STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	VA0145	A. BUILDING: _____ B. WING _____	09/07/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF NEW MARKET	315 EAST LEE HIGHWAY NEW MARKET, VA 22844

(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) COMPLETE DATE
F 000	Initial Comments An unannounced biennial State Licensure Inspection was conducted 9/5/18 through 9/7/18. Corrections are required to be in compliance with the Virginia Rules and Regulations for the Licensure of Nursing Facilities. The Life Safety Code survey/report will follow. The census in this 118 certified bed facility was 103 at the time of the survey. The survey sample consisted of 39 current resident reviews (Residents #72, #6, #73, #43, #70, #61, #42, #60, #55, #1, #75, #74, #62, #69, #2, #23, #48, #87, #30, #39, #37, #97, #26, #59, #17, #94, #40, #44, #29, #52, #65, #4, #58, #68, #88, #91, #95, #35, and #78) and 3 closed record reviews (Residents #100, #102, and #66).	F 000		
F 001	Non Compliance The facility was out of compliance with the following state licensure requirements: This RULE: is not met as evidenced by: 12VAC5-371-150. Resident rights. G. The nursing facility shall register with the Department of State Police to receive notice of the registration or reregistration of any sex offender within the same or a contiguous zip code area in which the facility is located pursuant to §9.1-914 of the Code of Virginia. Based on staff interview and facility document review, it was determined that the facility staff failed to register to receive automatic notifications from the Virginia Sex Offender Registry of any registered sex offenders in the same or contiguous zip code area of the facility. The findings include:	F 001	F 001 1. State licensure requires nursing facility to be registered with the Department of State Police to receive automatic notification of the registration or reregistration of any sex offender within the same or a contiguous zip code area in which facility is located. No resident was determined to be affected by identified concern. On 9/5/18 facility registered with the Department of State Police to receive automatic notification of the registration or reregistration of any sex offender within the same or a contiguous zip code area in which facility is located.	10/15/18

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Executive Director — (X5) DATE: 9/27/18

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F 001	Continued From page 1 On 95/18 at approximately 12:00 p.m., during the entrance conference with the ASM #1, the Executive Director, (Administrative Staff Member), and ASM #2, the Director of Nursing, evidence that the facility was registered with the Department of State Police (DSP) to receive notice of registration or reregistration of sex offenders in the same or contiguous zip code, was requested. On 9/5/18 at 2:35 p.m., ASM #1 stated that the facility was not registered to receive automatic notifications from the sex offender registry. He provided a print out dated the date of the survey (9/5/18), printed at 1:56 p.m. (survey started at 11:45 a.m.), from the Virginia State Police sex offender registry of a list of registered sex offenders for the one zip code the facility was located in, but not surrounding areas, and stated that this printout is what they check every day. No evidence was provided that it was in fact done on a daily basis. He also provided copies of a print out from the sex offender registry of people allegedly requesting admission, and stated that these were people that they checked and did not admit; but had no evidence of checking, printing and retaining the document of any current residents. It was noted that each of these documents of individuals that were checked, was printed from the Virginia State Police website on the date of survey (9/5/18) at 1:14 p.m. and 1:28 p.m., after request of evidence that residents are pre-screened prior to admission, however they were not for any current residents. A review of the facility policy, "Protection of Residents: Reducing the Threat of Abuse and Neglect" documented, "Procedure for Screening Residents: 1. For prospective residents, the	F 001	Continued from page 1 2. All residents residing within the facility have the potential to be affected by the identified concern. On 10/4/18, Social Services will notify resident council that facility is registered with the Department of State Police to receive automatic notification of any sex offender registered in the same contiguous zip code area in which facility is located. At that same time Social Services will inform residents they may access Sex Offender Registry via internet access or view binder with printed notifications by request through Social Services. 3. Executive Director will remain registered with the Department of State Police to receive automatic notification of the registration or reregistration of any sex offender within the same or a contiguous zip code area in which facility is located. Executive Director will print notifications and place in binder as they are received. Social Services Director will validate binder notifications weekly x4 weeks, then one time a month x 60 days. 4. Administrator will present findings of audit accurate assessment findings to the QAPI committee for review and recommendations for 90 days.	

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F 001	Continued From page 2 following must be reviewed: An assessment of the individual's functional and mood/behavioral status; Medical acuity; and Special needs...2. Refer to the Admission Policy in the Social Services Manual and any State-specific regulations or laws regarding the screening of residents." A review of a document from the admission packet, titled "Convicted Sex Offencer {sic}: New Responsibilities For Long Term Care Facilities" dated 6/7/2007, documented, "Recent legislation passed by the Virginia General Assembly requires that Long Term Care Facilities to: Register to receive information regarding convicted sex offenders living in or near the facility; To inform facility residents of the existence and use of the Virginia Sex Offender Registry and to assist resident in accessing the registry. Prior to admission to this facility, all potential residents will be screened utilizing the sex offender registry and the resident's previous home address in accordance with this new legislation effective 7/1/2007. (name of facility) is required to inform all residents and/or responsible family members that they may access the Sex Offender Registry at (web address). Resident s may access the register themselves at the facility by request to the Social Services Director. The Social Services Director will provide internet services and assist in accessing the web side upon request. All residents and/or responsible parties must sign below to acknowledge that they have received the above information." No further information was provided. 2. Based on staff interview and facility document	F 001	Continued from page 2 1.It is policy of Life Care to validate background check before associate attends facility orientation. The policy states Life Care has engaged an independent contractor as its CRA to perform certain background screening services in connection with prospective and/or current Life Care Associates. Such employment screening conducted through the Vendor conforms to the mandates of the FCRA and other relevant federal and state laws. Virginia State Nursing Home Regulation requires nursing facility to obtain criminal background check on new hires within 30 days of employment and background checks must be obtained using Central Criminal Records Exchange from the Virginia Department of State Police. No resident was determined to be affected by identified concern. On 9/7/18, associate files were reviewed, to verify background checks were completed. 1. It is the policy of this facility to screen staff for a history of abuse, neglect, exploitation, or misappropriation of resident property in order to prohibit abuse, neglect, and exploitation of resident property. Screening components include but are not limited to attempting to obtain information from previous	

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F 001	Continued From page 3 review, it was determined that the facility staff failed to ensure a criminal record background check was completed for 16 of 25 employee records reviewed (RN #1, RN #2, LPN #1, LPN #2, CNA #3, CNA #4, CNA #5, CNA #6, CNA #7, CNA #8, OSM #2, OSM #4, OSM #5, OSM #6, OSM #7, and OSM #8), and a licensure verification was obtained for 1 of 25 employee records reviewed (CNA #8), in accordance with the laws of the State of Virginia. The findings included: Review of the state regulation 12VAC5-371-140 documents "E. Personnel policies and procedures shall include, but are not limited to: 3. An accurate and complete personnel record for each employee including: a. Verification of current professional license, registration, or certificate or completion of a required approved training course; b. Criminal record check." Virginia Nursing Home Regulation 12VAC5-371-150 states that a facility must comply with the requirements of §32.1-126.01: Employment for compensation of persons convicted of certain offenses prohibited; criminal record checks required; suspension or revocation of license. "Any person desiring to work at a licensed nursing home shall provide the hiring facility with a sworn statement or affirmation disclosing any criminal convictions or any pending criminal charges...A nursing home shall, within 30 days of employment, obtain for any compensated employees an original criminal record clearance with respect to convictions for offenses specified in this section or an original criminal history record from the Central Criminal Records Exchange."	F 001	Continued from page 3 employers and/or current employers, and checking with appropriate licensing boards, registries, and background checks. No resident was determined to be affected by identified concern. 2. All residents residing within the facility have the potential to be affected by the identified concern. All new associates hired from 9/10/18 will have background checks within 30 days of employment through Central Criminal Records Exchange from the Virginia Department of State Police. 2. All residents residing within the facility have the potential to be affected by the identified concern. All licensed candidates for hire from 9/10/18 forward will have licensure verification completed as indicated on Life Care Centers of America Selection Process Checklist under Pre-Screening Stage. 3. Executive Director provided written education to Human Resources Director regarding Virginia State Nursing Home Regulation that requires nursing facility to obtain criminal background check on new hires within 30 days of employment and background checks must be obtained using Central Criminal Records Exchange from the Virginia Department of State Police. Human Resources Director will utilize a new hire tracking log to verify background check using Central Criminal Records Exchange was completed within 30 days of hire. Executive Director will validate new hire tracking log and completion of background	

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F 001	Continued From page 4 State law (§§ 32.1-126.01 and 32.1-162.9:1 Employment for compensation of persons convicted of certain offenses prohibited; criminal records check required; suspension or revocation of license.) requires that each nursing facility, home care or home health organization, and hospice obtain a criminal record background check on new hires within 30 days of employment. The law also requires that these background checks be obtained using the Central Criminal Records Exchange from the Virginia Department of State Police. See Appendix 2 for a copy of each law. On 9/7/18 a review of 25 employee records was conducted. The following concerns were identified: 1. For RN #1 (Registered Nurse), hired on 5/22/18, the 30-day criminal background check was not completed until 8/10/18. 2. For RN #2, hired on 10/24/17, the 30-day criminal background check was not completed until 12/1/17. 3. For LPN #1 (Licensed Practical Nurse), hired on 4/25/18, the 30-day criminal background check was not completed until 8/10/18. 4. For LPN #2, hired on 6/19/18, the 30-day criminal background check was not completed until 8/10/18. 5. For CNA #3 (Certified Nursing Assistant), hired on 1/3/18, the 30-day criminal background check was not completed until 3/23/18. 6. For CNA #4, hired on 2/6/18, the 30-day criminal background check was not completed	F 001	Continued from page 4 check within 30 days one time per month x90 days. 3. Executive Director provided written education to Human Resources Director regarding the policy of this facility to screen staff for a history of abuse, neglect, exploitation or misappropriation of resident property in order to prohibit abuse, neglect, and exploitation of resident property. Screening components include but are not limited to attempting to obtain information from previous employers and/or current employers, and checking with appropriate licensing boards, registries, and background checks. Human Resources Director will utilize Life Care Centers of America Selection Process Checklist to ensure licensure verification in the pre-screening stage for all licensed candidates for hire. Staffing Coordinator will validate licensure verification one time per week x90 days. 4.Administrator will present findings of audit accurate VSP criminal background checks within 30 days of hire and licensure verification findings to the Quality Assurance Performance Improvement committee for review and recommendations for 90 days.	

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F 001	Continued From page 5 until 3/23/18. 7. For CNA #5, hired on 6/19/18, the 30-day criminal background check was not completed until 8/10/18. 8. For CNA #6, hired on 7/11/17, the 30-day criminal background check was not completed until 9/13/17. 9. For CNA #7, hired on 9/7/17, the 30-day criminal background check was not completed until 12/1/17. 10. For CNA #8, hired on 10/24/17, the 30-day criminal background check was not completed until 8/10/18, AND the license verification was not completed until 1/12/18. 11. For OSM #2 (Other Staff Member), a housekeeper, hired on 1/3/18, the 30-day criminal background check was not completed until 3/23/18. 12. For OSM #4, a housekeeper, hired on 5/22/18, the 30-day criminal background check was not completed until 8/10/18. 13. For OSM #5, a receptionist, hired on 6/9/18, the 30-day criminal background check was not completed until 8/10/18. 14. For OSM #6, a laundry aide, hired on 11/8/17, the 30-day criminal background check was not completed until 3/23/18. 15. For OSM #7, a physical therapy assistant, hired on 11/29/16, the 30-day criminal background check was not completed until 2/3/17.	F 001	12 VAC 5 – 371 – 250 A cross reference to Plan of Correction F 641 12 VAC 5 – 371 – 250 C cross reference to Plan of Correction F 657 12 VAC 5 – 371 – 200 B 1 does not cross reference to Plan of Correction F 658 (past non-compliance: plan of correction not necessary) 12 VAC 5 – 371 – 220 B 1 does not cross reference to Plan of Correction F 760 (past non-compliance: plan of correction not necessary) 12 VAC 5 – 371 – 140 Policies and Procedures cross reference to Plan of Correction F 622, F 623, F624, F 625, F 645 12 VAC 5 – 371 – 280 A cross reference to Plan of Correction F 679 12 VAC 5 - 371 - 180 Infection Control cross references to F 695	

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F 001	Continued From page 6 16. For OSM #8, a physical therapist, hired on 12/9/17, the 30-day criminal background check was not completed until 3/23/18. On 9/7/18 at 12:14 p.m., in an interview with OSM #13, Human Resources, she stated that she had her "wires crossed and thought they had to be done within 90 days, not 30 days." Regarding the license verification for CNA #8, she stated she did not have anything obtained any earlier or closer to the date of hire. A review of the facility policy, "Protection of Residents: Reducing the Threat of Abuse and Neglect" documented, "Screening: It is the policy of this facility to screen staff (as defined in this policy) for a history of abuse, neglect, exploitation, or misappropriation of resident property in order to prohibit abuse, neglect, and exploitation of resident property. Screening components include but are not limited to attempting to obtain information from previous employers and/or current employers, and checking with appropriate licensing boards, registries, and background checks...." On 9/7/18 at 3:26 p.m. in a meeting with ASM #1 (Administrative Staff Member - the Executive Director) and ASM #2 (the Director of Nursing) they were made aware of the findings. No further information was provided by the end of the survey. 12 VAC 5 - 371 - 250 A cross references to F 641 12 VAC 5 - 371 - 250 C cross references to F 657 12 VAC 5 - 371 - 200 B 1 cross references to F 658	F 001		

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F 001	Continued From page 7 12 VAC 5 - 371 - 220 B cross references to F 760 12VAC5-371-180. Infection Control cross references to F880. 12VAC5-371-140. Policies and Procedures cross references to F622, F623, F624, F625, F645 Resident Activities 12VACS-371-280A cross reference to F679	F 001		

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	495139	A. BUILDING _____ B. WING _____	09/07/2018

