with RN# 3. The resident stated the RN was tending to her roommate, when all she said was "When you have a chance can you check my catheter?" She said it was at that time that the RN told her to "Shut up, you are always complaining, I will get to you when I get to you." The resident stated if she had been able, she would have rose from her chair and snatched her hair out. She stated she told the RN that she would not be talked to like that and that she was not a child. The resident also stated she spoke to CNA #2 and told her the same day about the incident and was shocked because the perpetrator was the RN supervisor. She stated she also shared details of the incident with a second CNA (#3) the following morning on 3/17/18, as well as the Administrator on 3/19/18. Resident #44 stated she was humiliated, insulted and hurt that someone would demean her by the tone and language exhibited by RN #3. She stated she shared the incident with her niece. The resident stated she tried to lay low through the weekend in order not to experience the abuse again from RN#3, but "I made sure I told several people along the way until I could see (Administrator's	F 609		

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F 609	Continued From page 31 name)." The resident said she has not had an abuse encounter since 3/16/18. Based on the corrective action plan, interviews with the resident, staff, review of the facility's investigation, as well as evidence that no additional abuse incidents had occurred since allegation of compliance dated 3/26/18, or during the current survey, Past Non-Compliance was granted for the deficient practice. The facility's policy and procedure titled "Resident Abuse" dated as revised on 7/28/17 indicated the facility would not tolerate abuse, neglect, mistreatment, exploitation of residents, and misappropriation of resident property by anyone. Verbal Abuse included actions of oral, written or gestured language that wilfully includes disparaging and derogatory terms to residents within hearing distance, regardless of their age, ability to comprehend or their disability. The policy further indicated the staff should report all allegations of abuse to the supervisor and the staff member accused or suspected of abuse would be removed from the facility and the schedule pending outcome of the investigation. All allegations of abuse would be reported immediately to the Administrator, the Director of Nursing (DON), but not later than 2 hours after the allegation was made, and to the applicable State agency.	F 609		
F 623 SS=E	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's	F 623		

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F 623	Continued From page 32 representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section	F 623	1. The ombudsman was notified of the discharge for res #38, 66, 69, 30, 79, and 102 after the survey. 2. 100% Audit of all discharges since 4/1/18 to identify discharges not sent to Ombudsman. 3. Inservice by Administrator or designee for Social Worker on requirements regarding discharge notification to Ombudsman. 4. Administrator or designee will audit planned and emergent discharges weekly for notification of ombudsman x 3 months. Audit results will be taken to QAPI meetings for discussion and revision as needed. 5. 5/23/18	

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F 623	Continued From page 33 must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge;(iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available.	F 623		

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F 623	Continued From page 34 §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 resident record review, staff interviews, State Long-Term Care Ombudsman interview, and facility document review, the facility failed to notify the Office of the State Long-Term Care Ombudsman in writing of hospital discharges for 6 of 37 residents in the survey sample, Resident #38, #66, #69, #30, 79, and Resident #102. 1. The facility staff failed to notify the Office of the State Long-Term Care Ombudsman of Resident #38's discharges to the hospital on 1/16/18 and 1/30/18. 2. The facility staff failed to notify the Office of the State Long-Term Care Ombudsman of Resident #66's discharge to the hospital on 12/24/17. 3. The facility staff failed to notify the Office of the State Long-Term Care Ombudsman of Resident #69's discharges to the hospital on 1/15/18 and 3/28/18. 4. The facility staff failed to notify the Office of the State Long-Term Care Ombudsman of Resident #30's discharge to the hospital on	F 623		

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F 623	Continued From page 35	F 623		

2/2/18, 2/21/18 and 3/7/18.

5. The facility staff failed to notify the Office of the State Long-Term Care Ombudsman of Resident #79's discharge to the hospital on 12/11/17.

6. The facility staff failed to notify the Ombudsman's office of Resident #102's discharge to the local hospital.

The findings included:

1. Resident #38 was a 77 year old originally admitted to the facility on 12/5/14 with diagnoses to include Hypertension and Diabetes Mellitus.

Resident #38's Progress Notes were reviewed and documented in part, as follows:

1/16/18 16:02 (4:02 P.M.) Send resident to (Hospital Name) ER (emergency room) for evaluation/tx (treatment) d/t (due to) low b/p (blood pressure) 94/58 via 911. Name (Nurse Practitioner), assesses resident at bedside and order received: call 911 for resident transport.

1/16/18 20:57 (8:57 P.M.) Admitted for UTI (Urinary Tract Infection) per ER Nurse

1/30/18 08:27 A.M. Summons to resident room by caregiver, upon arrival resident observed in bed with eyes open, alert, however confused with disorganized speech. Resident also noted to have some R (right) sided twitching. Dr. (Name) office made aware. New order received to send to ER for eval and treat. RP (Responsible Party) called and message left to return call to facility.

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F 623	Continued From page 36 Resident #38's Hospital Discharge Summaries were reviewed and are documented in part, as follows: Encounter Date: 1/16/18 Admit Date: 1/16/18 Discharge Date: 1/19/18 Disposition: SNF/NH (Skilled Nursing Facility/Nursing Home) Encounter Date: 1/30/18 Admitted: 1/30/18 Discharged: 2/1/18 Disposition: Transferred to nursing home. Facility Minimum Data Sets (MDS) were reviewed for Resident #38 and are documented in part, as follows: The MDS with an Assessment Reference Date (ARD) of 1/16/18 under Section A Identification Information A0310. Type of Assessment F. Entry/discharge reporting was coded as an 11 (Discharge assessment-return anticipated). G. Type of discharge was coded as a 2 (Unplanned). The MDS with an Assessment Reference Date (ARD) of 1/19/18 under Section A Identification Information A0310. Type of Assessment F. Entry/discharge reporting was coded as an 01 (Entry tracking record). The MDS with an Assessment Reference Date (ARD) of 1/30/18 under Section A Identification Information A0310. Type of Assessment F. Entry/discharge reporting was coded as an 11 (Discharge assessment-return anticipated). G. Type of discharge was coded as a 2 (Unplanned).	F 623		

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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 623	Continued From page 37 The MDS with an Assessment Reference Date (ARD) of 2/1/18 under Section A Identification Information A0310. Type of Assessment F. Entry/discharge reporting was coded as an 01 (Entry tracking record). On 04/05/18 at 11:05 A.M. the Director of Admissions asked for a copy of the bed hold policy and a copy of the notification to the Ombudsman Office for Resident #38's hospital discharges for 1/16/18 and 1/30/18. The Director of Admissions stated, "The bed hold policy is attached by the nurses to the transfer packet that is sent with them to the hospital and the following day I call the families to touch base with the families and log it into my book. I have not been sending a notification to the Ombudsman of hospital discharges, I did not know I was supposed to do that." The Social Worker was also in the admission office during this discussion and the Administrator was standing at the door with the surveyor. The Social Worker stated, "I send notices to the Ombudsman office once a month of the resident's that have discharged home, but not discharged to the hospital." The Administrator stated, "But they are still discharges." On 04/05/18 at 11:40 AM the area Ombudsman was called and asked if he had been receiving notifications of discharges to the hospital from the facility. The Ombudsman stated, "I have only been getting the ones that go home I have not been getting any of the ones regarding residents being discharged to the hospital." On 4/6/18 at 2:00 P.M. a pre-exit debriefing was held with the Administrator and the Director of Nursing (DON) where the above information was	F 623		

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	495194	A. BUILDING ______ B. WING ______	C 04/09/2018

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F 623	Continued From page 38 shared. The Administrator was asked when the facility started to notify the local Ombudsman of hospital discharges. The Administrator stated, "We started yesterday." Prior to exit no further information was shared. 2. Resident #66 was a 78 year old originally admitted to the facility on 1/1/2014 with diagnoses to include Dementia, Glaucoma and Osteoarthritis Resident #38's Progress Notes were reviewed and are documented in part, as follows: 12/24/2017 16:03 (4:03 P.M.) Notified on call we are sending pt (patient) out for resp (respiratory) distress, altered mental status. 12/24/17 16:59 (4:59 P.M.) sent to ER for respiratory distress. 12/14/17 23:10 (11:10 P.M. Spoke with (Name) at ED (emergency department) who stated pt. was being admitted to ICU (Intensive Care Unit) for respiratory distress. Facility Minimum Data Sets (MDS) were reviewed for Resident #66 and are documented in part, as follows: The MDS with an Assessment Reference Date (ARD) of 12/24/17 under Section A Identification Information A0310. Type of Assessment F. Entry/discharge reporting was coded as an 11 (Discharge assessment-return anticipated). G. Type of discharge was coded as a 2 (Unplanned). This assessment was also combined with an Annual Assessment	F 623		

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F 623	Continued From page 39	F 623		

Continued From page 39

The MDS with an Assessment Reference Date (ARD) of 1/02/18 under Section A Identification Information A0310. Type of Assessment F. Entry/discharge reporting was coded as an 01 (Entry tracking record).

On 04/05/18 at 11:05 A.M. the Director of Admissions asked for a copy of the bed hold policy and a copy of the notification to the Ombudsman Office for Resident #66's hospital discharge for 12/24/17. The Director of Admissions stated, "The bed hold policy is attached by the nurses to the transfer packet that is sent with them to the hospital and the following day I call the families to touch base with the families and log it into my book. I have not been sending a notification to the Ombudsman of hospital discharges, I did not know I was supposed to do that." The Social Worker was also in the admission office during this discussion and the Administrator was standing at the door with the surveyor. The Social Worker stated, "I send notices to the Ombudsman office once a month of the resident's that have discharged home, but not discharged to the hospital." The Administrator stated, "But they are still discharges."