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E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 09/05/18 through 09/07/18. Corrections are required for compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities.	E 000	The statements made in this plan of correction are not an admission and do not constitute agreement with the alleged deficiencies herein. To remain in compliance with all state and federal regulations, the facility has taken or will take the actions set forth in this Plan of Correction. The following plan constitutes the facilities allegation of compliance	
E 024 SS=C	Policies/Procedures-Volunteers and Staffing CFR(s): 483.73(b)(6) [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. At a minimum, the policies and procedures must address the following:] (6) [or (4), (5), or (7) as noted above] The use of volunteers in an emergency or other emergency staffing strategies, including the process and role for integration of State and Federally designated health care professionals to address surge needs during an emergency. *[For RNHCIs at §403.748(b):] Policies and procedures. (6) The use of volunteers in an emergency and other emergency staffing strategies to address surge needs during an emergency. This REQUIREMENT is not met as evidenced by: Based on staff interview and facility document review it was determined that the facility staff failed to have a complete emergency preparedness plan.	E 024	E 024 1. Facility Safety Committee will develop a complete emergency preparedness plan that includes Policy and Procedure For the use of Temporary Staffing in a Emergency Situation. No residents were affected by this identified concern. 2. All residents residing within the facility have the potential to be affected by this identified concern. 3. Facility Safety Committee will develop a complete Emergency Preparedness Plan that includes Policy and Procedure For the use of Temporary Staffing in a Emergency Situation. By 10/8/18, Staff Develop Coordinator and Safety Committee will educate all staff regarding the Emergency Preparedness Plan that includes Policy and Procedure For the use of Temporary Staffing in a Emergency Situation. Executive Director will lead Safety Committee and will review and make necessary changes to Emergency Preparedness Plan/Manuel monthly x90 days or until Plan is 100% compliant. Safety Committee will review and up date Emergency Preparedness Plan/Manuel annually thereafter.	10/15/18

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE Executive Director | (X6) DATE 9/27/18

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be exposed 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 024	Continued From page 1 The facility staff failed to develop policies and procedures for the use of volunteers and others. The findings include: On 09/07/18 at 12:00 p.m. a review of the facility's emergency preparedness plan and interview was conducted with ASM (administration staff member) # 1, the executive director. Review of the facility's emergency preparedness plan failed to evidence policies and procedures for the use of volunteers and other staffing strategies in the emergency plan. ASM # 1 stated that he did not have volunteers. That he would only rely on staff. On 09/07/18 at approximately 3:26 p.m., ASM (administrative staff member) # 1, the executive director and ASM # 2, the director of nursing, were made aware of the findings. No further information was provided prior to exit.	E 024	Continued from page 1 4. Executive Director will present the complete Emergency Preparedness Plan that includes Policy and Procedure For the use of Temporary Staffing in a Emergency Situation to the Quality Assurance Performance Improvement committee for review and recommendations for 90 days. The QAPI committee consist of Executive Director, Director of Nursing, Assistant Director of Nursing, Social Services, Activities, Dietary Manager, Pharmacy consultant, Medical Director.	
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	E 026	E026 1.Facility Safety Committee will develop a complete Emergency Preparedness Plan that includes Policy and Procedure describing the facility's role in providing care and treatment at altered care sites under a 1135 waiver. No residents were affected by this identified concern. 2. All residents residing within the facility have potential to be affected by this identified concern. 3. Facility Safety Committee will develop a complete Emergency Preparedness Plan that includes Policy and Procedure describing the facility's role in providing care and treatment	10/15/18

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E 026	Continued From page 2 [facility] under a waiver declared by the Secretary, in accordance with section 1135 of the Act, in the provision of care and treatment at an alternate care site identified by emergency management officials. *[For RNHCIs at §403.748(b):] Policies and procedures. (8) The role of the RNHCI under a waiver declared by the Secretary, in accordance with section 1135 of Act, in the provision of care at an alternative care site identified by emergency management officials. This REQUIREMENT is not met as evidenced by: Based on staff interview and facility document review it was determined that the facility staff failed to have a complete emergency preparedness plan. The facility staff failed to develop policies and procedures in the emergency plan that describe the facility's role in providing care and treatment at altered care sites under a 1135 waiver. The findings include: On 09/07/18 at 12:00 p.m., a review of the facility's emergency preparedness plan and interview was conducted with ASM (administration staff member) # 1, the executive director. Review of the facility's emergency preparedness plan failed to evidence policies and procedures in the emergency plan that describe the facility's role in providing care and treatment at altered care sites under an 1135 waiver. ASM #1 stated that he did not have it. On 09/07/18 at approximately 3:26 p.m., ASM (administrative staff member) # 1, the executive	E 026	Continued from page 2 at altered care sites under a 1135 waiver. By 10/8/18, Staff Develop Coordinator and Safety Committee will educate all staff regarding the Emergency Preparedness Plan that includes Policy and Procedure describing the facility's role in providing care and treatment at altered care sites under a 1135 waiver. Executive Director will lead Safety Committee and will review and make necessary changes to Emergency Preparedness Plan/Manuel monthly x90 days or until Plan is 100% compliant. Safety Committee will review and up date Emergency Preparedness Plan/Manuel annually thereafter. 4. Executive Director will present the complete Emergency Preparedness Plan that includes Policy and Procedure describing the facility's role in providing care and treatment at altered care sites under a 1135 waiver to the Quality Assurance Performance Improvement committee for review and recommendations for 90 days. The QAPI committee consist of Executive Director, Director of Nursing, Assistant Director of Nursing, Social Services, Activities, Dietary Manager, Pharmacy consultant, Medical Director.	

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	495139	A. BUILDING _____ B. WING _____	09/07/2018

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E 026	Continued From page 3 director and ASM # 2, the director of nursing were made aware of the above concerns. No further information was provided prior to exit.	E 026		
E 039 SS=C	EP Testing Requirements CFR(s): 483.73(d)(2) (2) Testing. The [facility, except for LTC facilities, RNHCIs and OPOs] must conduct exercises to test the emergency plan at least annually. The [facility, except for RNHCIs and OPOs] must do all of the following: *[For LTC Facilities at §483.73(d):] (2) Testing. The LTC facility must conduct exercises to test the emergency plan at least annually, including unannounced staff drills using the emergency procedures. The LTC facility must do all of the following:] (i) Participate in a full-scale exercise that is community-based or when a community-based exercise is not accessible, an individual, facility-based. If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in a community-based or individual, facility-based full-scale exercise for 1 year following the onset of the actual event. (ii) Conduct an additional exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, facility-based. (B) A tabletop exercise that includes a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or	E 039	E039 1. The Safety Committee will develop, plan and implement a full-scale emergency exercise drill that requires activation of Emergency Plan. No resident was affected by identified concern. 2. All residents residing within the facility have potential to be affected by identified concern. 3. Safety Committee will develop, plan and implement a full-scale emergency exercise drill that requires activation of Emergency Plan. The full scale exercises will be documented and facility's exercise analysis and critique will be used to update emergency program based on the exercise analysis when concerns are identified. Staff Development Coordinator and Safety Committee will review the critique of the full exercise with staff and educate all staff of any changes in the emergency plan at monthly all staff in-services. Planning of the facilities full scale exercise will Begin immediately and documented in the Safety Committee monthly minutes effective October Safety meeting.	10/15/18

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E 039	Continued From page 4 prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed. *[For RNHCIs at §403.748 and OPOs at §486.360] (d)(2) Testing. The [RNHCI and OPO] must conduct exercises to test the emergency plan. The [RNHCI and OPO] must do the following: (i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group discussion led by a facilitator, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (ii) Analyze the [RNHCI's and OPO's] response to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCI's and OPO's] emergency plan, as needed. This REQUIREMENT is not met as evidenced by: Based on staff interview and facility document review it was determined that the facility staff failed to have a complete emergency preparedness plan. The facility staff failed to provide documented evidence of the full scale exercises and documentation of the facility's exercise analysis and response and how the facility updated its emergency program based on the exercise analysis. The findings include:	E 039	Continued from page 4 4. Executive Director will present the Safety Committee minutes regarding the planning of the full scale Emergency plan exercise, to the Quality Performance Improvement committee for review and recommendations for 90 days or until exercise is completed. The QAPI committee consist of Executive Director, Director of Nursing, Assistant Director of Nursing, Social Services, Activities, Dietary Manager, Pharmacy consultant, Medical Director.	

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E 039	Continued From page 5 On 09/07/18 at 12 p.m. a review of the facility's emergency preparedness plan and interview was conducted with ASM (administration staff member) # 1, the executive director. Review of the facility's emergency preparedness plan failed to evidence documentation of full-scale exercises and documentation of the facility's exercise analysis and response and how the facility updated its emergency program based on the exercise analysis. ASM # 1 stated that the facility was going to look into participating in a full scale exercise but currently had nothing in the "works." On 09/07/18 at 3:26 p.m., ASM (administrative staff member) # 1, the executive director and ASM # 2, the director of nursing, were made aware of the findings. No further information was provided prior to exit.	E 039		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 9/5/18 through 9/7/18. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety code survey/report will follow. The census in this 118 certified bed facility was 103 at the time of the survey. The survey sample consisted of 39 current resident reviews (Residents #72, #6, #73, #43, #70, #61, #42, #60, #55, #1, #75, #74, #62, #69, #2, #23, #48, #87, #30, #39, #37, #97, #26, #59, #17, #94, #40, #44, #29, #52, #65, #4, #58, #68, #88, #91, #95, #35, and #78) and 3 closed record reviews (Residents	F 000		

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F 000	Continued From page 6 #100, #102, and #66).	F 000		
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1,	F 584	F 584 1. How will the corrective action be accomplished for those residents found to have been affected by the deficient practice? On 9/6/18 direct care staff were verbally educated on policy to serve residents their meals in a homelike environment in the dining room during all meals; including first and second dining. 2. How will the facility identify other residents having the potential to be affected by the same practice? All residents that consume their meals in the dining room have the potential to be affected by this practice. Social Services will notify resident council by 10/4/18 that meals served in the dining room during first and second dining will be served in a homelike environment to include removing items from food tray and placing them on the table for each resident. 3. What measures will be put into place or systematic changes made to ensure the practice will not reoccur?	10/15/18

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F 584	Continued From page 7 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observations, staff interview and facility document review, it was determined that the facility failed to provide a homelike environment for residents during dinning. The facility staff failed to serve residents in a homelike manner in the main dining room. The findings include: A dining observation was conducted on 09/05/18 at 12:00 p.m. in the main dining room. There were nine residents seated at five tables; four residents at one table; two residents at another table and three residents at one table each. All of the residents were served their lunches on trays. An interview was conducted on 09/06/18 at 8:43 a.m. with CNA (certified nursing assistant) # 1. When asked why the residents ate their meals on trays in the dining room, CNA # 1 stated, "The second dinning is not fine dining. Second dinning is where we are to assist the resident or feed them." When asked if she ate her meals on a tray on the table at home, CNA # 1 stated, "No." When asked what the facility was to the residents, CNA # 1 stated, "It's their home." When asked if eating off a tray was homelike, CNA #1 stated, "No." An interview was conducted on 09/06/18 at 9:43 a.m. with CNA # 2. When asked why the	F 584	Continued from page 7 By 10/8/18, Staff Development Coordinator will in-service Certified Nursing Assistants and Licensed Nurses on Creating a Positive Dining Experience for Residents by serving meal to each resident just as they would like to be served a meal in a home like environment. Staff will remove tray items and place them on the table for each resident. Any Certified Nursing Assistant or Licensed Nurse that has not been in-serviced by 10/8/18 will not be allowed to provide direct care until in-service is completed. All newly hired Certified Nursing Assistants and Licensed Nurses will receive education during orientation on Creating a Positive Dining Experience for Residents by serving the meal to each resident just as they would like to be served a meal in a home like environment by removing tray items and placing them on the table for each resident. Director of Nursing/Unit Manager/Staff Development Coordinator or Dietary Manager will evaluate home like environment in the dining room for all meals- including first and second dining- to ensure associates remove tray items and place them on the table for each resident 5 times a week x30 days, 3 times a week x30 days, 1 time a week x30 days.	

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F 584	Continued From page 8 residents ate their meals on trays in the dining room, CNA # 1 stated, "That's how I have always been told to set them up." When asked if she ate her meals on a tray on the table at home, CNA # 2 stated, "No." When asked what the facility was to the residents, CNA # 2 stated, "It's their home." When asked if eating off a tray was homelike, CNA #2 stated, "No." An interview was conducted on 09/06/18 at 10:50 a.m. with ASM (administrative staff member) # 2, director of nursing. When asked why the residents ate their meals on trays in the dining room, ASM # 2 stated, "They (the food) should be taken off and placed in front of them." The facility's policy "Create a Positive Dining Experience for Residents" documented, "Remember: Serve the meal to each resident just as you would like to have a meal served to you in a nice restaurant." On 09/06/18 at 6:10 p.m. ASM (administrative staff member) #1, the executive director, ASM #2, the director of nursing, were made aware of the findings. No further information was provided prior to exit.	F 584	Continued from page 8 4. How will the facility monitoring the corrective plan to ensure the deficient practice was corrected and not reoccur? Director of nursing will present findings of audit accurate assessment findings to the Quality Assurance Performance Improvement committee for review and recommendations for 90 days. The QAPI committee consist of Executive Director, Director of Nursing, Assistant Director of Nursing, Social Services, Activities, Dietary Manager, Pharmacy consultant, Medical Director.	
F 622 SS=E	Transfer and Discharge Requirements CFR(s): 483.15(c)(1)(i)(ii)(2)(i)-(iii) §483.15(c) Transfer and discharge- §483.15(c)(1) Facility requirements- (i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless- (A) The transfer or discharge is necessary for the resident's welfare and the resident's needs	F 622	F622 1. How will the corrective action be accomplished for those residents found to have been affected by the deficient practice? As of 9/21/18 patients #26, 40, 42, 59, 58, 88, 97, 94 have safely returned to facility	10/15/18

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F 622	Continued From page 9 cannot be met in the facility; (B) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility; (C) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident; (D) The health of individuals in the facility would otherwise be endangered; (E) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or (F) The facility ceases to operate. (ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose. §483.15(c)(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this	F 622	Continued from page 9 from facility initiated transfer to the hospital. 2. How will the facility identify other residents having the potential to be affected by the same practice? Any resident transferred to the hospital has the potential to be affected by this practice. •Director of Nursing/Unit manager will review all residents currently at hospital sent from our facility and send hospital a copy of updated care plan. •Director of Nursing/Unit manager will review all residents transferred to hospital since September 10, 2018 has physician's order for transfer. •Health Information Management will review all residents transferred to hospital since September 10, 2018 to assure physician's note regarding transfer is completed. 3. What measures will be put into place or systematic changes made to ensure the practice will not reoccur?	