On 04/05/18 at 11:40 AM the area Ombudsman was called and asked if he had been receiving notifications of discharges to the hospital from the facility. The Ombudsman stated, "I have only been getting the ones that go home I have not been getting any of the ones regarding residents being discharged to the hospital."

On 4/6/18 at 2:00 P.M. a pre-exit debriefing was held with the Administrator and the Director of Nursing (DON) where the above information was

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F 623	Continued From page 40 shared. The Administrator was asked when the facility started to notify the local Ombudsman of hospital discharges. The Administrator stated, "We started yesterday." Prior to exit no further information was shared. 3. Resident #69 was a 70 year old originally admitted to the facility on 7/7/16 with diagnoses to include Kidney Disease Hypertension. Resident #38's Progress Notes were reviewed and are documented in part, as follows: 1/15/18 8:13 A.M. Resident lying in bed. Resp. (Respirations) labored. Congestion noted bilaterally. VS (vital signs) 98.0, 95, 26, 80/50. MD (Medical Doctor) called and made aware of change in condition. New order received to send to ER for eval and treatment. Daughter was called and made aware of the resident's change in condition and new order. She stated that she would meet her father over at he hospital. Report called to nurse at hospital. 3/28/18 6:28 A.M. Resident #69's daughter was notified of his shunt and him being sent to ED (Emergency Department) at 04:10 A.M. and (Name) at hospital was notified of his departure to their ED at 04:15 A.M. 3/28/18 11:02 A.M. Resident returned from ED without new orders. No active bleeding noted to shunt. Transport here to take resident to dialysis. No complaints expressed. No distress noted. 3/28/18 15:08 P.M. Received call from dialysis center nurse stating that resident was rushed to ER. Daughter made aware.	F 623		

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F 623	Continued From page 41 Facility Minimum Data Sets (MDS) were reviewed for Resident #69 and are documented in part, as follows: The MDS with an Assessment Reference Date (ARD) of 1/15/18 under Section A Identification Information A0310. Type of Assessment F. Entry/discharge reporting was coded as an 11 (Discharge assessment-return anticipated). G. Type of discharge was coded as a 2 (Unplanned). The MDS with an Assessment Reference Date (ARD) of 2/10/18 under Section A Identification Information A0310. Type of Assessment F. Entry/discharge reporting was coded as an 01 (Entry tracking record). The MDS with an Assessment Reference Date (ARD) of 3/28/18 under Section A Identification Information A0310. Type of Assessment F. Entry/discharge reporting was coded as an 11 (Discharge assessment-return anticipated). G. Type of discharge was coded as a 2 (Unplanned). The MDS with an Assessment Reference Date (ARD) of 3/30/18 under Section A Identification Information A0310. Type of Assessment F. Entry/discharge reporting was coded as an 01 (Entry tracking record). On 04/05/18 at 11:05 A.M. the Director of Admissions asked for a copy of the bed hold policy and a copy of the notification to the Ombudsman Office for Resident #66's hospital discharge for 12/24/17. The Director of Admissions stated, "The bed hold policy is attached by the nurses to the transfer packet that is sent with them to the hospital and the following day I call the families to touch base with the	F 623		

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F 623	Continued From page 42 families and log it into my book. I have not been sending a notification to the Ombudsman of hospital discharges, I did not know I was supposed to do that." The Social Worker was also in the admission office during this discussion and the Administrator was standing at the door with the surveyor. The Social Worker stated, "I send notices to the Ombudsman office once a month of the resident's that have discharged home, but not discharged to the hospital." The Administrator stated, "But they are still discharges." On 04/05/18 at 11:40 AM the area Ombudsman was called and asked if he had been receiving notifications of discharges to the hospital from the facility. The Ombudsman stated, "I have only been getting the ones that go home I have not been getting any of the ones regarding residents being discharged to the hospital." On 4/6/18 at 2:00 P.M. a pre-exit debriefing was held with the Administrator and the Director of Nursing (DON) where the above information was shared. The Administrator was asked when the facility started to notify the local Ombudsman of hospital discharges. The Administrator stated, "We started yesterday." Prior to exit no further information was shared. 4. Resident #30 was originally admitted on 10/22/2018 with diagnosis included but not limited to Diabetes Mellitus Type II, Cirrhosis of Liver and Chronic Kidney Disease. The most recent Minimum Data Set (MDS) was an annual with Assessment Reference Date (ARD) of 1/22/2018. The Brief Interview for Mental Status (BIMS) was a 14 out of a possible 15, which indicated that resident #30 was	F 623	RECEIVED MAY 10 2018 VDH/OLC	

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F 623	Continued From page 43 cognitively intact and capable of daily decision making. The nursing note of Licensed Practical Nurse (LPN) #8, dated 1/29/2018 at 21:47: Received new order for stat CBC/Diff, CMP and CXR r/t c/o shortness of breath 138/86, 98.6, RA 98%. The nursing note of LPN #8, dated 1/30/2018 at 21:49: Received results from stat CXR. No infiltrate, mass or congestive heart failure, no evidence of pleural effusion, no lobar pneumonia. Notified Nurse Practitioner #1. No further orders. Review of the clinical record revealed the following documentation: 2/1/2018 at 5:30 a.m., Resident #30 came to nurse's station stating he wanted to go to er r/t (related to) sob (shortness of breath). Licensed Practical Nurse (LPN) #9 assessed resident # 30, all vital signs were WNL (within normal limites). Lungs assessed clear to all lobes. Resident # 30 continued to ask to be sent to er (emergency room). Nurse Practitioner (NP) #1 called and obtained new order for Ativan 1mg now. 2/2/2018 at 2:43 p.m., Received new order to send resident #30 to ER for AMS (altered mental status) per NP # 1. 2/2/2018 at 6:40 p.m., Resident # 30 sent to Mary view Medical Hospital for sepsis. The Situation, Background, Assessment, and Review (SBAR) Communication Form and Progress noted on 2/21/2018 at 3:30 p.m. documented, Symptoms started in afternoon. Pulse 113, temperature 99.2 and respirations 24. Resident on room air. Personality change. No	F 623		

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CENTERS FOR MEDICARE & MEDICAID SERVICES
FORM APPROVED OMB NO. 0938-0391

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F 623	Continued From page 44 eating or drinking at all and labored breathing. 2/21/2018 at 3:47 p.m., The Resident #30 was sent out to the hospital. 3/7/2018, at 2:51 p.m. Resident #30 blood sugar checked it was 33. Very lethargic, mouth breathing and restles, Resident #30 given 1 glucagon and rechecked in 30 minutes. Blood sugar 27. Given an additional glucagon and Glucotrol by mouth. Resident # 30 very lethargic and slow responding Called NP when blood sugar was 29 after 30 minutes. NP stated, "To give another dose of glucagon. Resident # 30 given glucagon. 30 minutes later blood sugar was 33. Resident #30 more alert and given orange juice. Resident was checked on in 15 minutes. Lethargic again. Blood sugar was 28. Given Boost, Given orders from Nurse Practitioner #1 to send to ER for evaluation and treatment. 3/7/2018 at 11:20 p.m., Resident # 30 admitted to Maryview for sepsis. On 04/05/18 at 11:05 a.m. the Director of Admissions asked for a copy of the bed hold policy and a copy of the notification to the Ombudsman Office for Resident #66's hospital discharge for 12/24/17. The Director of Admissions stated, "The bed hold policy is attached by the nurses to the transfer packet that is sent with them to the hospital and the following day I call the families to touch base with the families and log it into my book. I have not been sending a notification to the Ombudsman of hospital discharges, I did not know I was supposed to do that." The Social Worker was also in the admission office during this discussion and the Administrator was standing at the door	F 623		

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F 623	Continued From page 45 with the surveyor. The Social Worker stated, "I send notices to the Ombudsman office once a month of the resident's that have discharged home, but not discharged to the hospital." The Administrator stated, "But they are still discharges." On 04/05/18 at 11:40 a.m the area Ombudsman was called and asked if he had been receiving notifications of discharges to the hospital from the facility. The Ombudsman stated, "I have only been getting the ones that go home I have not been getting any of the ones regarding residents being discharged to the hospital." On 4/6/18 at 2:00 p.m. a pre-exit debriefing was held with the Administrator and the Director of Nursing (DON) where the above information was shared. The Administrator was asked when the facility started to notify the local Ombudsman of hospital discharges. The Administrator stated, "We started yesterday." Prior to exit no further information was shared. 5. Resident #79 was admitted to the facility on 03/01/18. Diagnosis for Resident #79 included but not limited to End Stage Renal Disease (Chronic irreversible kidney failure). The current Minimum Data Set (MDS), a quarterly assessment with an Assessment Reference Date (ARD) of 2/26/18 coded the resident with a 15 out of a possible score of 15 on the Brief Interview for Mental Status (BIMS) indicating no cognitive impairment. The clinical note revealed the following: on 12/11/17 at approximately 4:04 p.m., Resident #79's son came in the facility and walked down the hall to resident's room and was later observed	F 623		

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Continued From page 46 wheeling resident out the front door. The staff member asked the resident's son where are was taking Resident #79, he replied, "To the hospital." The son was informed he needed to sign the resident out but he keep (sic) going. The resident's physician was made aware. The facility received a phone call from Resident #79's son informing the facility that Resident #79 was admitted to the local hospital on 12/11/17 with a diagnosis of fever.

An interview was conducted with the Social Worker on 04/05/18 11:05 a.m., who stated, "I have not been sending a notification to the Ombudsman of hospital discharges, I did not know I was suppose to do that." The Social Worker was also in the admission office during this discussion and the Administrator was standing at the door with the surveyor. The Social Worker stated, "I send notices to the Ombudsman office once a month of the resident's that have discharged home, but not discharged to the hospital." The Administrator stated, "But they are still discharges."