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F 622	Continued From page 10 section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider. (i) Documentation in the resident's medical record must include: (A) The basis for the transfer per paragraph (c)(1)(i) of this section. (B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s). (ii) The documentation required by paragraph (c)(2)(i) of this section must be made by- (A) The resident's physician when transfer or discharge is necessary under paragraph (c) (1) (A) or (B) of this section; and (B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care. This REQUIREMENT is not met as evidenced by:	F 622	Continued from page 10 •By 10/8/18, Staff Development Coordinator will in-service Licensed Nurses on sending a copy of comprehensive care plan goals are sent with resident upon a facility initiated transfer to the hospital. •Staff Development Coordinator will in-service Licensed Nurses on obtaining physicians order regarding facility initiated transfer to the hospital. •Staff Development Coordinator will in-service Medical Director on writing a physician's note regarding facility initiated transfer to the hospital. Any Licensed Nurse that has not been in-serviced by 10/8/18 will not be allowed to provide direct care until in-service completed. All newly hired Licensed Nurses will receive education during orientation on sending a copy of comprehensive care plan goals, obtaining physician order, and sending with resident upon a facility initiated transfer to the hospital.	

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F 622	Continued From page 11 Based on staff interview, facility document review, and clinical record review, it was determined that the facility staff failed to evidence that all the required documentation was provided to the hospital upon transfer for eight of 42 residents, Resident #26, 40, 42, 59, 58, 88, 97, and 94. 1. The facility staff failed to evidence that Resident #26's comprehensive care plan goals were sent with the resident upon a facility initiated transfer to the hospital on 6/10/18 and 7/27/18. 2. The facility staff failed to evidence that Resident #40's comprehensive care plan goals were sent with the resident upon a facility initiated transfer to the hospital on 8/31/18. 3. The facility staff failed to provide evidence that the comprehensive care plan goals were sent with the resident upon a facility initiated transfer to the hospital on 07/05/18, for Resident # 42. 4. The facility staff failed to provide evidence that the comprehensive care plan goals were sent with the resident upon a facility initiated transfer to the hospital on 7/10/18, for Resident #59. 5. The facility staff failed to evidence that all of the required documentation, including but not limited to, the physician's order for transfer, the physician's note regarding transfer, and the comprehensive care plan or care plan goals were sent with Resident #58 upon transfer to the hospital. 6. The facility staff failed to provide evidence that the comprehensive care plan goals were sent with the resident upon a facility initiated transfer	F 622	Continued from page 11 Director of Nursing/Unit Manager will evaluate facility initiated transfers to the hospital to ensure comprehensive care plan goals and physician order was sent with resident to the hospital and ensure physician made a note in regards to facility transfer to the hospital 5 times a week x30days, 3 times a week x30days, 1 time a week x30days. 4. How will the facility monitoring the corrective plan to ensure the deficient practice was corrected and not reoccur? Director of nursing will present findings of audit accurate assessment findings to the Quality Assurance Performance Improvement committee for review and recommendations for 90 days. The QAPI committee consist of Executive Director, Director of Nursing, Assistant Director of Nursing, Social Services, Activities, Dietary Manager, Pharmacy consultant, Medical Director.	

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F 622	Continued From page 12 to the hospital on 7/21/18, for Resident #88. 7. Resident #97 was transferred and admitted to the hospital on 5/23/18, 6/11/18, and 7/28/18. There was no evidence in the clinical record that all required documentation including the comprehensive care plan or comprehensive care plan goals were provided to the receiving hospital for each facility initiated transfer. 8. Resident #94 was transferred and admitted to the hospital on 7/27/18 and 8/8/18. There was no evidence in the clinical record that all required documentation including the comprehensive care plan and comprehensive care plan goals were provided to the receiving hospital for each facility initiated transfer. The findings include: 1. The facility staff failed to evidence that Resident #26's comprehensive care plan goals were sent with the resident upon a facility initiated transfer to the hospital on 6/10/18 and 7/27/18. Resident #26 was admitted to the facility on 3/14/18 and readmitted on 7/31/18 with diagnoses that included but were not limited to type two diabetes, dysphagia (difficulty swallowing), repeated falls, and cognitive communication deficit. Resident #26's most recent MDS (minimum data set) assessment was a significant change assessment with an ARD (assessment reference date) of 8/30/18. Resident #26 was coded as being severely impaired in cognitive function scoring 01 out of possible 15 on the BIMS (Brief Interview for Mental Status) exam.	F 622		

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F 622	Continued From page 13 Review of Resident #26's clinical record revealed that she had been transferred to the hospital on 6/10/18 at 2:39 p.m. The following nursing note in part was documented: "Resident observed laying on her back on floor by CNA (certified nursing assistant). Resident stated that she was trying to put herself to bed. .....Neuro checks WNL (within normal limits). B/P (blood pressure) elevated 186/108. NP (nurse practitioner) aware of fall and new order to given to send residents to ER (emergency room) to eval (evaluate) and treat. Daughter, (Name of Daughter) called. No answer. Message left to return call. Resident aware of new order given." The next note dated 6/10/18, documented that Resident #26's daughter was made aware of the transfer. Review of Resident #26's "Nursing Home to Hospital Transfer" form evidence that the following required information was sent with the resident upon transfer to the receiving provider: 1. Contact information of the practitioner responsible for the care of the patient 2. Resident representative information. 3. Advanced directives 4. All special instructions and precautions for ongoing care. There was no evidence that Resident #26's comprehensive care plan goals were sent to the receiving provider upon transfer to the hospital. Review of Resident #26's clinical record revealed that she was sent for the second time to the hospital on 7/27/18. The following note in part was documented: "Resident to be found on floor	F 622		

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F 622	Continued From page 14 at approximately 12 pm, the resident noted to be on her back, the resident had c/o (complaints) of sever (sic) during movements of left leg, (sic) MD (medical doctor) was notified, (sic) the MD assessed the resident and felt it was best if the resident be sent out for evaluation of the left legs (sic). Daughter was notified of transfer, Emergency services has been contacted, Will continue to monitor..." Review of Resident #26's "Nursing Home to Hospital Transfer" form evidence that the following required information was sent with the resident upon transfer to the receiving provider: 1. Contact information of the practitioner responsible for the care of the patient 2. Resident representative information. 3. Advanced directives 4. All special instructions and precautions for ongoing care. There was no evidence that Resident #26's comprehensive care plan goals were sent to the receiving provider upon transfer to the hospital. On 9/7/18 at 12:12 p.m., an interview was conducted with LPN (licensed practical nurse) #3. LPN #3 was asked what documents are sent with residents who are transferred to the hospital. LPN #3 stated that she would send a copy of the resident's face sheet, most updated history and physical, copy of POS (physician order summary), copy of the nursing notes describing the change or incident, applicable labs and diagnostics and copy of the MAR (Medication Administration Record) and TAR (Treatment Administration Record). LPN #3 stated that she also send a transfer notice and sends a copy of	F 622		

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F 622	Continued From page 15 that notice to the business office. When asked if nurses send a copy of the resident's care plan or care plan goals, LPN #3 stated, "No." On 9/7/18 at 3:26 p.m., ASM (administrative staff member) #1, the Executive Director and ASM #2, the DON (Director of Nursing) were made aware of the above concerns. The facility policy titled, "Transfers and Discharges" documents in part, the following: "Transfer responsibilities of Nursing: Resident should have the following sent with them at a minimum: facesheet, medication list, contact information of the practitioner for care of the resident, Resident representative information, Advanced Directive information, All special instructions or precautions for ongoing care, Comprehensive Care Plan Goals.." No further information was presented prior to exit. 2. The facility staff failed to evidence that Resident #40's comprehensive care plan goals were sent with the resident upon a facility initiated transfer to the hospital on 8/31/18. Resident #40 was admitted to the facility on 12/28/16 and readmitted on 5/30/17 with diagnoses that included but were not limited to atrial fibrillation, muscle weakness, and acute kidney failure. Resident #40's most recent MDS (minimum data set) assessment was a quarterly assessment with an ARD (assessment reference date) of 7/8/18. Resident #40 was coded as being moderately impaired in cognitive function scoring 08 out of possible 15 on the BIMS (Brief Interview for Mental Status) exam.	F 622		

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F 622	Continued From page 16 Review of Resident #40's clinical record revealed that he had been transferred to the hospital on 8/31/18. The following nursing notes were documented: "8/31/18 at 4:33 AM: resident (sic) c/o (complaint) headache 9/10 after given Percocet (1). resident's (sic) increased 220/105 manually, urine output WNL (within normal limits) heart rate regular, no nausea noted, pupils reactive. MD (medical doctor) made aware, new orders received for clonidine (2) 0.1 mg (milligrams) x 1. recheck (sic) BO after one and half hours. BP still increased to 230/110, c/o headache 8/10. MD made aware. new (sic) orders received for clonidine 0.1 mg one time. will (sic) check BP. resident (sic) started on ceftin (3) 8/30/18...will continue to monitor..."after (sic) second dose of clonidine 0.1 mg there was no change in headache or BP: 230/110. (Name of MD) made aware and rounded on resident, with new orders to send to ER (emergency room) for eval. (evaluation) and treatment of acute refractory headache and hypertension (high blood pressure)." Review of Resident #40's "Nursing Home to Hospital Transfer" form evidence that the following required information was sent with the resident upon transfer to the receiving provider: 1. Contact information of the practitioner responsible for the care of the patient 2. Resident representative information. 3. Advanced directives 4. All special instructions and precautions for ongoing care. There was no evidence that Resident #40's comprehensive care plan goals were sent to the receiving provider upon transfer to the hospital.	F 622		

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F 622	Continued From page 17 On 9/7/18 at 12:12 p.m., an interview was conducted with LPN (licensed practical nurse) #3. When asked if nurses send a copy of the resident's comprehensive care plan or care plan goals with residents transferred to the hospital, LPN #3 stated, "No." On 9/7/18 at 3:26 p.m., ASM (administrative staff member) #1, the Executive Director and ASM #2, the DON (Director of Nursing) were made aware of the above concerns. No further information was presented prior to exit. (1) Percocet - Opioid analgesic indicated for the relief of moderate to moderately severe pain. This information was obtained from The National Institutes of Health https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=0a446947-2cda-4a32-aa6a-53e09245825a. (2) Clonidine is used to treat high blood pressure. This information was obtained from The National Institutes of Health. https://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0009680/?report=details. (3) Ceftin is a cephalosporin antibiotic used to treat infections. This information was obtained from The National Institutes of Health. https://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0009522/?report=details. (4) Pylenonephritis- Kidney infection is a type of urinary tract infection (UTI) that commonly begins in the bladder and moves upstream to one or both of the kidneys. This information was obtained from National Institutes of Health.	F 622		

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https://www.niddk.nih.gov/health-information/urologic-diseases/kidney-infection-pyelonephritis.
3. The facility staff failed to provide evidence that the comprehensive care plan goals were sent with the resident upon a facility initiated transfer to the hospital on 07/05/18, for Resident # 42.

Resident # 42 was admitted to the facility on 04/03/13 and a readmission of 07/08/18 with diagnoses that included but were not limited to heart failure, gastroesophageal reflux disease (1), atrial fibrillation, (2), and osteoarthritis (3).

Resident # 42's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 07/11/18, coded Resident # 42 as scoring a 15 on the brief interview for mental status (BIMS) of a score of 0 - 15, 15 - being cognitively intact for making daily decisions.

The nurse's "Progress Notes" for Resident # 42 dated 07/05/18 at 4:56 p.m., documented, "Resident with altered mental status, alert but confused and paranoid with visual hallucinations, irregular lab (laboratory) work as of today. VS (vital signs) 98.0 (temperature), 125/68 (125 over 68 -blood pressure), O2 SAT (oxygen saturation) 90% on 2L (two liters). Resque [sic] Squad notified at 1700 (5:00 p.m.). Resident's daughter-in-law, (Name of Daughter-in-law) notified by NP (nurse practitioner), (Name of Nurse Practitioner). Resident did fall out of bed on 7/1/18 without any apparent injuries. Resque [sic] squad here at 1715 (5:15 p.m.), to transport to (Name of Hospital)."

Review of the facility's transfer form entitled "NURSING HOME TO HOSPITAL TRANSFER

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F 622	Continued From page 19 FORM" dated 07/05/18 for Resident # 42 failed to evidence the resident's comprehensive care plan goals as part of the transfer paperwork. On 9/7/18 at 12:12 p.m., an interview was conducted with LPN (licensed practical nurse) #3. When asked if nurses send a copy of the resident's comprehensive care plan or care plan goals with residents transferred to the hospital, LPN #3 stated, "No." On 09/06/18 at approximately 3:26 p.m. ASM (administrative staff member) #1, the executive director, ASM #2, the director of nursing, were made aware of the findings. No further information was provided prior to exit. References: (1) Stomach contents to leak back, or reflux, into the esophagus and irritate it. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/gerd.html. (2) A problem with the speed or rhythm of the heartbeat. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/atrialfibrillation.html. (3) The most common form of arthritis. It causes pain, swelling, and reduced motion in your joints. It can occur in any joint, but usually it affects your hands, knees, hips or spine. This information was obtained from the website: https://medlineplus.gov/osteoarthritis.html. 4. The facility staff failed to provide evidence that the comprehensive care plan goals were sent	F 622		

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F 622	Continued From page 20	F 622		

with the resident upon a facility initiated transfer to the hospital on 7/10/18, for Resident #59.

Resident #59 was admitted to the facility on 3/25/15, with a most recent readmission of 7/12/18, with diagnoses that included but were not limited to: heart failure, stroke, Bell's palsy (weakness and paralysis of one side of the face) (1), high blood pressure, diabetes, and arthritis.

The most recent MDS (minimum data set) assessment, an annual assessment, with an assessment reference date of 7/20/18, coded the resident as scoring a "15" on the BIMS (brief interview for mental status) score, indicating the resident is cognitively intact for daily decision making.

The physician's note dated 7/10/18 [no time documented] stated, "Patient seen today for follow up on weight increase [and] SOB (shortness of breath) increase."

The nurse practitioner's telephone order dated 7/10/18 [no time documented] stated, "Send Resident to [hospital's name] for eval (evaluation) R/t (related to) SOB (shortness of breath)."

Review of the clinical record failed to evidence that Resident #59's comprehensive care plan or care plan goals were sent with him upon transfer to the hospital.

On 9/7/18 at 12:12 p.m., an interview was conducted with LPN (licensed practical nurse) #3. When asked if a copy of the resident's comprehensive care plan or care plan goals are sent with residents transferred to the hospital, LPN #3 stated, "No."

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F 622	Continued From page 21 On 9/7/18 at 3:26 p.m., ASM (administrative staff member) #1, the executive director, and ASM #2, the director of nursing, were made aware of the above findings. The nursing notes, as well as the resident transfer form, for date of service 7/10/18 were requested but were not received prior to surveyor's exit on 9/7/18 at 5:15 p.m. No further information was provided prior to exit. 1) This information was obtained from the National Institutes of Health at https://medlineplus.gov/bellspalsy.html 5. The facility staff failed to evidence that all of the required documentation, including but not limited to, the physician's order for transfer, the physician's note regarding transfer, and the comprehensive care plan or care plan goals were sent with Resident #58 upon transfer to the hospital. Resident #58 was admitted to the facility on 3/14/18, with a most recent readmission of 7/12/18, with diagnoses that included but were not limited to: atrial fibrillation (an abnormality of the speed and rhythm of a heart beat) (1), high blood pressure, diabetes, muscle weakness and history of a hip fracture in March 2018. The most recent MDS (minimum data set) assessment, a significant change assessment, with an assessment reference date of 8/20/18, coded the resident as scoring an "8" on the BIMS	F 622		

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F 622	Continued From page 22 (brief interview for mental status) score, indicating the resident is moderately impaired for daily decision making. The nursing note dated 7/12/18 at 4 p.m. stated, "Resident complains of feeling like he is dying, respirations labored, sat 89 [%] on room air, wheezes noted bilaterally, oxygen applied to [sic] at 2l (liter) per minute. NP (nurse practitioner) was in and recommended [sic] be sent to be evaluated, alert, heart rate regular, son called and informed of situation, pt (patient) to be sent to [hospital's name] via squad." Review of the clinical record failed to evidence that all of the required documentation, including but not limited to, the physician's order for transfer, the physician's note regarding transfer, and the comprehensive care plan or comprehensive care plan goals were sent with Resident #58 upon transfer to the hospital. On 9/7/18 at 12:12 p.m., an interview was conducted with LPN (licensed practical nurse) #3. LPN #3 was asked what documents are sent with residents who are transferred to the hospital. LPN #3 stated that she would send a copy of the resident's face sheet, most updated history and physical, copy of POS (physician order summary), copy of the nursing notes describing the change or incident, applicable labs and diagnostics and copy of the MAR (Medication Administration Record) and TAR (Treatment Administration Record). LPN #3 stated that she also send a transfer notice and sends a copy of that notice to the business office. When asked if nurses send a copy of the resident's care plan or care plan goals, LPN #3 stated, "No."	F 622		

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F 622	Continued From page 23 On 9/7/18 at 3:26 p.m., ASM (administrative staff member) #1, the executive director, and ASM #2, the director of nursing, were made aware of the above findings. No further information was provided prior to exit. 1) This information was obtained from the National Institutes of Health at https://medlineplus.gov/atrialfibrillation.html 6. The facility staff failed to provide evidence that the comprehensive care plan goals were sent with the resident upon a facility initiated transfer to the hospital on 7/21/18, for Resident #88. Resident #88 was admitted to the facility on 5/7/16, with a most recent readmission of 7/27/18, with diagnoses that included but were not limited to: stroke, paralysis secondary to stroke, muscle weakness, difficulty speaking, difficulty swallowing, hypertension, and dementia. The most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 8/12/18, coded the resident as rarely- never being able to make himself understood as well as rarely- never understanding others. The nurse practitioner's telephone order dated 7/21/18 [no time documented] stated, "Send Resident to ED (emergency department) for eval (evaluation)/treatment." The nursing note dated 7/21/18 at 12:31 p.m. documented in part, "Resident noted to have diminished respirations, clammy and appears to be in distress. Lung sounds diminished with	F 622		

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F 622	Continued From page 24 rhales [sic] (rales are small clicking, bubbling, or rattling sounds in the lungs which could indicate inflammation of the lungs) (1) bilaterally ...NP (nurse practitioner) notified and new order obtained for resident to be sent to ED for evaluation and treatment." Review of the clinical record failed to evidence that Resident #88's comprehensive care plan or comprehensive care plan goals were sent with him upon transfer to the hospital. On 9/7/18 at 12:12 p.m., an interview was conducted with LPN (licensed practical nurse) #3. When asked if nurses send a copy of the resident's comprehensive care plan or care plan goals with residents transferred to the hospital, LPN #3 stated, "No." On 9/7/18 at 3:26 p.m., ASM (administrative staff member) #1, the executive director, and ASM #2, the director of nursing, were made aware of the above findings. No further information was provided prior to exit. 1) This information was obtained from the National Institutes of Health athttps://medlineplus.gov/ency/article/007535.htm 7. Resident #97 was transferred and admitted to the hospital on 5/23/18, 6/11/18, and 7/28/18. There was no evidence in the clinical record that all required documentation including the comprehensive care plan or comprehensive care plan goals were provided to the receiving hospital for each facility initiated transfer. Resident #97 was admitted to the facility on	F 622		

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F 622	Continued From page 25 4/30/18 with the diagnoses of but not limited to pulmonary embolism, atrial fibrillation, sepsis, congestive heart failure, hypoxemia, and surgical aftercare. The quarterly MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 8/7/18 coded the resident as being cognitively intact in ability to make daily life decisions. A nurse's note dated 5/23/18 documented, "MD (medical doctor) in room this AM to assess patients. Resident was diaphoretic and SOB (shortness of breath). Lungs with rales and diminished right base. Assessed again by nurse and O2 (oxygen) sats (saturation) were 78% on 2l (two liters) O2 via nasal cannula, O2 was increased to 3l. continues {sic} to be short of breath and complains of dizziness and weakness. (name of son) called and notified of condition and of decision to send patient to hospital. Squad called and resident sent to (name of hospital) for further evaluation." A physician's note dated 5/23/18 documented, "When I walked into the room to check on her roommate, (Resident #97) was obviously tachypneic and diaphoretic. She reported symptoms of mild nausea, feeling bad, feeling somewhat short of breath. Heart rate was 115 to 118, respiratory rate in the mid 20's and O2 saturation 93% on 2 L/m by nasal cannula; by the nurses at the end of my initial evaluation vital signs were as follows: Blood pressure 141/74, heart rate 105, Respiratory rate 24, Temperature 96.8...Plan: She needs evaluation to clarify the reason for acute tachypnea, tachycardia, and diaphoresis with potential etiologies including urologic causes, PE (pulmonary embolism). Transfer to the ER (emergency room) for urgent evaluation."	F 622		

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F 622	Continued From page 26 A review of the Nursing Home to Hospital Transfer Form dated 5/23/18 failed to reveal any evidence Resident #97's comprehensive care plan goals were provided to the hospital. A review of the clinical record revealed a nurse's note dated 6/11/18 that documented, "Patient felt drowsy, denied any pain, and she stated, "I just don't feel right." Her VS (vital signs) at the beginning of the shift was 98.7-105-16-126/74-96% (temperature-pulse-respirations-blood pressure-oxygen saturation). After making the statement that she did not feel well a new set of VS was obtained at 5:30pm and were 98.2 (temperature)-76/50 (manually) (blood pressure)-26 (respirations)-98% 5L (oxygen saturation on 5 liters). MD (medical doctor) notified and assessed patient. He feels that based on her history that she may be presenting with pleural effusions. Order obtained to send patient to the ED (Emergency Department) for evaluation. Son notified." A physician's note dated 6/11/18 documented, "Patient seen today for dropping B/P (blood pressure) increase pleural effusions, etc. Pt (patient) to be sent to ER (emergency room) for further eval (evaluation)." A review of the Nursing Home to Hospital Transfer Form dated 6/11/18 failed to reveal any evidence of the comprehensive care plan goals being provided to the hospital. A review of the nurse's notes revealed one dated 7/28/18 that documented, "This nurse was notified by CNA (certified nursing assistant) that	F 622		

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Resident was clammy and not responding. Resident c/o (complained of) dizziness, hard to focus on anything, and nausea. Periods of hypotension (low blood pressure) this am. MD notified with new orders to send for evaluation. Son (name of son) notified but yet to be contacted. 911 activated."

A review of the Nursing Home to Hospital Transfer Form dated 7/28/18 failed to reveal any evidence of the comprehensive care plan goals being provided to the hospital.

On 9/7/18 at 12:12 p.m., an interview was conducted with LPN (licensed practical nurse) #3. LPN #3 was asked what documents are sent with residents who are transferred to the hospital. LPN #3 stated that she would send a copy of the resident's face sheet, most updated history and physical, copy of POS (physician order summary), copy of the nursing notes describing the change or incident, applicable labs and diagnostics and copy of the MAR (Medication Administration Record) and TAR (Treatment Administration Record). LPN #3 stated that she also send a transfer notice and sends a copy of that notice to the business office. When asked if nurses send a copy of the resident's care plan or care plan goals, LPN #3 stated, "No."

On 9/7/18 at 3:26 PM in a meeting with ASM #1 (Administrative Staff Member - the Executive Director) and ASM #2 (the Director of Nursing) they were made aware of the findings. No further information was provided by the end of the survey.

8. Resident #94 was transferred and admitted to

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F 622	Continued From page 28 the hospital on 7/27/18 and 8/8/18. There was no evidence in the clinical record that all required documentation including the comprehensive care plan and comprehensive care plan goals were provided to the receiving hospital for each facility initiated transfer. Resident #94 was admitted to the facility on 6/28/18 with the diagnoses of but not limited to orthopedic aftercare, ischemic heart disease, high blood pressure, and chronic kidney disease. The admission/5-day MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 7/5/18 coded the resident as being cognitively intact in ability to make daily life decisions. A review of the clinical record revealed the following nurses notes: 7/26/18 at 1:09 PM: "....Res (resident) presented this am with nausea and vomiting, Res did not want to go to ER. (emergency room). went to prior sched (scheduled) ortho (orthopedic) apt (appointment) and is to have labs [laboratory test] drawn there....Tremors remain at this time....Brother made aware....cont (continue) to assess. MD (medical doctor) was aware, decided best course of reatment {sic}." 7/27/18 at 9:54 AM: "....Resident was alert and oriented at beginning of shift this AM. Later morning resident became very lethargic and was having a hard time staying awake. MD was notified and resident was assessed. Had started promethazine {1} and Norco {2} this AM. and lethargy was noted to be related to medication changes....Lungs with slight crackles bilaterally. O2 (oxygen) sats were 86% on room air. 95% on 2l (two liters of oxygen) via nasal cannula....Addendum: Resident continues with	F 622		

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F 622	Continued From page 29 extreme lethargy at this time with continued need for supplemental O2. Reassessed by MD and orders given to sent to ER for further evaluation. Brother was notified. Addendum: Resident was admitted to (hospital) for acute kidney injury." A physician's note dated 7/26/18 documented, "Follow up on heart failure and weight, renal function. (Have been following him daily)....now being seen earlier because of vomiting....Recent history is being reiterated for the benefit of ER and hospital personnel. After hospitalizations he typically has problems afterward with increased fluid retention, etiology not entirely clear. Most recent hospitalization was late June because of right femoral trochanter fracture treated nonoperatively, followed by transfer here June 28....Plan: 1. Onset vomiting yesterday morning after breakfast and today...significant underlying renal and cardiovascular issues....2: With the emesis, I think he needs labs more urgently than we will have available from blood specimen sent this morning. I will make arrangements for him to transfer to the ER...." A review of the Nursing Home to Hospital Transfer Form dated 7/27/18 failed to reveal any evidence of the comprehensive care plan goals being provided to the hospital. A nurse's note dated 8/8/18 at 1:30 PM documented, "Resident with increasing tremors throughout today. Temp (temperature) this AM was 98. is {sic} now 102.1. Heart rate of 151. Respirations 32. NP (nurse practitioner) notified of changes. Resident sent to (name of hospital) ER (emergency room). Family notified. Squad arrived at 1:30 PM."	F 622		

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F 622	Continued From page 30 A review of the Nursing Home to Hospital Transfer Form dated 8/8/18 failed to reveal any evidence of the comprehensive care plan goals being provided to the hospital. On 9/7/18 at 12:12 p.m., an interview was conducted with LPN (licensed practical nurse) #3. LPN #3 was asked what documents are sent with residents who are transferred to the hospital. LPN #3 stated that she would send a copy of the resident's face sheet, most updated history and physical, copy of POS (physician order summary), copy of the nursing notes describing the change or incident, applicable labs and diagnostics and copy of the MAR (Medication Administration Record) and TAR (Treatment Administration Record). LPN #3 stated that she also send a transfer notice and sends a copy of that notice to the business office. When asked if nurses send a copy of the resident's care plan or care plan goals, LPN #3 stated, "No." On 9/7/18 at 3:26 PM in a meeting with ASM #1 (Administrative Staff Member - the Executive Director) and ASM #2 (the Director of Nursing) they were made aware of the findings. No further information was provided by the end of the survey. {1} Promethazine - "Promethazine is also used to prevent and control nausea and vomiting that may occur after surgery, and with other medications to help relieve pain after surgery. Promethazine is also used to prevent and treat motion sickness. Promethazine helps control symptoms, but will not treat the cause of the symptoms or speed recovery..." Information obtained from	F 622		

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F 622	Continued From page 31 https://medlineplus.gov/druginfo/meds/a682284.html {2} Norco - Hydrocodone and acetaminophen combination is used to relieve moderate to moderately severe pain. Information obtained from https://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0010590/	F 622		
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 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	F 623	F 623 1. How will the corrective action be accomplished for those residents found to have been affected by the deficient practice? Business office staff sent notification of Transfer/Discharge to the responsible party and long term care ombudsman on 9/25/18 for Resident #26 transfer to hospital 6/10/18 and 7/27/18. Resident #40 transfer to hospital 8/31/18. Resident #42 transfer to hospital 7/5/18. Resident #59 transfer to hospital 7/10/18. Resident #58 transfer to hospital 7/12/18. Resident #88 transfer to hospital 7/21/18. Resident #97 transfer to hospital 5/23/18, 6/11/18, and 7/28/18. Resident #94 transfer to hospital 7/27/18 and 8/8/18.	10/15/18

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F 623	Continued From page 32 be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State 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	F 623	Continue from page 32 2. How will the facility identify other residents having the potential to be affected by the same practice? Any resident transferred to hospital from facility has the potential to be affected by this practice. •Director of Nursing, Assistant Director of Nursing, Business office Manager, and/or Executive Director to audit all transfers/ discharges since September 1, 2018, to ensure the resident and/or the resident's representative were notified in writing of transfers or discharges to include the reason for transfer or discharge. •Director of Nursing, Assistant Director of Nursing, Business office, and/or Executive Director to audit all transfers/discharges since September 1, 2018, to ensure the State Long-Term Care Ombudsman were notified in writing of transfers or discharges to include the reason for transfer or discharge.	