On 04/05/18 at approximately 11:40 a.m., a phone interview was conducted with the local Ombudsman who stated, "I have only been receiving discharge information for the residents being discharged to home but not to the hospital."

The above information was shared with Administration staff during a pre-exit meeting on 4/09/18 at 4:00 p.m. No additional information was provided.

6. Resident #102 was admitted to the nursing facility on 12/22/17 with diagnoses that included displaced fracture of second cervical vertebra.

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F 623	Continued From page 47 The Admission MDS assessment was dated 12/29/17 and coded the resident on the Brief Interview for Mental Status (BIMS) with a score of 15 out of a possible score of 15 which indicated the resident was intact in the cognitive skills for daily decision making. The Discharge MDS assessment was dated 1/3/18. The nurse's notes dated 1/3/18 at 5:16 p.m. indicated Emergency Medical Services (EMS) was called at 1:11 p.m. due to a change in the resident's condition (BP-101/47; respirations-24; and severe shortness of breath). The Transfer Discharge Report indicated Resident #102 was discharged to the local hospital on 1/3/18. An interview was conducted with the Director of Admissions on 04/05/18 at 11:05 A.M. who stated she had not been sending notifications to the Ombudsman of hospital discharges, and did not know she was supposed to. The Social Worker and the Administrator were in the admissions office during this discussion. The Social Worker stated, "I send notices to the Ombudsman office once a month of the resident's that have discharged home, but not discharged to the hospital." The Administrator responded, "But they are still discharges." On 04/05/18 at 11:40 AM the area Ombudsman was called and asked if he had been receiving notifications of discharges to the hospital from the facility. The Ombudsman stated, "I have only been getting the ones that go home I have not been getting any of the ones regarding residents	F 623		

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F 623	Continued From page 48 being discharged to the hospital." On 4/6/18 at 2:00 P.M.. a pre-exit debriefing was held with the Administrator and the Director of Nursing (DON) where the above information was shared. The Administrator was asked when the facility started to notify the local Ombudsman of hospital discharges. The Administrator stated, "We started yesterday." The facility policy and procedures titled Discharge/Transfer Letter Policy dated 10/5/17 indicated the Social Service or designee will assure that one list of emergency transfers be sent to the Ombudsman at the end of the month. No further information was shared prior to survey exit.	F 623		
F 644 SS=D	Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2) §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a	F 644		

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F 644	Continued From page 49 related condition for level II resident review upon a significant change in status assessment. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to ensure a Level II Pre-Admission Screening and Resident Review (PASARR) was completed for 1 of 37 sampled residents, Resident #55, who had a major mental illness (MI) of Schizophrenia. Findings included: Resident #55 was admitted 2/7/18 with diagnoses: Morbid obesity with respiratory impairment/hypoventilation syndrome, s/p Right Ankle ORIF with MRSA wound infection, Schizoaffective disorder, hallucinations, and obstructive sleep apnea due to obesity. Admission MDS dated 2/14/2018 showed a diagnosis of Schizophrenia in I6000. The PASARR Level I for resident #55 was provided by the facility and reviewed. It was dated 9/27/2017. It did not include the resident's mental illness or prior psychiatric admission, and documented the resident did not need a Level II PASARR. No Level II PASARR was observed in the clinical record. An initial psychiatric evaluation dated 2/14/18, documented a resident-reported history of self-mutilation and extensive auditory hallucination. It included diagnoses of Schizophrenia, Post-Traumatic Stress Disorder (PTSD), Anxiety, Paranoia, auditory hallucinations, and a risk for self-harm. It showed the resident reported a psychiatric hospitalization	F 644	1. ASCEND was notified by Social Worker and records sent regarding resident # 55 to request a PASARR Level 2. They will see the resident the week of 4/23/18 to complete it. 2. 100% audit of current residents will be done to identify residents with the potential for this deficiency. 3. Inservice by the administrator or designee for the social worker on regulations regarding PASARR screenings. 4a. Social worker will audit new admissions weekly for the need/presence of a level 2 PASARR x 3 months. 4b. Social worker will audit psych notes/consults weekly for new diagnosis requiring a level 2 PASARR x 3 months. Audit results will be taken to QAPI meetings for discussion and revision as needed. 5. 5/23/18	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF PORTSMOUTH	3610 WINCHESTER DR PORTSMOUTH, VA 23707

(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 644	Continued From page 50 "last year in (city)." On 04/06/18 at 09:47 AM,Social Worker (SW) #1 was interviewed. The Initial Psychiatric evaluation and Level I PASARR was reviewed with SW #1. When asked if a Level II PASARR had been completed for resident #55, SW#1 stated "her Level I was negative, so she didn't need a Level II." SW #1 also stated "according to the initial Psych (psychiatric) eval (evaluation) the resident has Schizophrenia and a psychiatric admission last year in (city)." The surveyor asked SW#1 what the facility policy for PASARRs contained. SW stated that on initial admission "the Admission staff gets the PASARR, and all residents admitted have to have a Level I. If the Level I is coded yes, then a Level II is requested." When asked what the process was if a resident later was diagnosed with mental illness, the SW stated "any resident who has a new diagnosis of MR/MI(mental retardation/mental illness) has to have a Level II requested. SW #1 then stated "We should have done a Level II for (Resident #55)." The facility did not provide a separate policy or procedure for PASARR completion, however a copy of the Social Services policy dated May 2009 was provided. Under Procedure, letter H the policy stated: H) Completing Significant Change PASRRs when needed: a) Referral of all residents with newly evident or possible serious mental disorder, intellectual disability or related condition for a level II review upon significant change in assessment status. No further information was provided prior to exit.	F 644		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES
FORM APPROVED
OMB 0938-0391

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F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care	F 656	1. Care plan revised for resident # 55 to include Schizophrenia, PTSD and a history of self mutilation. 2. 100% audit completed on current residents with psych diagnosis to identify those who have the potential to be affected by this deficiency. 3. Inservice by the MDS Coordinator for the social worker on providing a comprehensive care plan to include psych diagnosis and potential for self harm. 4. MDS Coordinator will audit care plans weekly for accuracy and completion x 3 months. Audit results will be taken to QAPI meetings for discussion and revision as needed. 5. 5/23/18	

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F 656	Continued From page 52 plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to develop a person-centered comprehensive care plan for Schizophrenia and Post-traumatic Stress Disorder (PTSD), for one of 37 residents in the survey sample (Resident #55) Findings included: Resident #55 was admitted 2/7/18 with diagnoses: Morbid obesity with respiratory impairment/hypoventilation syndrome, Schizoaffective disorder, hallucinations, and obstructive sleep apnea due to obesity. The admission MDS dated 2/14/2018 showed a diagnosis of Schizophrenia in I6000. The initial psychiatric evaluation completed on 2/14/18 documented a resident-reported history of self-mutilation and extensive auditory hallucination. It included diagnoses of Schizophrenia, Post-Traumatic Stress Disorder (PTSD), Anxiety, Paranoia, auditory hallucinations, and a risk for self-harm. It showed the resident reported a psychiatric hospitalization "last year in (city)." Review of Resident #55's Admission care plan showed no objectives or interventions for monitoring or treatment of Resident #55's risk for self-harm, hallucinations, or PTSD. Use of an antipsychotic was listed in the problem statement for Fall Risk, but no objectives or interventions	F 656		

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F 656	Continued From page 53 addressed use of this medication or the diagnosis of Schizophrenia. On 04/06/18 at 09:20 AM Social Worker (SW) #1 was interviewed. The Initial Psychiatric evaluation and Resident #55's care plan was reviewed with SW #1. The surveyor asked if there was care planning for Schizophrenia, PTSD, mood/behavior, or other mental health needs. SW #1 stated "Schizophrenia is mentioned several times in the computer but since the resident does not have any behaviors she does not have a specific care plan." SW #1 stated "according to the initial Psych (psychiatric) eval (evaluation) the resident has Schizophrenia and a psychiatric admission last year in (city)." The surveyor asked SW#1 if there was a care plan for psychosocial needs, including risk for self-harm or PTSD. SW #1 stated " I should have care planned that." The facility Social Services Policy, dated May 2009, stated: POLICY: The Facility provides social services to assure that each resident can attain or maintain his/her highest practicable physical, mental and/or psychosocial well-being. PROCEDURE: B) Social Services will assist in implementing interventions for the resident's needs by developing and maintaining care plans which are individualized, realistic with measurable goals, including but not limited to: 4. Current and/or history of mood/behavior, cognition, and/or psychosocial issues... No further information was provided before exit.	F 656		
F 657	Care Plan Timing and Revision	F 657		

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F 657 SS=D	Continued From page 54 CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-(A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff.(E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on staff interviews, clinical record review, and facility documentation review, the facility staff failed to revise comprehensive personal centered care plan for three (3) of 37 residents in the survey sample (Resident #5, 26 and 3). 1. The facility staff failed to revise Resident #5's comprehensive person centered care plan to	F 657	1. Care plan revised for resident # 5 to address Seroquel, resident # 26 to address Risperdal and resident # 3 to address oxygen therapy. 2. 100% audit of current residents with psychotropic drug use and/or oxygen therapy to identify those with the potential to be affected by this deficiency. 3. Inservice by the Corporate RDCS for the IDT team on revising care plans to reflect the resident's care and needs to include use of psychotropic drugs and oxygen therapy. 4. MDS Coordinator will randomly audit care plans due weekly to ensure they reflect the current needs of the residents x 3 months. Audit results will be taken to QAPI meetings for discussion and revision as needed. 5. 5/23/18	

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F 657	Continued From page 55 include the use of psychoactive medication (Seroquel). 2. The facility staff failed to revise Resident #26's comprehensive person centered care plan to include the use of psychoactive medication (Risperdal). 3. The facility staff failed to revise Resident #'3 comprehensive personal centered care plan to include the use of oxygen therapy. The findings included: 1. Resident #5 was admitted to the nursing facility on 04/28/14. Diagnosis for included but not limited to *Dementia without behavioral disturbance. * 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). The current Minimum Data Set (MDS) a quarterly MDS with an Assessment Reference Date (ARD) of 03/26/18 coded the resident with a 02 of a total possible score of 15 on the Brief Interview for Mental Status (BIMS), indicating severe cognitive impairment. The resident's MDS was coded for the usage of antipsychotic medication. The section N on the MDS under medications read as follows: Indicate the number of DAYS the resident receiving the medication during the last 7	F 657		

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F 657	Continued From page 56 days; the MDS was coded for receiving an antipsychotic for 7 days. According to the Physician Order Form for April 2018, Resident #5 was started on *Seroquel 25 mg every evening for combative behaviors on 2/15/18 and Seroquel 12.5 mg twice daily for combative behaviors on 3/6/18. *Seroquel tablets and extended-release tablets are also used alone or with other medications to treat episodes of mania (frenzied, abnormally excited or irritated mood) or depression in patients with bipolar disorder (manic depressive disorder; a disease that causes episodes of depression, episodes of mania, and other abnormal moods) (https://medlineplus.gov/ency/article/007365.htm). The review of the Resident #5's comprehensive care plan did not include a care plan for the use a psychoactive medication (Seroquel). On 4/5/18 an approximately 8:45 a.m., the surveyor asked the Administrator if there was a psychoactive care plan for Resident #5. On the same day on 4/5/18 at approximately 10:40 a.m., the MDS Coordinator stated, "We did not have a care plan for the use of psychoactive medication for Resident #5 but we do now." The MDS Coordinator stated, "We were trying to condense our care plans to make them shorter." The MDS Coordinator stated, "We were just talking about that last week that we needed to make sure the psychoactive care plans separate." The MDS Coordinator gave the surveyor a psychoactive care plan that was created on 04/05/18 but only after it was requested from the	F 657		

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F 657	Continued From page 57 surveyor. The care plan included the following: The resident is at risk for adverse effects related to (r/t) psychoactive medication use: R/T Psychosis, depression and hallucinations. The goal: will be free from the adverse effects r/t psychoactive medication use through next review. Some of the interventions to manage goal: Psych evaluation and treatment as needed, Reduction in medication doses when indicated, monitor for medication side effects: sedation, hypotension, insomnia, anorexia, Abnormal Involuntary Movement Scale (AIMS) testing per facility policy and report to physician any negative outcomes associated with use of psychoactive drug. An interview was conducted with the Director of Nursing (DON) on 4/6/18 at approximately 8:40 a.m. who stated, "Yes, there should have been a psychoactive care plan per regulations with the appropriate diagnosis." The facility administration was informed of the finding during a briefing on 04/06/18 at approximately 2:00 p.m. The facility did not present any further information about the findings. 2. Resident #26 was admitted to the nursing facility on 06/04/12. Diagnosis for included but not limited to *Dementia without behavioral disturbance. *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	F 657		

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F 657	Continued From page 58 (https://medlineplus.gov/ency/article/007365.htm). The current Minimum Data Set (MDS) a quarterly MDS with an Assessment Reference Date (ARD) of 01/19/18 coded the resident with a 02 of a total possible score of 15 on the Brief Interview for Mental Status (BIMS), indicating severe cognitive impairment. The resident's MDS was coded for the usage of antipsychotic medication. The section N on the MDS under medications read as follows: Indicate the number of DAYS the resident receiving the medication during the last 7 days, the MDS was coded for receiving an antipsychotic for 7 days. According to the Physician Order Form for April 2018, Resident #26 was started on *Risperdal 0.5 mg twice daily for hallucinations and psychosis on 6/21/16. *Risperdal is in a class of medications called atypical antipsychotics. It works by changing the activity of certain natural substances in the brain (https://medlineplus.gov/druginfo/meds/a694015.html). The review of the Resident #26's comprehensive care plan did not include a care plan for the use a psychoactive medication (Risperdal). On 4/5/18 an approximately 8:45 a.m., the surveyor asked the Administrator if there was a psychoactive care plan for Resident #5. On the same day on 4/5/18 at approximately 10:40 a.m., the MDS Coordinator stated, "We did not have a care plan for the use of psychoactive medication for Resident #5 but we do now." The MDS Coordinator stated, "We were trying to condensed our care plans to make them shorter." The MDS	F 657		

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F 657		F 657		

Continued From page 59

Coordinator stated, "We were just talking about that last week that we needed to make sure the psychoactive care plans separate."

The MDS Coordinator gave the surveyor a psychoactive care plan that was created on 04/05/18 but only after it was requested from the surveyor. The care plan included the following: The resident is at risk for adverse effects related to (r/t) psychoactive medication use: R/T Psychosis, depression and hallucinations. The goal: will be free from the adverse effects r/t psychoactive medication use through next review. Some of the interventions to manage goal: Psych evaluation and treatment as needed, Reduction in medication doses when indicated, monitor for medication side effects: sedation, hypotension, insomnia, anorexia, Abnormal Involuntary Movement Scale (AIMS) testing per facility policy and report to physician any negative outcomes associated with use of psychoactive drug.

An interview was conducted with the Director of Nursing (DON) on 4/6/18 at approximately 8:40 a.m. who stated, "Yes, there should have been a antipsychotic care plan per regulations with the appropriate diagnosis."

The facility administration was informed of the finding during a briefing on 04/06/18 at approximately 2:00 p.m. The facility did not present any further information about the findings.

The facility's policy titled: Psychotropic Medication Documentatin and Review (7/16/13).

Policy: All residents receiving psychotropic medication will have their behaviors, effectiveness of interventions (pharmacological

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F 657	Continued From page 60 and non-pharmacological) and potentional for a gradual dose of reduction of psychotropic medicaion monitored and documented. Procedure include but not limited to: -The resident's Plan of Care (POC) will be reviewed and updated with any changes in behavior and/or treatment. 3. Resident #30 was originally admitted on 10/22/2015 and readmitted on 3/19/2018 with diiagnosis of Cirrhosis of Liver. The most recent Minimum Data Set (MDS) was an annual with Assessment Reference Date (ARD) of 1/22/2018. The Brief Interview for Mental Status (BIMS) was a 14 out of a possible 15, which indicated that resident #30 was cognitively intact and capable of daily decision making. Resident #30's 3Medication Administration Record (MAR) was reviewed on 3/23/2018. An order was written as follows: Oxygen 2 LPM (liters per minute) via Nasal Cannula PRN (as needed) for shortness of breath/comfort. The Comprehensive Person Center Care Plan initiated on 1/22/2018 did not indicate that a revision had been made to include Oxygen administration for Resident # 30. On 4/3/2018 approximately 2:18 a.m., an Oxygen concentrator with tubing attached beside Resident # 30 bed was observed. Certified Nursing Assistant (CNA) #1 came into room and stated, "Does resident #30 need some help?" CNA #1 was asked, "Does resident #30 use Oxygen?" CNA #1 stated, "I believe only at night."	F 657		

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F 657	Continued From page 61 On 4/09/2018 at 11:00 a.m. an interview was conducted with Unit Manager (UM) #1 regarding revision of the person-centered care plan for Resident #30. UM #1 was asked, "Is Resident #30 currently on Oxygen? UM #1 stated "yes". UM #1 was then asked, "Should Residents #30's care plan be revised to include?"UM #1 stated, "Yes. I should have revised the care plan to include Oxygen. It is a lot of work to keep this information updated." On 4/13/18 at 2:04 p.m., a pre-exit interview was conducted with the Administrator, the Director of Nursing (DON). The surveyor shared the above findings with the DON. The DON was asked about the expectations for updating the residents care plans. The DON stated' "I expect the care plans to be updated." No further information was shared at this time. The facility's policy and procedures titled "Care Plan" dated, April 6, 2017(revision) indicated: An Interdisciplinary pan of care will be established for every resident and updated in accordance with state and federal regulatory requirements and on an as needed basic. In states where pre-admission screening applies, this will be coordinated with the facility assessment. Goals must be measurable and objective. "The facility must develop a comprehensive Care Plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessments'." (Federal Register 483.20 Sept. 26, 1991).	F 657		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2)	F 677		

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F 677	Continued From page 62 §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observations, resident interview, staff interviews, medical record review, and facility documentation review, the facility failed to ensure necessary services maintain personal grooming for 1 of 37 residents in the survey sample was provided, Resident #66. The facility staff failed to ensure that fingernail care was provided to Resident #66, who was unable to carry out this activity of daily grooming task independently. The findings included: Resident #66 was a 78 year old admitted to the facility on 1/1/2014 with diagnoses to include dementia, glaucoma and osteoarthritis. The most recent Minimum Data Set (MDS) assessment was a Quarterly with an Assessment Reference Date (ARD) of 1/29/18 with a Brief Interview for Mental Status (BIMS) of a 15 out of a possible 15 which indicated that Resident #66 was cognitively intact and capable of daily decision making. Under Section G Functional Status J. Personal Hygiene Resident #66 was coded a 3/2 requiring extensive one person physical assist. Resident #66's Comprehensive Care Plan last revised 2/12/18 was reviewed and documented in part:	F 677	1. Resident # 66 had his fingernails trimmed and cleaned during survey. 2. 100% audit of current resident's nails audited for length and cleanliness to identify any residents with the potential to be affected by this deficiency. 3. Inservice by the DON or designee for nursing department staff on ADL care to include nail care. 4. Weekly audits by the Unit Managers on dependant residents who require assistance with nail care to ensure nails are trimmed and clean x 3 months. Audit results will be taken to QAPI meetings for discussion and revision as needed. 5. 5/23/18	