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F 623	Continued From page 33 and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, and clinical record review, it was determined that facility staff failed to evidence written notification to the RP (responsible party) and the long term care ombudsman for a facility initiated transfer to the hospital for eight of 42 residents in the survey sample, Resident #26, #40, #42, #59, #58, #88, #97 and #94. 1. The facility staff failed to evidence written	F 623	Continue from page 33 3. What measures will be put into place or systematic changes made to ensure the practice will not reoccur? •By 10/8/18, Staff Development Coordinator will in-service Licensed Nurses on completing Notice of Resident Transfer or Discharge and giving it to business office. •By 10/8/18, Staff Development Coordinator will in-service Business office staff to assure Notice of Resident Transfer or Discharge to be sent to resident and/or the resident's representative and State Long-Term Care Ombudsman. Any Licensed Nurses and Business office staff that has not been in-serviced by 10/8/18 will not be allowed to provide care until in-service completed. All newly hired Licensed Nurses and Business office staff will receive education during orientation on Notice of Resident Transfer or Discharge to be sent to resident and/or the resident's representative and State Long-Term Care Ombudsman.	

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F 623	Continued From page 34 notification to the responsible party and long term care ombudsman for Resident #26's facility initiated transfer to the hospital on 6/10/18 and 7/27/18. 2. The facility staff failed to evidence written notification to the responsible party and long term care ombudsman for Resident #40's facility initiated transfer to the hospital on 8/31/18. 3. The facility staff failed to provide Resident # 42 or the resident's representative and the ombudsman written notification of the facility initiated transfer to the hospital on 07/05/18. 4. The facility staff failed to provide written notification to the Resident/Responsible Representative and the ombudsman of the facility initiated transfer to the hospital on 7/10/18, for Resident #59. 5. The facility staff failed to provide written notification to the Resident/Responsible Representative and the ombudsman of the facility initiated transfer to the hospital on 7/12/18, for Resident #58. 6. The facility staff failed to provide written notification to the Resident/Responsible Representative and the ombudsman of the facility initiated transfer to the hospital on 7/21/18, for Resident #88. 7. Resident #97 was transferred and admitted to the hospital on 5/23/18, 6/11/18, and 7/28/18. There was no evidence in the clinical record evidencing that the Ombudsman and/or the Resident Representative was notified, in writing, of the facility initiated hospital transfers.	F 623	Continue from page 34 Business office Manager will evaluate facility initiated transfers to assure Notice of Resident Transfer or Discharge was sent to resident and/or the resident's representative and State Long-Term Care Ombudsman 5 times a week x 30days, 3 times a week x30days, 1 time a week x30days. 4. How will the facility monitoring the corrective plan to ensure the deficient practice was corrected and not reoccur? Director of nursing will present findings of audit accurate assessment findings to the Quality Assurance Performance Improvement committee for review and recommendations for 90 days. The QAPI committee consist of Executive Director, Director of Nursing, Assistant Director of Nursing, Social Services, Activities, Dietary Manager, Pharmacy consultant, Medical Director.	

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F 623	Continued From page 35 8. Resident #94 was transferred and admitted to the hospital, on 7/27/18, and 8/8/18. There was no evidence in the clinical record evidencing that the Ombudsmand and/or the Resident Representative was notified, in writing, of the facility initiated hospital transfers. The findings include: 1. The facility staff failed to evidence written notification to the responsible party and long term care ombudsman for Resident #26's facility initiated transfer to the hospital on 6/10/18 and 7/27/18. Resident #26 was admitted to the facility on 3/14/18 and readmitted on 7/31/18 with diagnoses that included but were not limited to type two diabetes, dysphagia (difficulty swallowing), repeated falls, and cognitive communication deficit. Resident #26's most recent MDS (minimum data set) assessment was a significant change assessment with an ARD (assessment reference date) of 8/30/18. Resident #26 was coded as being severely impaired in cognitive function scoring 01 out of possible 15 on the BIMS (Brief Interview for Mental Status) exam. Review of Resident #26's clinical record revealed that she had been transferred to the hospital on 6/10/18 at 2:39 p.m. The following nursing note was documented: "NP (nurse practitioner) aware of fall and new order to given to send residents to ER (emergency room) to eval (evaluate) and treat. Daughter, (Name of Daughter) called. No answer. Message left to return call. Resident	F 623		

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F 623	Continued From page 36 aware of new order given." The next note dated 6/10/18, documented that Resident #26's daughter was made aware of the transfer. There was no evidence that written notification was provided to the responsible party and the long term care ombudsman documenting the reason for Resident #26's transfer to the hospital. Review of Resident #26's clinical record revealed that she was readmitted to the facility on 6/10/18 at 7:12 p.m. with no new orders. Review of Resident #26's clinical record revealed that she was sent for the second time to the hospital on 7/27/18. The following note was documented: "Resident to be found on floor at approximately 12 pm, the resident noted to be on her back, the resident had c/o (complaints) of sever (sic) during movements of left leg, (sic) MD (medical doctor) was notified, (sic) the MD assessed the resident and felt it was best if the resident be sent out for evaluation of the left legs (sic). Daughter was notified of transfer, Emergency services has been contacted, Will continue to monitor..." There was no evidence that written notification was provided to the responsible party and the long term care ombudsman documenting the reason for Resident #26's transfer to the hospital on 7/27/18. On 9/7/18 at 8:39 a.m., an interview was conducted with OSM (other staff member) #12, the social worker regarding her role when a resident is sent out to the hospital. OSM #12 stated that she did not have a role. OSM #12	F 623		

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F 623	Continued From page 37 stated that she did not notify the long term care ombudsman for a transfer to the hospital. OSM #12 stated that social services did not provide written notification to the responsible party documenting the reason for hospital transfer. On 9/7/18 at 9:11 a.m., an interview was conducted with OSM #11, the Director of Social Services. OSM #11 stated that the ombudsman was only notified of a hospital transfer if the resident was not expected back to the facility. OSM #11 stated that the receptionist notified the long term care ombudsman. On 9/7/18 at 10:12 a.m., an interview was conducted with OSM #9, the receptionist. OSM #9 stated that sometime in June she had stopped notifying the long term care ombudsman regarding hospital transfers. OSM #9 provided a copy of an email from the long term care ombudsman dated 5/31/18, telling the facility only to notify their office if the resident does not return to the facility after a transfer to the hospital. OSM #9 stated that this was also when she stopped providing written notification to the RP for hospital transfers. A copy of an email from the local Ombudsman to the facility, dated 5/31/18, documented, "....The discharge notices are to be faxed to the State Ombudsman office at (phone number). They will then send them to me. If the discharge is a planned and initiated by the resident, such as persons who are there for therapy and going to go home, do not need a discharge notice. The do get all the information regarding doctor appts (appointments), DME (durable medical equipment) contact information and when home health is scheduled. These are the resident	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
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initiated. If the resident is "transferred" to the hospital it is expected they will return unless they choose not to return or the facility will not accept back. If that is the case a discharge notice is needed. The chart also need a note as to why sent and expected return "when ready." They also need the bed hold information. The notice the facility is using is fine, but do not mark one of the reasons if they are sent to the hospital and not being discharged."

On 9/7/18 at 12:12 p.m., an interview was conducted with LPN (licensed practical nurse) #3. When asked about the process staff follows when a resident is being transferred to the hospital, LPN #3 stated that she would first assess the resident, send the appropriate documents, and then notify the RP (responsible party). When asked how she would notify the RP, LPN #3 stated that she notifies the RP verbally. When asked if she notifies the RP in writing the reason for hospital transfer, LPN #3 stated that she wasn't entirely sure but thought that the business office provided that notification to the RP and long term care ombudsman. LPN #3 stated that the nurses did not provide written notification to the RP or long term care ombudsman.

On 9/7/18 at 3:26 p.m., ASM (administrative staff member) #1, the Executive Director, and ASM #2, the DON (Director of Nursing) were made aware of the above concerns.

The facility policy titled "Transfers and Dicharges" documents in part, the following: "The facility ensures that systems are in implemented to provide written notification to the resident and resident representative prior to transfer. This written notification is provided on the Notification

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F 623	Continued From page 39 of Discharge/Transfer form. This information will be presented in a language manner that the resident/resident/representative can understand...A copy of the notice of transfer/discharge will be sent to a representative of the Office of the State Long Term Care Ombudsman for all facility-initiated transfers or discharges." No further information was presented prior to exit. 2. The facility staff failed to evidence written notification to the responsible party and long term care ombudsman for Resident #40's facility initiated transfer to the hospital on 8/31/18. Resident #40 was admitted to the facility on 12/28/16 and readmitted on 5/30/17 with diagnoses that included but were not limited to atrial fibrillation, muscle weakness, and acute kidney failure. Resident #40's most recent MDS (minimum data set) assessment was a quarterly assessment with an ARD (assessment reference date) of 7/8/18. Resident #40 was coded as being moderately impaired in cognitive function scoring 08 out of possible 15 on the BIMS (Brief Interview for Mental Status) exam. Review of Resident #40's clinical record revealed that he had been transferred to the hospital on 8/31/18. The following nursing notes were documented: "8/31/18 at 4:33 AM: resident (sic) c/o (complaint) headache 9/10 after given Percocet (1). resident's (sic) increased 220/105 manually, urine output WNL (within normal limits)m heart rate regular, no nausea noted, pupils reactive. MD	F 623		

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(medical doctor) made aware, new orders received for clonidine (2) 0.1 mg (milligrams) x1. recheck (sic) BO after one and half hours. BP still increased to 230/110, c/o headache 8/10. MD made aware. new (sic) orders received for clonidine 0.1 mg one time. will (sic) check BP. resident (sic) started on ceftin (3) 8/30/18...will continue to monitor..." "after (sic) second dose of clonidine 0.1 mg there was no change in headache or BP: 230/110. (Name of MD) made aware and rounded on resident, with new orders to send to ER (emergency room) for eval. (evaluation) and treatment of acute refractory headache and hypertension (high blood pressure)."

There was no evidence that written notification was provided to the responsible party and the long term care ombudsman documenting the reason for Resident #40's transfer to the hospital on 8/31/18.

Further review of the clinical record revealed that Resident #40 returned to the facility on 9/1/18 with a diagnosis of acute pylenonephritis (4) (kidney infection).

On 9/7/18 at 8:39 a.m., an interview was conducted with OSM (other staff member) #12, the social worker regarding her role when a resident is sent out to the hospital. OSM #12 stated that she did not have a role. OSM #12 stated that she did not notify the long term care ombudsman for a transfer to the hospital. OSM #12 stated that social services did not provide written notification to the responsible party documenting the reason for hospital transfer.

On 9/7/18 at 9:11 a.m., an interview was

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F 623	Continued From page 41 conducted with OSM #11, the Director of Social Services. OSM #11 stated that the ombudsman was only notified of a hospital transfer if the resident was not expected back to the facility. OSM #11 stated that the receptionist notified the long term care ombudsman. On 9/7/18 at 10:12 a.m., an interview was conducted with OSM #9, the receptionist. OSM #9 stated that sometime in June she had stopped notifying the long term care ombudsman regarding hospital transfers. OSM #9 provided a copy of an email from the long term care ombudsman dated 5/31/18, telling the facility only to notify their office if the resident does not return to the facility after a transfer to the hospital. OSM #9 stated that this was also when she stopped providing written notification to the RP for hospital transfers. A copy of an email from the local Ombudsman to the facility, dated 5/31/18, documented, "....The discharge notices are to be faxed to the State Ombudsman office at (phone number). They will then send them to me. If the discharge is a planned and initiated by the resident, such as persons who are there for therapy and going to go home, do not need a discharge notice. The do get all the information regarding doctor appts (appointments), DME (durable medical equipment) contact information and when home health is scheduled. These are the resident initiated. If the resident is "transferred" to the hospital it is expected they will return unless they choose not to return or the facility will not accept back. If that is the case a discharge notice is needed. The chart also need a note as to why sent and expected return "when ready." They also need the bed hold information. The notice	F 623		

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F 623	Continued From page 42	F 623		

the facility is using is fine, but do not mark one of the reasons if they are sent to the hospital and not being discharged."

On 9/7/18 at 12:12 p.m., an interview was conducted with LPN (licensed practical nurse) #3. When asked about the process staff follows when a resident is being transferred to the hospital, LPN #3 stated that she would first assess the resident, send the appropriate documents, and then notify the RP (responsible party). When asked how she would notify the RP, LPN #3 stated that she notifies the RP verbally. When asked if she notifies the RP in writing the reason for hospital transfer, LPN #3 stated that she wasn't entirely sure but thought that the business office provided that notification to the RP and long term care ombudsman. LPN #3 stated that the nurses did not provide written notification to the RP or long term care ombudsman.

On 9/7/18 at 3:26 p.m., ASM (administrative staff member) #1, the Executive Director, and ASM #2, the DON (Director of Nursing) were made aware of the above concerns.