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F 677	Continued From page 63 Focus: (Resident #66) requires staff assist for ADL'S (Activities of Daily Living) R/T (related to) Dementia, impaired mobility, frequent B/B (bowel and bladder) incontinence. Date Initiated: 10/13/16, Revision on: 11/26/16. Goal: Will have ADL'S met daily through next review. Date Initiated: 10/13/16, Revision on: 03/28/18, Target Date: 04/28/18. Interventions: *Dressing/Grooming with assist of : 1. Revision on: 10/13/16 *Provide needed assistance with self care daily and prn (as needed). On 04/03/18 at 3:58 PM Resident #66's fingernails on both hands were observed extremely long, with dark debris noted under the nails. Resident #66 was asked if he liked his nails that long. Resident #66 stated, "No I need them to be cut, they are supposed to cut them for me." On 04/04/18 at 12:46 PM Resident #66 was observed outside smoking with supervision, fingernails on both hands remained long and with debris under nailbeds. On 04/04/18 at 2:15 PM Resident #66 was observed up in his wheelchair in the hallway; fingernails on both hands were still uncut with debris under the nails. On 04/05/18 at 09:40 AM Resident #66 was observed in his room up in his wheelchair. CNA	F 677		

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F 677	Continued From page 64 (Certified Nursing Assistant) #1 was cutting resident's nails. CNA #1 was asked if she normally cut residents nails and she stated, "I do if they are in my group but I was walking him this morning and noticed his nails were dirty and needed to be cut." The facility policy titled "Nail Care" last reviewed January 2014 was reviewed and is documented in part, as follows: POLICY: Nursing staff will administer nail care in order to provide cleanliness and prevent infection. On 4/6/18 at 2:00 P.M.. a pre-exit debriefing was held with the Administrator and the Director of Nursing (DON) where the above information was shared. The DON was asked what was expected from the nursing staff in regards to nail care for the resident's. The DON stated, "I expect them to provide nail care during during bathing and as needed for the resident's." Prior to exit no further information was provided.	F 677		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and record	F 695		

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F 695	Continued From page 65 review, the facility failed to ensure sterile technique was maintained during tracheostomy suctioning for one of 27 residents in the suvey sample, Resident #92. The findings included: Resident #92 was admitted 12/21/2018, and readmitted to the facility 1/24/2018. Resident #92's diagnoses included tracheostomy, percutaneous endoscopic gastrostomy (PEG), respiratory failure with hypoxia, hypertension, Type 2 Diabetes Mellitus without complications, unspecified dementia without behavioral disturbance, pulmonary embolism. The most recent Minimum Date Set (MDS) was an Admission MDS dated 12/27/2017. It documented an inability to communicate or understand communication, and that staff provided total assistance for self-care, hygiene, caloric intake, tracheostomy care, suctioning, and oxygen therapy. Physician orders on admission included: 1. Trach care every shift 2. #9 cuffed trach On 04/05/2018 at 11:15AM the surveyor observed tracheostomy care provided by Licensed Practical Nurse (LPN) #1. External cannula and skin care was provided. For tracheostomy suctioning, LPN #1 created a sterile field, applied sterile gloves, and connected the sterile suction cannula with her left hand on the suction machine tubing and her right hand on the sterile suction catheter. This contaminated her left hand. LPN #1 then realized that saline had not been dispensed, put down the	F 695	1. Trach care was performed by LPN #1 a 2nd time and observed by the surveyor with no deficient practice noted. 2. Current residents requiring trach care and/or suctioning have the potential to be affected by this deficiency. 3. A. Inservice by the DON or designee for licensed nursing staff on sterile technique when providing trach care and proper procedure for suctioning a trach. B. Trach care and suctioning competencies were completed on licensed nursing staff and will also be added to competencies done twice a year on licensed nursing staff. C. Trach care and suctioning competencies will be checked on new hired licensed nursing staff during orientation. 4. DON or designee will audit all new hired Licensed nursing staff to ensure competencies are completed weekly x 3 months. DON will audit nurses for bi-annual competency checks including trach care and suctioning to ensure competencies are complete. Audit results will be taken to QAPI meetings for discussion and revision as needed. 5. 5/23/18	

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F 695	Continued From page 66 suction catheter, and grasped the non-sterile bottle of saline solution with both hands to remove the lid and dispense. This contaminated both gloves. LPN #1 then grasped the suction catheter with her right hand, which contaminated the catheter. LPN #1 then suctioned the resident with this contaminated suction catheter. When asked after the procedure if tracheostomy suctioning was a sterile procedure, she stated "This is supposed to be a sterile procedure." When asked about opening the saline container, she stated "that contaminated my gloves and the catheter. I forgot to open it." On 04/05/2018 at 11:50AM the surveyor asked Administration #2 (the Director of Nursing) if tracheostomy suctioning was to be done with sterile technique. He stated "Yes, that is supposed to be sterile." The facility policy dated 1/28/2011 stated "Care of the tracheostomy is important to maintain an open airway and to prevent infection of the site." The facility policy stated that the procedure for tracheostomy care was: 1. Physician's orders for tracheostomy care should be obtained. 2. Aseptic technique is used: a. During all dressing changes, unless the tracheostomy is healed b. During endotracheal suctioning c. During cleaning and sterilization of reusable tracheostomy tube No further information was provided prior to exit.	F 695		
F 698 SS=E	Dialysis CFR(s): 483.25(l)	F 698		

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§483.25(l) Dialysis.
The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences.
This REQUIREMENT is not met as evidenced by:
Based on resident interview, staff interviews, clinical record review, and facility documentation review, the facility staff failed to ensure that residents who require dialysis receive such services, cosistent with professional standards of practice for two (2) of 37 residents in the survey sample (Resident #79 and #41)

1. The facility staff failed to communicate an ongoing assessment with the dialysis center for Resident #79, who attended an outpatient dialysis three days per week every Tuesday, Thursday and Saturday.

2. The facility staff failed to ensure hemodialysis care was provided for Resident #41 to include consistent assessments of bruit and thrill by the licensed nurses.

The findings include:

1. Resident #79 was admitted to the facility on 03/01/18. Diagnosis for Resident #79 included but not limited to End Stage Renal Disease (ESRD) (Chronic irreversible kidney failure). The resident was receiving *hemodialysis treatments three times a week on Tuesdays, Thursdays and Fridays.

*Hemodialysis-cleans blood by removing it from

Provider's Plan of Correction (F 698):

1. The nurse caring for resident # 41 was immediately educated on checking bruit and thrill and performed the competency correctly. The communication book was sent to the dialysis center for resident # 79 to obtain any missing communication.
2. Residents receiving dialysis through a shunt have been identified as having the potential to be affected by this deficiency.
3. A. Inservice by the DON or designee for licensed nursing staff on performing a check of the bruit and thrill with return demonstration by the nurses completed immediately.
   B. Education and competency on checking the bruit and thrill will be completed during orientation of licensed nursing staff.
   C. Inservice by DON or designee for licensed nursing staff on use of the communication book for dialysis residents. This education will also be shared with licensed nursing staff during orientation.
4. Random audits weekly by Unit Managers or designee of bruit and thrill being performed
   X 3 months. Audit of communication book for use by facility and dialysis center weekly x 3 months. Audits results will be taken to QAPI meetings for discussion and revision as needed.
5. 5/23/18

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F 698	Continued From page 68 the body and passing it through a dialyzer, or artificial kidney. The process of removing blood from the body, filtering it and returning it takes time. Hemodialysis treatment usually takes three to five hours and is repeated three times a week. *For dialysis, a catheter is inserted into a large vein in either the neck or chest. A catheter is usually a short-term option; however, in some cases a catheter is used as a permanent access. With most dialysis catheters, a cuff is placed under the skin to help hold the catheter in place. The blood flow rate from the catheter to the dialyzer may not be as fast as for an AV graft or AV fistula; therefore, the blood may not be cleaned as thoroughly as with an arteriovenous access (https://www.davita.com/kidney-disease/dialysis/treatment/arteriovenous-av-fistula-%2597-the-gold-standard-hemodialysis-access/e/1301). The current Minimum Data Set (MDS), a quarterly assessment with an Assessment Reference Date (ARD) of 2/26/18 coded the resident with a 15 out of a possible score of 15 on the Brief Interview for Mental Status (BIMS) indicating no cognitive impairment. In addition, the MDS was coded under section O for receiving dialysis treatments. The comprehensive care plan documented Resident #79 was on hemodialysis related to ESRD. The goal: the resident will maintain patent vascular access/vascular access will be free from signs/symptoms of infection. Some of the intervention/approaches to manage goal included dialysis service three times a week, monitor shunt site to right arm for swelling, abnormal warmth, pain, and redness. Report abnormal finding	F 698		

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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES
FORM APPROVED OMB 0938-0391

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F 698	Continued From page 69 promptly to MD, check bruit and thrill and report to the physician/Dialysis center: fever chills or hypotension. Resident #79's physician orders contained the following orders: May attend Dialysis on Tues, Thurs and Sat, departure/return dialysis assessments to be completed in assessments, check bruit and thrill to right lower arm and for bleeding at insertion site: apply pressure to right lower arm x 15 minutes. Resident 79#'s Dialysis Book revealed the following title: To dialysis center, please provide the facility with residents before and after weight. The dialysis binder content reviewed on 4/5/18 revealed only three communication forms from the outpatient dialysis center, 3/31/18, 4/3/18 and 4/5/18. Resident #79 was admitted to the facility on 3/1/18 indicating that there were 12 missing communication sheets from the dialysis center to the facility. An interview was conducted with Resident #79 on 4/5/18 at approximately 12:00 p.m., who stated, "I just started last week taking a book to the dialysis center." An interview was conducted with License Practical Nurse (LPN) #2 on 4/5/18 at approximately 2:10 p.m., who stated, "The nurse assigned to Resident #79 should make sure the communication sheet is complete and if not to call the dialysis center to have the communication sheet faxed over right away." The surveyor asked, "What is the purpose of the communication book form the dialysis center?" LPN #2 replied, "We need to know exactly what occurred at the dialysis center so we can take	F 698	RECEIVED MAY 10 2018 VDH/OLC	

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F 698	Continued From page 70 care of our residents after the return back to the facility from dialysis." An interview was conducted with the Director of Nursing (DON) on 4/6/18 at approximately 8:40 a.m., who stated, "We have had issues in the past with the dialysis center not filling out the communication book." The DON said the nurses should be checking to make sure the communication sheet was completed and if not, they are to call the dialysis center right way to have them fax over a completed communication sheet. The DON continued to say, "The staff have been educated to make sure the communication sheet have been completed and if not to contact the dialysis center right away and notify me." An interview was conducted with LPN #2 on 4/5/18 at approximately 2:15 p.m. The surveyor asked LPN #2, "How do you check for bruit?" LPN #2 placed her finger on her left upper arm and said, "You feel, right?" The surveyor asked, "How do you check for thrill?" The LPN stated, "The same way right", placing her finger to her left upper arm. On the same day at approximately the LPN #2 approached this surveyor and stated, "I know the correct answer now, you use a stethoscope to check for bruit and you palpate for thrill." An interview was conducted with the DON on 4/6/18 at approximately 8:40 a.m., who was made aware LPN #2 was unable to demonstrate how to successfully assess a dialysis shunt site for bruit and thrill. The surveyor asked the DON, "What is the reason for checking for bruit at thrill?" He replied, to make sure there is patency, no patency means no dialysis, no bruit or thrill could lead to a negative outcome such as infection.	F 698		

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The DON proceeded to say, "The nurses have already been educated on how to take care of a resident on dialysis; the assessment of the shunt site for bruit and thrill."

The above information was shared with Administration staff during a pre-exit meeting on 4/09/18 at 4:00 p.m. No additional information was provided.

2. Resident #41 was re-admitted to the nursing facility on 1/14/18 with a diagnosis that included end stage renal disease (ESRD) on hemodialysis.

The most recent Minimum Data Set (MDS) assessment dated 2/2/18, coded the resident on the Brief Interview for Mental Status (BIMS) with a score of 11 out of a possible score of 15 which indicated the resident was moderately impaired in the skills needed for daily decision making. The resident was coded to receive hemodialysis.

The care plan dated as revised 3/17/18 identified Resident #41 on dialysis Monday, Wednesday and Friday. The goal the staff set for the resident was that she would receive treatments as scheduled with monitoring of disease process through next review. One of the approaches to accomplish this goal included monitor thrill and bruit every shift.

On 4/3/18 at 11:30 a.m., Resident #41 was observed in bed. The Certified Licensed Nurse (CNA) #8 stated when she bathed the resident, she made sure she protected her right arm because that was the location of her hemodialysis shunt. The Arterio-Venous (AV) dialysis shunt was observed in the right arm without a dressing per hemodialysis recommendations and physician's orders.

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On 4/05/18 at 2:15 PM Licensed Practical Nurse (LPN) #2 stated she was asked to check bruit and thrill on another resident and did it incorrectly, so she had to look it up after another surveyor observed her attempting to check shunt access. When asked if she ever checked bruit and thrill as the Resident #4's assigned nurse, she stated "Not really, I just made sure everything looked normal and signed off because I thought that was all I needed to do, but after the other surveyor discovered I could not perform the assessment. I looked it up, went back and assessed the resident's shunt and I probably could do it now." When asked if she was able to explain the significance of the practice, she said, "I may not be able to tell you that, but I can tell you now where I place my hands and stethoscope." LPN #2 stated she had worked for the facility as an LPN for three years and never had any training related to assessment of a hemodialysis shunt to include bruit and thrill. Based on this information, another LPN (#4) who had taken care of other hemodialysis patients in the facility, as well as Resident #41 in the past, was asked to demonstrate assessment of bruit and thrill on the resident. LPN #4 looked up the location of the AV shunt, retrieved a stethoscope and proceeded to check bruit and thrill with a stethoscope above and below the site. Each time she positioned the stethoscope, she asked, "Is this correct for the bruit and thrill?" She did not use her fingers to palpate the site for the thrill. Additionally, she was unable to explain the significance of the assessment. She stated she had not received any formal training on the practice of assessing bruit and thrill from the facility.

The Administrator presented on 4/6/18 at 10:30

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F 698	Continued From page 73 a.m., the Annual Inservice Calendar for 2017 that indicated the head to toe assessment competency would include assessment of the hemodialysis resident's shunt. The 2017 inservice calendar indicated September 2017 was the planned inservice for head to toe assessments. Review of the licensed nurse competency/skills review competencies for head to toe assessment did not include assessment of a hemodialysis resident to include the hemodialysis shunt. The 2018 inservice calendar indicated March would be the month for head to toe assessments, but again the hemodialysis resident was not included in the assessment. The 2018 licensed nurse competency/ skills review did not include assessment of the hemodialysis patient. On 4/6/18 at 11:30 a.m., the Administrator presented a new licensed nurse competency/skills review and stated it was implemented on 3/1/18 where they added care and assessment of the hemodialysis patient and the demonstration of bruit and thrill, and that the head to toe assessments were scheduled for 3/26/18. The Administrator was unable to produce evidence of any currently employed licensed nurses who had completed the head to toe assessment competencies on 3/26/18. He stated they were waiting on the mannequin to implement the head to toe assessment competency and he would be following up on the status of the order. On 4/9/18 from 11:45 a.m. to 12:10 a.m., four additional random licensed nurses were individually asked to demonstrate assessment of bruit and thrill, and two (LPN #8 and LPN #9) were not able to successfully voice or demonstrate competency for this assessment.	F 698		

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F 698	Continued From page 74 On 4/6/18 at 2:05 p.m., an interview was conducted with the Administrator and the Director of Nursing (DON). During this interview the DON was unable to explain the definitions or the process to assess bruit and thrill on a hemodialysis resident other than the nurse needed to check for patency. The DON stated he expected competencies to be completed per inservice schedule to include a full assessment of a resident's hemodialysis shunt, site, access, as well as assessment of bruit and thrill. They both stated they really did not need to wait on the mannequin to complete the head to toe assessment competencies for licensed nurses. The Administrator indicated and produced the admission service agreement that the facility could provide the necessary care and services by competent qualified nursing staff. The facility's policy titled Hemodialysis Care (Effective 6/2017). Plan of care Protocol -Pre and post dialysis weight for every visit provided by dialysis center. -Vital signs pre and post dialysis provided by dialysis center. -Monitor and Document daily condition of shunt/CVP line (type, location, thrill, brill) in treatment record/or EHR (this should be scheduled to include post dialysis/return to facility). Most problems that arise with hemodialysis occur during or immediately afterwards. Communicate any negative findings with the attending physician and the dialysis clinic. The dialysis clinic will be responsible for providing the facility with the needed documentation to care for the patient.	F 698		

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	495194	A. BUILDING ______ B. WING ______	C 04/09/2018

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F 726 SS=E	Competent Nursing Staff CFR(s): 483.35(a)(3)(4)(c) §483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. §483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. §483.35(c) Proficiency of nurse aides. The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, and facility documentation review, the facility staff failed to ensure licensed nurses received the necessary training to become competent in the assessment and management of hemodialysis	F 726	RECEIVED MAY 10 VDH/OLC 1. LPN # 2 and # 7 were immediately educated on checking Bruitt and Thrill with return demonstration. 2. Residents receiving dialysis through a shunt have been identified as having the potential to be affected by this deficiency. 3. A. Inservice by the DON or designee for licensed nursing staff on performing a check of the bruit and thrill with return demonstration by the nurses completed immediately. B. Education and competency on checking the bruit and thrill will be completed during orientation of licensed nursing staff. 4. Random audits weekly by Unit Managers or designee of bruit and thrill being performed X 3 months. 5. 5/23/18	

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F 726	Continued From page 76 residents. Several licensed nurses could not demonstrate the assessment of bruit and thrill in their residents on hemodialysis per physician's orders. It was determined the facility had not included this training in the licensed nurse competency/skills review, nor were there any inservices presented that taught the skill and significance of assessing bruit and thrill on residents with hemodialysis. The facility had 6 residents on hemodialysis. The findings include: On 4/05/2018 At 2:15 PM Licensed Practical Nurse (LPN) #2 stated she was asked to check Bruit and thrill on a resident and did it incorrectly, so she had to look it up after the surveyor observed her attempting to check shunt access. When this surveyor asked if she ever checked bruit and thrill as a resident's assigned nurse, she stated "Not really, I just made sure everything looked normal and signed off because I thought that was all I needed to do, but after the other surveyor discovered I could not perform the assessment. I looked it up, went back and assessed the resident's shunt and I probably could do it now." When asked if she was able to explain the significance of the practice, she said, " I may not be able to tell you that, but I can tell you now where I place my hands and stethoscope." LPN #2 stated she had worked for the facility as an LPN for three years and never had any training related to assessment of a hemodialysis shunt to include bruit and thrill. Based on this information, another LPN (#4) who had taken care of other hemodialysis patients in the facility was asked to demonstrate assessment of bruit and thrill on the resident. LPN #4 looked	F 726		