(1) Percocet - Opioid analgesic indicated for the relief of moderate to moderately severe pain. This information was obtained from The National Institutes of Health https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=0a446947-2cda-4a32-aa6a-53e09245825a.
(2) Clonidine is used to treat high blood pressure. This information was obtained from The National Institutes of Health. https://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0009680/?report=details.
(3) Ceftin is a cephalosporin antibiotic used to

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F 623	Continued From page 43 treat infections. This information was obtained from The National Institutes of Health. https://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0009522/?report=details. (4) Pylenonephritis- Kidney infection is a type of urinary tract infection (UTI) that commonly begins in the bladder and moves upstream to one or both of the kidneys. This information was obtained from National Institutes of Health. https://www.niddk.nih.gov/health-information/urologic-diseases/kidney-infection-pyelonephritis. 3. The facility staff failed to provide Resident # 42 or the resident's representative and the ombudsman written notification of the facility initiated transfer to the hospital on 07/05/18. Resident # 42 was admitted to the facility on 04/03/13 and a readmission of 07/08/18 with diagnoses that included but were not limited to heart failure, gastroesophageal reflux disease (1), atrial fibrillation, (2), and osteoarthritis (3). Resident # 42's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 07/11/18, coded Resident # 42 as scoring a 15 on the brief interview for mental status (BIMS) of a score of 0 - 15, 15 - being cognitively intact for making daily decisions. The nurse's "Progress Notes" for Resident # 42 dated 07/05/18 at 4:56 p.m., documented, "Resident with altered mental status, alert but confused and paranoid with visual hallucinations, irregular lab (laboratory) work as of today. VS (vital signs) 98.0 (temperature), 125/68 (125 over 68 -blood pressure), O2 SAT (oxygen saturation)	F 623		

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F 623	Continued From page 44 90% on 2L (two liters). Resque [sic] Squad notified at 1700 (5:00 p.m.). Resident's daughter-in-law, (Name of Daughter-in-law) notified by NP (nurse practitioner), (Name of Nurse Practitioner). Resident did fall out of bed on 7/1/18 without any apparent injuries. Resque [sic] squad here at 1715 (5:15 p.m.), to transport to (Name of Hospital)." On 9/7/18 at 10:12 a.m., an interview was conducted with OSM #9, the receptionist. OSM #9 stated that sometime in June she had stopped notifying the long term care ombudsman regarding hospital transfers. OSM #9 provided a copy of a letter from the long term care ombudsman dated 5/31/18 telling the facility only to notify their office if the resident does not return to the facility after a transfer to the hospital. OSM #9 stated that this was also when she stopped providing written notification to the RP for hospital transfers. A copy of an email from the local Ombudsman to the facility, dated 5/31/18, documented, "....The discharge notices are to be faxed to the State Ombudsman office at (phone number). They will then send them to me. If the discharge is a planned and initiated by the resident, such as persons who are there for therapy and going to go home, do not need a discharge notice. The do get all the information regarding doctor appts (appointments), DME (durable medical equipment) contact information and when home health is scheduled. These are the resident initiated. If the resident is "transferred" to the hospital it is expected they will return unless they choose not to return or the facility will not accept back. If that is the case a discharge notice is needed. The chart also need a note as to why	F 623		

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F 623	Continued From page 45 sent and expected return "when ready." They also need the bed hold information. The notice the facility is using is fine, but do not mark one of the reasons if they are sent to the hospital and not being discharged." On 9/7/18 at 12:12 p.m., an interview was conducted with LPN (licensed practical nurse) #3. When asked about the process staff follows when a resident is being transferred to the hospital, LPN #3 stated that she would first assess the resident, send the appropriate documents, and then notify the RP (responsible party). When asked how she would notify the RP, LPN #3 stated that she notifies the RP verbally. When asked if she notifies the RP in writing the reason for hospital transfer, LPN #3 stated that she wasn't entirely sure but thought that the business office provided that notification to the RP and long term care ombudsman. LPN #3 stated that the nurses did not provide written notification to the RP or long term care ombudsman. On 09/06/18 at approximately 3:26 p.m. ASM (administrative staff member) #1, the executive director, ASM #2, the director of nursing, were made aware of the findings. No further information was provided prior to exit. References: (1) Stomach contents to leak back, or reflux, into the esophagus and irritate it. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/gerd.html. (2) A problem with the speed or rhythm of the heartbeat. This information was obtained from the website:	F 623		

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F 623	Continued From page 46 https://www.nlm.nih.gov/medlineplus/atrialfibrillation.html. (3) The most common form of arthritis. It causes pain, swelling, and reduced motion in your joints. It can occur in any joint, but usually it affects your hands, knees, hips or spine. This information was obtained from the website: https://medlineplus.gov/osteoarthritis.html. 4. The facility staff failed to provide written notification to the Resident/Responsible Representative and the ombudsman of the facility initiated transfer to the hospital on 7/10/18, for Resident #59. Resident #59 was admitted to the facility on 3/25/15, with a most recent readmission of 7/12/18, with diagnoses that included but were not limited to: heart failure, stroke, Bell's palsy (weakness and paralysis of one side of the face) (1), high blood pressure, diabetes, and arthritis. The most recent MDS (minimum data set) assessment, an annual assessment, with an assessment reference date of 7/20/18, coded the resident as scoring a "15" on the BIMS (brief interview for mental status) score, indicating the resident is cognitively intact for daily decision making. The physician's note dated 7/10/18 [no time documented] stated, "Patient seen today for follow up on weight increase [and] SOB (shortness of breath) increase." The nurse practitioner's telephone order dated 7/10/18 [no time documented] stated, "Send Resident to [hospital's name] for eval (evaluation)	F 623		

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F 623	Continued From page 47 R/t (related to) SOB (shortness of breath)." A review of the clinical record failed to evidence that written notification was provided to the Resident/Responsible Representative and the ombudsman for Resident #59's transfer to the hospital on 7/10/18. An interview was conducted on 9/7/18 at 8:47 a.m. with OSM (other staff member) #11, the director of social services. OSM #11 stated that the nursing staff provides the information regarding resident transfers to the hospital to OSM #9, the receptionist. OSM #9 then faxes the information to the ombudsman. An interview was conducted on 9/7/18 at 9:39 a.m. with OSM #10, the business office manager. OSM #10 stated the facility was faxing information to the ombudsman until about "early June" but that the ombudsman asked the facility only to send discharges from the facility to her. At that time, OSM # 10 stated that they also stopped providing written notification of transfer to a facility to the resident and responsible representative. She stated OSM #9 was responsible for faxing the information to the ombudsman "Up until about the first of June". On 9/7/18 at 12:12 p.m., an interview was conducted with LPN (licensed practical nurse) #3. When asked about the process staff follows when a resident is being transferred to the hospital, LPN #3 stated that she would first assess the resident, send the appropriate documents, and then notify the RP (responsible party). When asked how she would notify the RP, LPN #3 stated that she notifies the RP verbally. When asked if she notifies the RP in writing the reason	F 623		

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F 623	Continued From page 48 for hospital transfer, LPN #3 stated that she wasn't entirely sure but thought that the business office provided that notification to the RP and long term care ombudsman. LPN #3 stated that the nurses did not provide written notification to the RP or long term care ombudsman. An interview was conducted on 9/7/18 at 10:12 a.m. with OSM #9, the receptionist. OSM #9 confirmed she was faxing information regarding transfers to a facility to the ombudsman until the beginning of June but that the ombudsman requested that she only be sent discharges and not transfers. OSM #9 stated she was not responsible for sending any notification to the resident or responsible party. On 9/7/18 at 3:26 p.m., ASM (administrative staff member) #1, the executive director, and ASM #2, the director of nursing, were made aware of the above findings. No further information was provided prior to exit. 1) This information was obtained from the National Institutes of Health at https://medlineplus.gov/bellspalsy.html 5. The facility staff failed to provide written notification to the Resident/Responsible Representative and the ombudsman of the facility initiated transfer to the hospital on 7/12/18, for Resident #58. Resident #58 was admitted to the facility on 3/14/18, with a most recent readmission of 7/12/18, with diagnoses that included but were not limited to: atrial fibrillation (an abnormality of	F 623		

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the speed and rhythm of a heart beat) (1), high blood pressure, diabetes, muscle weakness and history of a hip fracture in March 2018.

The most recent MDS (minimum data set) assessment, a significant change assessment, with an assessment reference date of 8/20/18, coded the resident as scoring an "8" on the BIMS (brief interview for mental status) score, indicating the resident is moderately impaired for daily decision making.

The nursing note dated 7/12/18 at 4 p.m. stated, "Resident complains of feeling like he is dying, respirations labored, sat 89 [%] on room air, wheezes noted bilaterally, oxygen applied to [sic] at 2l (liter) per minute. NP (nurse practitioner) was in and recommended [sic] be sent to be evaluated, alert, heart rate regular, son called and informed of situation, pt (patient) to be sent to [hospital's name] via squad."

A review of the clinical record failed to evidence that written notification was provided to the Resident/Responsible Representative and the ombudsman of the Resident's transfer to the hospital.

An interview was conducted on 9/7/18 at 8:47 a.m. with OSM (other staff member) #11, the director of social services. OSM #11 stated that the nursing staff provides the information regarding resident transfers to the hospital to OSM #9, the receptionist. OSM #9 then faxes the information to the ombudsman.

An interview was conducted on 9/7/18 at 9:39 a.m. with OSM #10, the business office manager. OSM #10 stated the facility was faxing

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information to the ombudsman until about "early June" but that the ombudsman asked the facility only to send discharges from the facility to her. At that time, OSM # 10 stated that they also stopped providing written notification of transfer to a facility to the resident and responsible representative. She stated OSM #9 was responsible for faxing the information to the ombudsman "Up until about the first of June".

On 9/7/18 at 12:12 p.m., an interview was conducted with LPN (licensed practical nurse) #3. When asked about the process staff follows when a resident is being transferred to the hospital, LPN #3 stated that she would first assess the resident, send the appropriate documents, and then notify the RP (responsible party). When asked how she would notify the RP, LPN #3 stated that she notifies the RP verbally. When asked if she notifies the RP in writing the reason for hospital transfer, LPN #3 stated that she wasn't entirely sure but thought that the business office provided that notification to the RP and long term care ombudsman. LPN #3 stated that the nurses did not provide written notification to the RP or long term care ombudsman.

On 9/7/18 at 3:26 p.m., ASM (administrative staff member) #1, the executive director, and ASM #2, the director of nursing, were made aware of the above findings.

No further information was provided prior to exit.

1) This information was obtained from the National Institutes of Health at https://medlineplus.gov/atrialfibrillation.html

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F 623	Continued From page 51 6. The facility staff failed to provide written notification to the Resident/Responsible Representative and the ombudsman of the facility initiated transfer to the hospital on 7/21/18, for Resident #88. Resident #88 was admitted to the facility on 5/7/16, with a most recent readmission of 7/27/18, with diagnoses that included but were not limited to: stroke, paralysis secondary to stroke, muscle weakness, difficulty speaking, difficulty swallowing, hypertension, and dementia. The most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 8/12/18, coded the resident as rarely- never being able to make himself understood as well as rarely - never understanding others. The nurse practitioner's telephone order dated 7/21/18 [no time documented] stated, "Send Resident to ED (emergency department) for eval (evaluation)/treatment." The nursing note dated 7/21/18 at 12:31 p.m. documented in part, "Resident noted to have diminished respirations, clammy and appears to be in distress. Lung sounds diminished with rhales [sic] (rales are small clicking, bubbling, or rattling sounds in the lungs which could indicate inflammation of the lungs) (1) bilaterally ...NP (nurse practitioner) notified and new order obtained for resident to be sent to ED (emergency department)for evaluation and treatment." A review of the clinical record failed to evidence that written notification was provided to the	F 623		

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F 623	Continued From page 52 Resident/Responsible Representative and the ombudsman of the Resident's transfer to the hospital. An interview was conducted on 9/7/18 at 8:47 a.m. with OSM (other staff member) #11, the director of social services. OSM #11 stated that the nursing staff provides the information regarding resident transfers to the hospital to OSM #9, the receptionist. OSM #9 then faxes the information to the ombudsman. An interview was conducted on 9/7/18 at 9:39 a.m. with OSM #10, the business office manager. OSM #10 stated the facility was faxing information to the ombudsman until about "early June" but that the ombudsman asked the facility only to send discharges from the facility to her. At that time, OSM # 10 stated that they also stopped providing written notification of transfer to a facility to the resident and responsible representative. She stated OSM #9 was responsible for faxing the information to the ombudsman "Up until about the first of June". On 9/7/18 at 12:12 p.m., an interview was conducted with LPN (licensed practical nurse) #3. When asked about the process staff follows when a resident is being transferred to the hospital, LPN #3 stated that she would first assess the resident, send the appropriate documents, and then notify the RP (responsible party). When asked how she would notify the RP, LPN #3 stated that she notifies the RP verbally. When asked if she notifies the RP in writing the reason for hospital transfer, LPN #3 stated that she wasn't entirely sure but thought that the business office provided that notification to the RP and long term care ombudsman. LPN #3 stated that the	F 623		

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F 623	Continued From page 53 nurses did not provide written notification to the RP or long term care ombudsman. On 9/7/18 at 3:26 p.m., ASM (administrative staff member) #1, the executive director, and ASM #2, the director of nursing, were made aware of the above findings. No further information was provided prior to exit. 1) This information was obtained from the National Institutes of Health at https://medlineplus.gov/ency/article/007535.htm 7. Resident #97 was transferred and admitted to the hospital on 5/23/18, 6/11/18, and 7/28/18. There was no evidence in the clinical record evidencing that the Ombudsman and/or the Resident Representative was notified, in writing, of the facility initiated hospital transfers. Resident #97 was admitted to the facility on 4/30/18 with the diagnoses of but not limited to pulmonary embolism, atrial fibrillation, sepsis, congestive heart failure, hypoxemia, and surgical aftercare. The quarterly MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 8/7/18 coded the resident as being cognitively intact in ability to make daily life decisions. A nurse's note dated 5/23/18 documented, "MD (medical doctor) in room this AM to assess patients. Resident was diaphoretic and SOB (shortness of breath). Lungs with rales and diminished right base. Assessed again by nurse and O2 (oxygen) sats (saturation) were 78% on 2l (two liters) O2 via nasal cannula, O2 was increased to 3l. continues {sic} to be short of breath and complains of dizziness and weakness. (name of son) called and notified of condition and	F 623		

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of decision to send patient to hospital. Squad called and resident sent to (name of hospital) for further evaluation."

There was no evidence in the clinical record that the Resident Representative was notified of Resident #97's 5/23/18, hospital transfer in writing.

A review of the clinical record revealed a nurse's note dated 6/11/18 that documented, "Patient felt drowsy, denied any pain, and she stated, "I just don't feel right." Her VS (vital signs) at the beginning of the shift was 98.7-105-16-126/74-96% (temperature-pulse-respirations-blood pressure-oxygen saturation). After making the statement that she did not feel well a new set of VS was obtained at 5:30pm and were 98.2 (temperature)-76/50 (manually) (blood pressure)-26 (respirations)-98% 5L (oxygen saturation on 5 liters). MD (medical doctor) notified and assessed patient. He feels that based on her history that she may be presenting with pleural effusions. Order obtained to send patient to the ED (Emergency Department) for evaluation. Son notified."

There was no evidence that the Ombudsman and Resident Representative were notified of Resident #97's 6/11/18, hospital transfer in writing.

A review of the nurse's notes revealed one dated 7/28/18 that documented, "This nurse was notified by CNA (certified nursing assistant) that Resident was clammy and not responding. Resident c/o (complained of) dizziness, hard to focus on anything, and nausea. Periods of

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F 623	Continued From page 55	F 623		

hypotension (low blood pressure) this am. MD notified with new orders to send for evaluation. Son (name of son) notified but yet to be contacted. 911 activated."

There was no evidence that the Ombudsman and Resident Representative were notified of Resident #97's 7/28/18, hospital transfer in writing.

On 9/7/18 at 8:39 a.m., in an interview with OSM #12 (Other Staff Member) the social worker, she stated that she has no role in the process of residents being transferred to the hospital. She stated that she does not notify the Ombudsman nor does she provide a written letter to the family.