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F 726	Continued From page 77 up the location of the AV shunt of the resident she was demonstrating assessment, retrieved a stethoscope and proceeded to check bruit and thrill with a stethoscope above and below the site. Each time she positioned the stethoscope, she asked, "Is this correct for the bruit and thrill?" She did not use her fingers to palpate the site for the thrill. Additionally, she was unable to explain the significance of the assessment. She stated she had not received any formal training on the practice of assessing bruit and thrill from the facility. The Administrator presented on 4/6/18 at 10:30 a.m., the Annual Inservice Calendar for 2017 that indicated the head to toe assessment competency would include assessment of the hemodialysis resident's shunt. The 2017 inservice calendar indicated September 2017 was the planned inservice for head to toe assessments. Review of the licensed nurse competency/skills review competencies for head to toe assessment did not include assessment of a hemodialysis resident to include the hemodialysis shunt. The 2018 inservice calendar indicated March would be the month for head to toe assessments, but again the hemodialysis resident was not included in the assessment. The 2018 licensed nurse competency/ skills review did not include assessment of the hemodialysis patient. On 4/6/18 at 11:30 a.m., the Administrator presented a new licensed nurse competency/skills review and stated it was implemented on 3/1/18 where they added care and assessment of the hemodialysis patient and the demonstration of bruit and thrill, and that the head to toe assessments were scheduled for 3/36/18. The Administrator was unable to produce evidence of any currently employed	F 726		

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F 726	Continued From page 78 licensed nurses who had completed the head to toe assessment competencies on 3/26/18. He stated they were waiting on the mannequin to implement the head to toe assessment competency and he would be following up on the status of the order. On 4/9/18 from 11:45 a.m. to 12:10 a.m., four additional random licensed nurses that were individually asked to demonstrate assessment of bruit and thrill, and two (LPN #8 and LPN #9) were not able to successfully voice or demonstrate competency for this assessment. On 4/6/18 at 2:05 p.m., an interview was conducted with the Administrator and the Director of Nursing (DON). During this interview the DON was unable to explain the definitions or the process to assess bruit and thrill on a hemodialysis resident other than the nurse needed to check for patency. The DON stated he expected competencies to be completed per inservice schedule to include a full assessment of a resident's hemodialysis shunt, site, access, as well as assessment of bruit and thrill. They both stated they really did not need to wait on the mannequin to complete all components of the head to toe assessment competencies for licensed nurses. The Administrator indicated and produced the admission service agreement that indicated the facility could provide the necessary care and services by competent qualified nursing staff. The facility policy and procedures titled "Hemodialysis Care" dated 6/16/17 indicated the licensed nurse, on a regular basis, will palpate the AV (Arterio-Venous) hemodialysis shunt site that is usually in the arm, to feel the "thrill" and use the	F 726		

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F 726	Continued From page 79 stethoscope to hear the "whoosh" or "bruit" of blood flow through the access to detect possible clots and obstruction of the shunt. Emergency guidelines are to be followed if it is determined blood flow is disrupted and the physician is to be called immediately.	F 726		
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 observation, staff interviews, and facility documentation review, the facility failed to	F 761	1. The 2 vials of Aplisol were immediately discarded. 2. All residents have the potential to be affected by this deficiency. 3. Inservice by the DON or designee for licensed nursing staff on regulations regarding storage of biologicals. 4. Unit Managers will audit storage of biologicals bi-weekly to ensure all open vials are dated x 3 months. Audits results will be taken to QAPI meetings for discussion and revision as needed. 5. 5/23/18	

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F 761	Continued From page 80 date the label of two (2) multi-use biological vials when the vials were first accessed, to ensure precautions and safe administration of the medications. The facility staff failed to ensure two (2) open multi-dose vials of Aplisol (tuberculin skin test serum) were dated when opened. The findings included: On 04/05/18 at 4:30 P.M. the Unit 1 medication room observation was completed with LPN (Licensed Practical Nurse) #4 present. The locked medication refrigerator was opened by LPN #4 and this surveyor opened a large pill bottle that had 6 multi-dose vials of Tuberculin, Purified Protein Derivative Diluted Aplisol present. There were 3 vials that had not been opened, and 3 vials that were opened. One of the opened vials was dated but 2 of the open vials were not dated. LPN #4 was asked if the opened vials should be dated. LPN # 4 stated, "Yes, anything you open should always be dated." LPN #4 was asked if she knew when the open vials expired. LPN #4 stated, "I'm not sure probably on the expiration date because that is the date we put in the chart when we give it." Open Vial #1 and #2: Lot #307583 Manufacture Expiration date 8/19 Aplisol: is a sterile aqueous solution of a purified protein fraction for intradermal administration as an aid in the diagnosis of tuberculosis. www.fda.gov/downloads, Food and Drug Administration On 04/05/18 at 5:00 PM an interview was	F 761		

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F 761	Continued From page 81 conducted with the Director of Nursing asking what he expected from his nurses after opening medication vials in the facility. The Director of Nursing stated, "I would clearly expect for them to have dated the vials when they were opened and to discard the vials within 30 days." The facility Pharmacy document titled "Recommended Minimum Medication Storage Parameters" (based on manufacturer guidance) last revised March 31, 2017 was reviewed and is documented in part, as follows: Drug Brand Name (Generic): Aplisol Injection (tuberculin test) Storage Recommendations: Store in refrigerator at 36 to 46 degrees Fahrenheit. protect from light. Date when opened and discard unused portion after 30 days. The facility policy titled "6.0 General Dose Preparation and Medication Administration" last revised 1/1/13 was reviewed and is documented in part, as follows: Procedure: 3.11 Facility staff should enter the date opened on the label of medications with shortened expiration dates (e.g., insulins, irrigation solutions, etc.). 3.11.1 Facility staff may record the expiration date based on the date opened on the label of medications with shortened expiration dates. On 4/6/18 at 2:00 P.M.. a pre-exit debriefing was held with the Administrator and the Director of Nursing (DON) where the above information was shared. Prior to exit no further information was shared.	F 761	RECEIVED MAY 10 2018 VDH/OLC	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES
FORM APPROVED OMB 0938-0391

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F 842 SS=E	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented;(iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted	F 842	1. LPN # 2 has been educated regarding checking bruit and thrill as well as inaccurate documentation regarding checking bruit and thrill. 2. Residents with shunt access for dialysis have been identified to be at potential risk for this deficiency. 3. A. Inservice by the DON or designee for licensed nursing staff on performing a check of the bruit and thrill with return demonstration by the nurses completed immediately. B. Education and competency on checking the bruit and thrill will be completed during orientation of licensed nursing staff. C. Inservice by DON or designee on accurate documentation in the medical record for licensed nursing staff. 4. Random audits weekly by Unit Managers or designee of bruit and thrill being performed and documented X 3 months. Audit results will be taken to QAPI committee for discussion and revision as needed. 5. 5/23/18	

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F 842	Continued From page 83 by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on staff interviews, observation, clinical record review and facility documentation review the facility staff failed ensure the clinical record was accurate for 2 of 37 residents (Resident #79 and 41) in the survey sample. 1. The facility staff failed to ensure the Medication Administration Record (MAR) for April 2018 was accurate for Resident #79, a hemodialysis patient for assessment of bruit and thrill.	F 842		

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F 842	Continued From page 84 2. The facility staff failed to ensure accurate documentation by licensed nurses of the assessment of bruit and thrill, for Resident #41, a hemodialysis resident. The findings included: 1. Resident #79 was admitted to the facility on 03/01/18. Diagnosis for Resident #79 included but not limited to *End Stage Renal Disease (Chronic irreversible kidney failure). The resident was receiving *hemodialysis treatments three times a week on Tuesdays, Thursdays and Fridays. *Hemodialysis-cleans blood by removing it from the body and passing it through a dialyzer, or artificial kidney. The process of removing blood from the body, filtering it and returning it takes time. Hemodialysis treatment usually takes three to five hours and is repeated three times a week. The current Minimum Data Set (MDS), a quarterly assessment with an Assessment Reference Date (ARD) of 2/26/18 coded the resident with a 15 out of a possible score of 15 on the Brief Interview for Mental Status (BIMS) indicating no cognitive impairment. In addition, the MDS was coded under section O for receiving dialysis treatments. During the initial tour on 04/03/18 at approximately 3:19 p.m., an interview was conducted with Resident #79 who stated, "The nurse here today hardly every checks my site that I use for dialysis." The resident was asked, "Where is you dialysis site located?" Sshe replied, "Right here", then rolled up her sleeve to her right arm. The resident said she goes to dialysis every	F 842		

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F 842	Continued From page 85 Tuesday, Thursday, and Saturday. The MAR for April 2018, include the following physician order: Check bruit and thrill to right lower arm every shift starting on 03/06/18. On 4/5/18 at approximately 9:50 a.m., Resident #79 was observed returning to the facility from dialysis via stretcher transport. At approximately 10:00 a.m., the Certified Nursing Assistant (CNA) went into Resident #79's room and provided ADL care. On the same day at 10:20 a.m., the therapist came down and transported resident via wheelchair the therapy gym. At 12:00 p.m., the resident was in her room eating lunch. The resident was asked, "Did the nurse look at your dialysis site after you returned from dialysis today?" She replied, "No ma'am, the CNA came down and got me ready for therapy but the nurse never came down to look at my dialysis site to even see if it was bleeding." The review of Resident's #79's Medication Administration Audit Report for April 2018 revealed the following: Check bruit and thrill to right lower arm. The License Practical Nurse (LPN) #2 had signed off on 4/5/18 at 10:06 a.m., that she had completed the dialysis site assessment for bruit and thrill. An interview was conducted with LPN #2 on 4/5/18 at approximately 12:30 p.m., who stated, "I checked Resident's #79 shunt dialysis site right after she came back from dialysis.: The surveyor informed the LPN she was sitting in the hallway across from Resident #79's door when she arrived back to the facility from dialysis. The surveyor asked the LPN again, "Did you assess Resident #79's dialysis shunt site when she	F 842		

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F 842	Continued From page 86 returned from dialysis?" She replied, "No." On 4/5/18 at approximately 1:05 p.m., the review of Resident #79's clinical record revealed the following: Resident #79 returned to the facility from dialysis. Residents dialysis fistula shut site was evaluated for bruit and thrill on 4/5/18 at approximately 12:35 p.m. The surveyor asked the DON, "When do you expect your nurses to document a resident's assessment has been completed on the MAR?" He stated, "I expect for the nurses to document immediately after they have completed their treatment or assessment." The above information was shared with Administration staff during a pre-exit meeting on 4/09/18 at 4:00 p.m. No additional information was provided. 2. Resident #41 was re-admitted to the nursing facility on 1/14/18 with a diagnosis that included end stage renal disease (ESRD) on hemodialysis. The most recent Minimum Data Set (MDS) assessment dated 2/2/18 coded the resident on the Brief Interview for Mental Status (BIMS) with a score of 11 out of a possible score of 15 which indicated the resident was moderately impaired in the skills needed for daily decision making. The resident was coded to receive hemodialysis. The care plan dated as revised 3/17/18 identified Resident #41 on dialysis related to ESRD Monday, Wednesday and Friday. The goal the staff set for the resident was that she would receive treatments as scheduled with monitoring of disease process through next review. One of the approaches to accomplish this goal included	F 842		

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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 842	Continued From page 87 monitor thrill and bruit every shift. On 4/3/18 at 11:30 a.m., Resident #41 was observed in bed. The Certified Licensed Nurse (CNA) #8 stated when she bathed the resident, she made sure she protected her right arm because that was the location of her hemodialysis shunt. The Arterio-Venous (AV) dialysis shunt was observed in the right arm without a dressing per hemodialysis recommendations and physician's orders. On 4/05/18 At 2:15 PM Licensed Practical Nurse (LPN) #2 stated she was asked to check bruit and thrill on another resident and did it incorrectly, so she had to look it up after another surveyor observed her attempting to check shunt access. When asked if she ever checked bruit and thrill as the Resident #4's assigned nurse, she stated "Not really, I just made sure everything looked normal and signed off because I thought that was all I needed to do, but after the other surveyor discovered I could not perform the assessment. I looked it up, went back and assessed the resident's shunt and I probably could do it now." When asked if she was able to explain the significance of the practice, she said, " I may not be able to tell you that, but I can tell you now where I place my hands and stethoscope." LPN #2 stated she had worked for the facility as an LPN for three years and never had any training related to assessment of a hemodialysis shunt to include bruit and thrill. The Medication Administration Record (MAR) listed the assessment for bruit and thrill, and four months (2/1/2018 through 4/8/2018) of MARs were reviewed to identify the number of times LPN #2 had documented assessment of bruit and	F 842		

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	495194	A. BUILDING ____ B. WING ____	C 04/09/2018

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F 842	Continued From page 88 thrill. LPN #2 inaccurately signed off on checking for bruit and thrill 23 times, an assessment she stated she did not know how to perform. On 4/6/18 at 2:05 p.m., an interview was conducted with the Administrator and the Director of Nursing (DON). During this interview the DON stated he expected nurses to accurately sign off for completion of all procedures and medications. The DON further stated LPN #2 should not have signed off on a procedure she had not had not performed. The Administrator stated he was in agreement with the DON that the practice was not acceptable. No additional information was provided prior to survey exit. The facility's policy and procedures titled "Hemodialysis Care" dated 6/16/17 indicated the nurse should include in the documentation for the resident on hemodialysis, patency of the AV (bruit and thrill) every shift.	F 842		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:	F 880		

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F 880	Continued From page 89 §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents	F 880	1. A disposable stethoscope was placed in resident # 41's room. 2. Residents with contact precautions or any type of isolation have been identified as having the potential to be affected by this deficiency. 3. Inservice by DON or designee for licensed nursing staff on equipment needed in an isolation or contact precaution room. 4. Unit Managers will audit isolation/precaution rooms bi-weekly to ensure all equipment is available in the room x 3 months. Audit results will be taken to QAPI committee for discussion and revision as needed. 5. 5/23/18	

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F 880	Continued From page 90 identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, and review of facility documentation, the facility failed to ensure they implemented their infection control program to prevent the development and transmission of communicable infections and diseases for 1 of 37 residents in the survey sample (Resident #41). The facility failed to ensure Resident #41 with *Clostridium Difficile (C. Difficile) infection and on transmission based contact precautions, was provided dedicated equipment to include a stethoscope. The findings included: Resident #41 was re-admitted to the nursing facility on 1/14/18 with a diagnosis that included end stage renal disease (ESRD) on hemodialysis and C. Diff. *C. Difficile is a bacterium that causes inflammation of the colon, known as colitis. The elderly, are at greater risk of acquiring this disease. The bacteria are found in the feces. People can become infected if they touch items	F 880		

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F 880	Continued From page 91 or surfaces that are contaminated with feces and then touch their mouth or mucous membranes. Healthcare workers can spread the bacteria to patients or contaminate surfaces through hand contact. Symptoms of C. difficile include watery diarrhea, fever, loss of appetite, nausea. Transmission of C. difficile-Clostridium difficile is shed in feces. Any surface, device, or material that becomes contaminated with feces may serve as a reservoir for the Clostridium difficile spores. Clostridium difficile spores are transferred to patients mainly via the hands of healthcare personnel who have touched a contaminated surface or item. Clostridium difficile can live for long periods on surfaces. One of the things a healthcare worker can do to prevent the spread of C. Diff is to carefully clean hospital rooms and medical equipment that have been used for patients with C. diff. Use Contact Precautions to prevent C. diff from spreading to other patients. Contact Precautions mean: -Whenever possible, patients with C. diff will have a single room or share a room only with someone else who also has C. diff. -Healthcare providers will put on gloves and wear a gown over their clothing while taking care of patients with C. diff. -The Clorox Germicidal Wipes and Solution DO have the EPA Registered C Diff Kill with 3 minute contact time and 3 minute dry time. (https://www.cdc.gov/hai/organisms/cdiff/cdiff-patient.html). The most recent Minimum Data Set (MDS) assessment dated 2/2/18 coded the resident on the Brief Interview for Mental Status (BIMS) with a score of 11 out of a possible score of 15 which	F 880	RECEIVED MAY 1 VDH/OLC	

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F 880	Continued From page 92 indicated the resident was moderately impaired in the skills needed for daily decision making. The resident was coded to receive hemodialysis. This MDS did not assess that the resident had an infectious disease that required isolation. The care plan dated as revised 3/17/18, identified Resident #41 on dialysis related to ESRD Monday, Wednesday and Friday. The goal the staff set for the resident was that she would receive treatments as scheduled with monitoring of disease process through next review. One of the approaches to accomplish this goal included monitor thrill and bruit every shift. The resident was also identified with C. Diff infection and on contact isolation. On 4/3/18 at 11:30 a.m., Resident #41 was observed in bed. The Certified Licensed Nurse (CNA) #8 stated when she bathed the resident, she made sure she protected her right arm because that was the location of her hemodialysis shunt. The Arterio-Venous (AV) dialysis shunt was observed in the right arm without a dressing per hemodialysis recommendations and physician's orders. Personal protective equipment was used to include gowning and donning gloves. On 4/5/18 at 2:15 p.m., Licensed Practical Nurse (LPN #4) was asked to demonstrate assessment of bruit and thrill on the resident on Resident #41. LPN #4 looked up the location of the AV shunt, retrieved a stethoscope from medication cart #1 and proceeded to check bruit and thrill with a stethoscope above and below the site. Prior to assessing the resident she cleaned off the bell of the stethoscope with alcohol wipes. After she assessed the resident's AV shunt site she brought the stethoscope out of the room to cart #1,	F 880		

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F 880	Continued From page 93 retrieved a Clorox wipe and wiped the bell of the stethoscope with one swipe, and placed it back in cart #1. On 4/6/18 at 2:05 p.m., an interview was conducted with the Administrator and the Director of Nursing (DON). During this interview the DON stated there should have been a stethoscope dedicated for the resident because of contact transmission based precautions and the possibility of spreading C. Diff to other residents with continued use of the same stethoscope. Additionally, the DON stated she did not properly clean the stethoscope after she used it on Resident #41. The DON stated she should have cleaned it for 3 minutes of contact time and allowed to dry for 3-4 minutes. He stated C-Diff has the longest contact time because it can live on surfaces for several months. The DON stated more training would take place regarding infection control related to isolation protocols. The facility's policy and procedures titled Infection Control-Transmission Based Precautions dated 4/2016 indicated that contact precautions include resident care equipment that are disposable non-critical equipment (thermometers, blood pressure cuffs, stethoscope, etc.) or implement dedicated equipment. If common use of equipment is unavoidable, properly clean and disinfect equipment before use on another resident.	F 880		

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