An interview was conducted on 9/7/18 at 8:47 a.m. with OSM (other staff member) #11, the director of social services. OSM #11 stated that the nursing staff provides the information regarding resident transfers to the hospital to OSM #9, the receptionist. OSM #9 then faxes the information to the ombudsman.

An interview was conducted on 9/7/18 at 9:39 a.m. with OSM #10, the business office manager. OSM #10 stated the facility was faxing information to the ombudsman until about "early June" but that the ombudsman asked the facility only to send discharges from the facility to her. At that time, OSM # 10 stated that they also stopped providing written notification of transfer to a facility to the resident and responsible representative. She stated OSM #9 was responsible for faxing the information to the ombudsman "Up until about the first of June".

On 9/7/18 at 12:12 p.m., an interview was

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F 623	Continued From page 56 conducted with LPN (licensed practical nurse) #3. When asked about the process staff follows when a resident is being transferred to the hospital, LPN #3 stated that she would first assess the resident, send the appropriate documents, and then notify the RP (responsible party). When asked how she would notify the RP, LPN #3 stated that she notifies the RP verbally. When asked if she notifies the RP in writing the reason for hospital transfer, LPN #3 stated that she wasn't entirely sure but thought that the business office provided that notification to the RP and long term care ombudsman. LPN #3 stated that the nurses did not provide written notification to the RP or long term care ombudsman. On 9/7/18 at 3:26 PM in a meeting with ASM #1 (Administrative Staff Member - the Executive Director) and ASM #2 (the Director of Nursing) they were made aware of the findings. No further information was provided by the end of the survey. 8. Resident #94 was transferred and admitted to the hospital, on 7/27/18, and 8/8/18. There was no evidence in the clinical record evidencing that the Ombudsman and/or the Resident Representative was notified, in writing, of the facility initiated hospital transfers. Resident #94 was admitted to the facility on 6/28/18 with the diagnoses of but not limited to orthopedic aftercare, ischemic heart disease, high blood pressure, and chronic kidney disease. The admission/5-day MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 7/5/18 coded the resident as being cognitively intact in ability to make daily life decisions.	F 623		

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F 623	Continued From page 57 A review of the clinical record revealed the following nurses notes: 7/27/18 at 9:54 AM: "....Resident was alert and oriented at beginning of shift this AM. Later morning resident became very lethargic and was having a hard time staying awake. MD (medical doctor) was notified and resident was assessed. Had started promethazine {1} and Norco {2} this AM. and lethargy was noted to be related to medication changes....Lungs with slight crackles bilaterally. O2 (oxygen) sats were 86% on room air. 95% on 2l (two liters of oxygen) via nasal cannula....Addendum: Resident continues with extreme lethargy at this time with continued need for supplemental O2. Reassessed by MD and orders given to sent to ER for further evaluation. Brother was notified. Addendum: Resident was admitted to (hospital) for acute kidney injury." There was no evidence that the Ombudsman and Resident Representative were notified of this hospital transfer on 7/27/18 for Resident #94 in writing. A nurse's note dated 8/8/18 at 1:30 PM documented, "Resident with increasing tremors throughout today. Temp (temperature) this AM was 98. is {sic} now 102.1. Heart rate of 151. Respirations 32. NP (nurse practitioner) notified of changes. Resident sent to (name of hospital) ER (emergency room). Family notified. Squad arrived at 1:30 PM." There was no evidence that the Ombudsman and Resident Representative were notified of this hospital transfer on 8/8/18 for Resident #94 in writing.	F 623		

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F 623	Continued From page 58 On 9/7/18 at 8:39 a.m., in an interview with OSM #12 (Other Staff Member) the social worker, she stated that she has no role in the process of residents being transferred to the hospital. She stated that she does not notify the Ombudsman nor does she provide a written letter to the family. An interview was conducted on 9/7/18 at 8:47 a.m. with OSM (other staff member) #11, the director of social services. OSM #11 stated that the nursing staff provides the information regarding resident transfers to the hospital to OSM #9, the receptionist. OSM #9 then faxes the information to the ombudsman. An interview was conducted on 9/7/18 at 9:39 a.m. with OSM #10, the business office manager. OSM #10 stated the facility was faxing information to the ombudsman until about "early June" but that the ombudsman asked the facility only to send discharges from the facility to her. At that time, OSM # 10 stated that they also stopped providing written notification of transfer to a facility to the resident and responsible representative. She stated OSM #9 was responsible for faxing the information to the ombudsman "Up until about the first of June". On 9/7/18 at 12:12 p.m., an interview was conducted with LPN (licensed practical nurse) #3. When asked about the process staff follows when a resident is being transferred to the hospital, LPN #3 stated that she would first assess the resident, send the appropriate documents, and then notify the RP (responsible party). When asked how she would notify the RP, LPN #3 stated that she notifies the RP verbally. When asked if she notifies the RP in writing the reason for hospital transfer, LPN #3 stated that she	F 623		

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F 623	Continued From page 59 wasn't entirely sure but thought that the business office provided that notification to the RP and long term care ombudsman. LPN #3 stated that the nurses did not provide written notification to the RP or long term care ombudsman. On 9/7/18 at 3:26 PM in a meeting with ASM #1 (Administrative Staff Member - the Executive Director) and ASM #2 (the Director of Nursing) they were made aware of the findings. No further information was provided by the end of the survey. {1} Promethazine - "Promethazine is also used to prevent and control nausea and vomiting that may occur after surgery, and with other medications to help relieve pain after surgery. Promethazine is also used to prevent and treat motion sickness. Promethazine helps control symptoms, but will not treat the cause of the symptoms or speed recovery..." Information obtained from https://medlineplus.gov/druginfo/meds/a682284.html {2} Norco - Hydrocodone and acetaminophen combination is used to relieve moderate to moderately severe pain. Information obtained from https://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0010590/	F 623		
F 624 SS=D	Preparation for Safe/Orderly Transfer/Dschrg CFR(s): 483.15(c)(7) §483.15(c)(7) Orientation for transfer or discharge.	F 624	F624 1. How will the corrective action be accomplished for those residents found to have been affected by the	10/15/18

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F 624	Continued From page 60 A facility must provide and document sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility. This orientation must be provided in a form and manner that the resident can understand. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview, facility document review and clinical record review, it was determined that facility staff failed to provide evidence that they oriented residents to a facility initiated transfer for three of 42 residents, Resident #40, #97, #94. 1. The facility staff failed to provide evidence that they oriented Resident #40 to a facility initiated transfer on 8/31/18. 2. Resident #97 was transferred and admitted to the hospital on 5/23/18, 6/11/18, and 7/28/18. There was no evidence in the clinical record that the resident was prepared and oriented for the hospital transfer. 3. Resident #94 was transferred and admitted to the hospital on 7/27/18 and 8/8/18. There was no evidence in the clinical record that the resident was prepared and oriented for the hospital transfer. The findings include: 1. The facility staff failed to provide evidence that they oriented Resident #40 to a facility initiated transfer on 8/31/18. Resident #40 was admitted to the facility on	F 624	Continue from page 60 deficient practice? On 9/20/18 patient #40, 97, and 94 had safely returned to facility after their facility initiated transfer to the hospital. 2. How will the facility identify other residents having the potential to be affected by the same practice? All residents transferred to hospital from facility have the potential to be affected by this practice. Director of Nursing/Unit Manager will review all residents transferred to hospital since September 10, 2018 to assure the resident was oriented and prepared for facility initiated transfer to the hospital. 3. What measures will be put into place or systematic changes made to ensure the practice will not reoccur? By 10/8/18, Staff Development Coordinator will in-service Licensed Nurses on resident being oriented and prepared for facility initiated transfer to the hospital and provide sufficient documentation in the medical record. Any Licensed Nurse that has not been in-serviced by 10/8/18 will not be allowed to provide direct care until in-service	

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F 624	Continued From page 61 12/28/16 and readmitted on 5/30/17 with diagnoses that included but were not limited to atrial fibrillation, muscle weakness, and acute kidney failure. Resident #40's most recent MDS (minimum data set) assessment was a quarterly assessment with an ARD (assessment reference date) of 7/8/18. Resident #40 was coded as being moderately impaired in cognitive function scoring 08 out of possible 15 on the BIMS (Brief Interview for Mental Status) exam. Review of Resident #40's clinical record revealed that he had been transferred to the hospital on 8/31/18. The following nursing notes were documented: "8/31/18 at 4:33 a.m.: resident (sic) c/o (complaint) headache 9/10 after given Percocet (1). resident's (sic) increased 220/105 manually, urine output WNL (within normal limits)m heart rate regular, no nausea noted, pupils reactive. MD (medical doctor) made aware, new orders received for clonidine (2) 0.1 mg (milligrams) x 1. recheck (sic) BO after one and half hours. BP still increased to 230/110, c/o headache 8/10. MD made aware. new (sic) orders received for clonidine 0.1 mg one time. will (sic) check BP. resident (sic) started on ceftin (3) 8/30/18...will continue to monitor... "after (sic) second dose of clonidine 0.1 mg there was no change in headache or BP: 230/110. (Name of MD) made aware and rounded on resident, with new orders to send to ER (emergency room) for eval. (evaluation) and treatment of acute refractory headache and hypertension (high blood pressure)." There was no documented evidence that Resident #40 was oriented to the facility initiated transfer on 8/31/18.	F 624	Continued from page 61 completed. All newly hired Licensed Nurses will receive education during orientation on resident being oriented and prepared for facility initiated transfer to the hospital and provide sufficient documentation in the medical record. Director of Nursing/Unit Manager will evaluate resident was oriented and prepared for facility initiated transfer to the hospital and that sufficient documentation is present in the medical record 5 times a week x30days, 3times a week x30days, and 1 time a week x30days. 4. How will the facility monitoring the corrective plan to ensure the deficient practice was corrected and not reoccur? Director of nursing will present findings of audit accurate assessment findings to the Quality Assurance Performance Improvement committee for review and recommendations for 90 days. The QAPI committee consist of Executive Director, Director of Nursing, Assistant Director of Nursing, Social Services, Activities, Dietary Manager, Pharmacy consultant, Medical Director.	

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F 624	Continued From page 62 On 9/5/18 at approximately 1:50 p.m., an interview was conducted with Resident #40. He could not recall why he was recently hospitalized. Resident #40 stated that he thinks he was told he had a kidney infection. Resident #40 could not recall if he was made aware at the time of transfer why he was going to to the hospital. On 9/7/18 at 12:12 p.m., an interview was conducted with LPN (licensed practical nurse) #3. When asked the process when a resident is being transferred to the hospital, LPN #3 stated that she would first assess the resident, send the appropriate documents, and then notify the RP (responsible party). When asked if the reason for their transfer, was explained to the resident, if able to understand, LPN #3 stated that she usually explains to residents why they are being transferred to the hospital. When asked if this is documented anywhere in the clinical record, LPN #3 stated that normally does not chart that the resident was notified. On 9/7/18 at 3:26 p.m., ASM (administrative staff member) #1, the Executive Director, and ASM #2, the DON (Director of Nursing) were made aware of the above concerns. Facility policy titled,"Transfers and Discharges" did not address the above concerns. No further information was presented prior to exit. (1) Percocet - Opioid analgesic indicated for the relief of moderate to moderately severe pain. This information was obtained from The National Institutes of Health https://dailymed.nlm.nih.gov/dailymed/drugInfo.cf	F 624		

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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 624	Continued From page 63 m?setid=0a446947-2cda-4a32-aa6a-53e09245825a. (2) Clonidine is used to treat high blood pressure. This information was obtained from The National Institutes of Health. https://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0009680/?report=details. (3) Ceftin is a cephalosporin antibiotic used to treat infections. This information was obtained from The National Institutes of Health. https://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0009522/?report=details. (4) Pylenonephritis- Kidney infection is a type of urinary tract infection (UTI) that commonly begins in the bladder and moves upstream to one or both of the kidneys. This information was obtained from National Institutes of Health. https://www.niddk.nih.gov/health-information/urologic-diseases/kidney-infection-pyelonephritis. 2. Resident #97 was transferred and admitted to the hospital on 5/23/18, 6/11/18, and 7/28/18. There was no evidence in the clinical record that the resident was prepared and oriented for the hospital transfer. Resident #97 was admitted to the facility on 4/30/18 with the diagnoses of but not limited to pulmonary embolism, atrial fibrillation, sepsis, congestive heart failure, hypoxemia, and surgical aftercare. The quarterly MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 8/7/18 coded the resident as being cognitively intact in ability to make daily life decisions. The resident was coded as requiring extensive assistance for transfers and toileting; assistance of one person for dressing and hygiene; and was	F 624		

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F 624	Continued From page 64 independent for eating. A nurse's note dated 5/23/18 documented, "MD (medical doctor) in room this a.m. to assess patients. Resident was diaphoretic and SOB (shortness of breath). Lungs with rales and diminished right base. Assessed again by nurse and O2 (oxygen) sats (saturation) were 78% on 2l (two liters) O2 via nasal cannula, O2 was increased to 3l. continues {sic} to be short of breath and complains of dizziness and weakness. (name of son) called and notified of condition and of decision to send patient to hospital. Squad called and resident sent to (name of hospital) for further evaluation." A review of the Nursing Home to Hospital Transfer Form dated 5/23/18 failed to reveal any evidence of the resident being prepared and oriented for the hospital transfer. A review of the clinical record revealed a nurse's note dated 6/11/18 that documented, "Patient felt drowsy, denied any pain, and she stated, "I just don't feel right." Her VS (vital signs) at the beginning of the shift was 98.7-105-16-126/74-96% (temperature-pulse-respirations-blood pressure-oxygen saturation). After making the statement that she did not feel well a new set of VS was obtained at 5:30pm and were 98.2 (temperature)-76/50 (manually) (blood pressure)-26 (respirations)-98% 5L (oxygen saturation on 5 liters). MD notified and assessed patient. He feels that based on her history that she may be presenting with pleural effusions. Order obtained to send patient to the ED (Emergency Department) for evaluation. Son notified."	F 624		

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F 624	Continued From page 65 A review of the Nursing Home to Hospital Transfer Form dated 6/11/18 failed to reveal any evidence of the resident being prepared and oriented for the hospital transfer. A review of the nurse's notes revealed one dated 7/28/18 that documented, "This nurse was notified by CNA (certified nursing assistant) that Resident was clammy and not responding. Resident c/o (complained of) dizziness, hard to focus on anything, and nausea. Periods of hypotension (low blood pressure) this am. MD notified with new orders to send for evaluation. Son (name of son) notified but yet to be contacted. 911 activated." A review of the Nursing Home to Hospital Transfer Form dated 7/28/18 failed to reveal any evidence of the resident being prepared and oriented for the hospital transfer. On 9/7/18 at 12:12 p.m., an interview was conducted with LPN (licensed practical nurse) #3. When asked the process when a resident is being transferred to the hospital, LPN #3 stated that she would first assess the resident, send the appropriate documents, and then notify the RP (responsible party). When asked if the reason for their transfer was explained to the resident, if able to understand, LPN #3 stated that she usually explains to residents why they are being transferred to the hospital. When asked if this is documented anywhere in the clinical record, LPN #3 stated that normally does not chart that the resident was notified. On 9/7/18 at 3:26 p.m. in a meeting with ASM #1 (Administrative Staff Member - the Executive	F 624		

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F 624	Continued From page 66 Director) and ASM #2 (the Director of Nursing) they were made aware of the findings. No further information was provided by the end of the survey. 3. Resident #94 was transferred and admitted to the hospital on 7/27/18 and 8/8/18. There was no evidence in the clinical record that the resident was prepared and oriented for the hospital transfer. Resident #94 was admitted to the facility on 6/28/18 with the diagnoses of but not limited to orthopedic aftercare, ischemic heart disease, high blood pressure, and chronic kidney disease. The admission/5-day MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 7/5/18 coded the resident as being cognitively intact in ability to make daily life decisions. The resident was coded as requiring extensive assistance for transfers, dressing, and bathing; limited assistance for hygiene and toileting; and supervision for eating. A nurse's note dated 7/27/18 at 9:54 a.m., documented "...Resident was alert and oriented at beginning of shift this a.m. Later morning resident became very lethargic and was having a hard time staying awake. MD (medical doctor) was notified and resident was assessed. Had started promethazine {1} and Norco {2} this a.m. and lethargy was noted to be related to medication changes...Lungs with slight crackles bilaterally. O2 (oxygen) sats were 86% on room air. 95% on 2l (two liters of oxygen) via nasal cannula....Addendum: Resident continues with	F 624		

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F 624	Continued From page 67 extreme lethargy at this time with continued need for supplemental O2. Reassessed by MD and orders given to sent to ER (emergency room) for further evaluation. Brother was notified. Addendum: Resident was admitted to (hospital) for acute kidney injury." A review of the Nursing Home to Hospital Transfer Form dated 7/27/18 failed to reveal any evidence of the resident being prepared and oriented for the hospital transfer. A nurse's note dated 8/8/18 at 1:30 p.m. documented, "Resident with increasing tremors throughout today. Temp (temperature) this a.m. was 98. is {sic} now 102.1. Heart rate of 151. Respirations 32. NP (nurse practitioner) notified of changes. Resident sent to (name of hospital) ER (emergency room). Family notified. Squad arrived at 1:30 PM." A review of the Nursing Home to Hospital Transfer Form dated 8/8/18 failed to reveal any evidence of the resident being prepared and oriented for the hospital transfer. On 9/7/18 at 12:12 p.m., an interview was conducted with LPN (licensed practical nurse) #3. When asked the process when a resident is being transferred to the hospital, LPN #3 stated that she would first assess the resident, send the appropriate documents, and then notify the RP (responsible party). When asked if the reason for their transfer was explained to the resident, if able to understand, LPN #3 stated that she usually explains to residents why they are being transferred to the hospital. When asked if this is documented anywhere in the clinical record, LPN #3 stated that normally does not chart that the	F 624		

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F 624	Continued From page 68 resident was notified. On 9/7/18 at 3:26 PM in a meeting with ASM #1 (Administrative Staff Member - the Executive Director) and ASM #2 (the Director of Nursing) they were made aware of the findings. No further information was provided by the end of the survey. {1} Promethazine - "Promethazine is also used to prevent and control nausea and vomiting that may occur after surgery, and with other medications to help relieve pain after surgery. Promethazine is also used to prevent and treat motion sickness. Promethazine helps control symptoms, but will not treat the cause of the symptoms or speed recovery..." Information obtained from https://medlineplus.gov/druginfo/meds/a682284.html {2} Norco - Hydrocodone and acetaminophen combination is used to relieve moderate to moderately severe pain. Information obtained from https://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0010590/	F 624		
F 625 SS=E	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that	F 625	F625 1. How will the corrective action be accomplished for those residents found to have been affected by the deficient practice? Resident #26, 40, 65, 42, 59, 58, 88, 97, and 94 have safely returned to facility after facility initiated transfer to hospital.	10/15/18

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F 625	Continued From page 69 specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, and clinical record review, it was determined that the facility staff failed to provide written bed hold notification for a transfer to the hospital for nine of 42 residents in the survey sample, Resident #26, 40, 65, 42, 59, 58, 88, 97 and 94. 1. The facility staff failed to evidence documentation that a copy of the bed hold policy was provided to Resident #26 and/or the resident representative upon transfer to the hospital on 7/27/18. 2. The facility staff failed to evidence documentation that a copy of the bed hold policy	F 625	Continued from page 69 2. How will the facility identify other residents having the potential to be affected by the same practice? All residents transferred to the hospital have the potential to be affected by this practice. On 9/25/18, Director of Nursing reviewed all residents from facility currently residing at the hospital and validated bed hold policy was sent with resident upon discharge from facility to hospital. 3. What measures will be put into place or systematic changes made to ensure the practice will not reoccur? By 10/8/18, Staff Development Coordinator will in-service Licensed Nurses on sending a copy of bed hold notice with resident upon a facility initiated transfer to the hospital. Any Licensed Nurse that has not been in-serviced by 10/8/18 will not be allowed to provide direct care until in-service completed. All newly hired Licensed Nurses will receive education during orientation on sending a copy of bed hold notice with resident upon a facility initiated transfer to the hospital.	

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F 625	Continued From page 70 was provided to the Resident #40 and/or the resident representative upon transfer to the hospital on 8/31/18. 3. The facility staff failed to evidence documentation that a copy of the bed hold policy was provided to Resident #65 and/or the resident representative upon transfer to the hospital on 8/1/18. 4. The facility staff failed to evidence documentation that a copy of the bed hold policy was provided to Resident # 42 and/or resident representative upon a facility initiated transfer to the hospital on 07/05/18. 5. The facility staff failed to evidence documentation that a copy of the bed hold policy was provided to the Resident #59 and/or the resident representative upon transfer to the hospital on 7/10/18. 6. The facility staff failed to evidence documentation that a copy of the bed hold policy was provided to the Resident #58 and/or the resident representative upon transfer to the hospital on 7/12/18. 7. The facility staff failed to evidence documentation that a copy of the bed hold policy was provided to the Resident #88 and/or the resident representative upon transfer to the hospital on 7/21/18. 8. Resident #97 was transferred and admitted to the hospital on 5/23/18, 6/11/18, and 7/28/18. There was no evidence in the clinical record that the resident and/or Resident Representative was provided with a written bed hold notification for	F 625	Continued from page 70 Director of Nursing/Unit Manager will evaluate facility initiated transfers to the hospital have bed hold notice sent with patient during transfer to hospital 5 times a week x30days, 3 times a week x30days, 1 time a week x30days. 4. How will the facility monitoring the corrective plan to ensure the deficient practice was corrected and not reoccur? Director of nursing will present findings of audit accurate assessment findings to the Quality Assurance Performance Improvement committee for review and recommendations for 90 days. The QAPI committee consist of Executive Director, Director of Nursing, Assistant Director of Nursing, Social Services, Activities, Dietary Manager, Pharmacy consultant, Medical Director.	

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F 625	Continued From page 71 either transfer. 9. Resident #94 was transferred and admitted to the hospital on 7/27/18 and 8/8/18. There was no evidence in the clinical record that the resident and/or Resident Representative was provided with a written bed hold notification for either transfer. The findings include: 1. The facility staff failed to evidence documentation that a copy of the bed hold policy was provided to Resident #26 and/or the resident representative upon transfer to the hospital on 7/27/18. Resident #26 was admitted to the facility on 3/14/18 and readmitted on 7/31/18 with diagnoses that included but were not limited to type two diabetes, dysphagia (difficulty swallowing), repeated falls, and cognitive communication deficit. Resident #26's most recent MDS (minimum data set) assessment was a significant change assessment with an ARD (assessment reference date) of 8/30/18. Resident #26 was coded as being severely impaired in cognitive function scoring 01 out of possible 15 on the BIMS (Brief Interview for Mental Status) exam. Review of Resident #26's clinical record revealed that she was sent to the hospital on 7/27/18. Further review of Resident #26's clinical record revealed that she was admitted back to the facility on 8/1/18 with a diagnosis of left hip repair post fracture.	F 625		

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F 625	Continued From page 72 There was no evidence that a copy of the bed hold policy was provided to the resident and/or resident representative upon transfer to the hospital on 7/27/18. On 9/7/18 at 8:39 a.m., an interview was conducted with OSM (other staff member) #12, the social worker, regarding social services role when a resident is transferred to the hospital. OSM #12 stated that her department did not have a role. When asked who was responsible for sending bed hold notifications to residents, OSM #12 stated that the business office was responsible. On 9/7/18 at 9:11 a.m., an interview was conducted with OSM #11, the Director of Social Services. OSM #11 stated that she checked with the business office and found that the facility was not enforcing their bed hold policy because the census has been low and that the facility always had a bed available. An interview was conducted on 9/7/18 at 9:39 a.m. with OSM #10, the business office manager. OSM #10 stated that they do not provide bed hold information upon transfer to a facility, as the facility census has been "way down for over a year", so they always know they have a bed available for returning residents. On 9/7/18 at 3:26 p.m., ASM (administrative staff member) #1, the Executive Director, and ASM #2, the DON (Director of Nursing) were made aware of the above concerns. The facility policy titled, "Bed Hold/Reservation of Room Policy," documents in part, the following:	F 625		

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F 625	Continued From page 73 "Bed hold policies will be provided and explained to the patient upon admission and explained to the patient before each temporary absence. Before the patient transfers to the hospital or the patient goes on therapeutic leave, the facility will provide written notification to the patient or patient representative that specifies: -The duration of the state bed hold policy, if any, during which the patient is permitted to return and resume residence in the nursing facility. - The reserve bed payment policy in the state plan, if any - The facility policy regarding bed-hold.. In cases of emergency transfers, notice "at the time of transfer" means that the family, surrogate, or patient representative are provided with written notification within 24 hours of the transfer." No further information was presented prior to exit. 2. The facility staff failed to evidence documentation that a copy of the bed hold policy was provided to the Resident #40 and/or the resident representative upon transfer to the hospital on 8/31/18. Resident #40 was admitted to the facility on 12/28/16 and readmitted on 5/30/17 with diagnoses that included but were not limited to atrial fibrillation, muscle weakness, and acute kidney failure. Resident #40's most recent MDS (minimum data set) assessment was a quarterly assessment with an ARD (assessment reference date) of 7/8/18. Resident #40 was coded as being moderately impaired in cognitive function scoring 08 out of possible 15 on the BIMS (Brief Interview for Mental Status) exam.	F 625		

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F 625	Continued From page 74	F 625		

Review of Resident #40's clinical record revealed that he had been transferred to the hospital on 8/31/18. Further review of the clinical record revealed that Resident #40 returned to the facility on 9/1/18 with a diagnosis of acute pylenonephritis (4) (kidney infection).

There was no evidence that a copy of the bed hold policy was provided to Resident #40 and/or the resident representative upon transfer to the hospital on 8/31/18.

On 9/7/18 at 8:39 a.m., an interview was conducted with OSM (other staff member) #12, the social worker, regarding social services role when a resident is transferred to the hospital. OSM #12 stated that her department did not have a role. When asked who was responsible for sending bed hold notifications to residents, OSM #12 stated that the business office was responsible.

On 9/7/18 at 9:11 a.m., an interview was conducted with OSM #11, the Director of Social Services. OSM #11 stated that she checked with the business office and found that the facility was not enforcing their bed hold policy because the census has been low and that the facility always had a bed available.

An interview was conducted on 9/7/18 at 9:39 a.m. with OSM #10, the business office manager. OSM #10 stated that they do not provide bed hold information upon transfer to a facility, as the facility census has been "way down for over a year", so they always know they have a bed available for returning residents.

On 9/7/18 at 3:26 p.m., ASM (administrative staff

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F 625	Continued From page 75 member) #1, the Executive Director, and ASM #2, the DON (Director of Nursing) were made aware of the above concerns. (1) Percocet - Opioid analgesic indicated for the relief of moderate to moderately severe pain. This information was obtained from The National Institutes of Health https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=0a446947-2cda-4a32-aa6a-53e09245825a. (2) Clonidine is used to treat high blood pressure. This information was obtained from The National Institutes of Health. https://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0009680/?report=details. (3) Ceftin is a cephalosporin antibiotic used to treat infections. This information was obtained from The National Institutes of Health. https://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0009522/?report=details. (4) Pylenonephritis- Kidney infection is a type of urinary tract infection (UTI) that commonly begins in the bladder and moves upstream to one or both of the kidneys. This information was obtained from National Institutes of Health. https://www.niddk.nih.gov/health-information/urologic-diseases/kidney-infection-pyelonephritis. 3. The facility staff failed to evidence documentation that a copy of the bed hold policy was provided to Resident #65 and/or the resident representative upon transfer to the hospital on 8/1/18. Resident #65 was admitted to the facility on	F 625		

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LIFE CARE CENTER OF NEW MARKET	315 EAST LEE HIGHWAY NEW MARKET, VA 22844

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F 625	Continued From page 76 11/7/17 and readmitted on 8/18/18 with diagnoses that included but were not limited to urinary tract infection, atrial fibrillation, chronic kidney disease, and high blood pressure. Resident #65's most recent MDS (minimum data set) assessment was a quarterly assessment with an ARD (assessment reference date) of 8/13/18. Resident #65 was coded as being moderately impaired in cognitive function scoring 12 out of possible 15 on the BIMS (Brief Interview for Mental Status) exam. Review of Resident #65's clinical record revealed that she was sent to the hospital on 8/1/18. Further review of the clinical record revealed that Resident #65 was admitted to the hospital with diagnoses of acute renal failure (1) and a urinary tract infection. There was no evidence that a copy of the bed hold policy was provided to Resident #65 and/or the resident representative upon transfer to the hospital on 8/1/18. On 9/7/18 at 8:39 a.m., an interview was conducted with OSM (other staff member) #12, the social worker, regarding social services role when a resident is transferred to the hospital. OSM #12 stated that her department did not have a role. When asked who was responsible for sending bed hold notifications to residents, OSM #12 stated that the business office was responsible. On 9/7/18 at 9:11 a.m., an interview was conducted with OSM #11, the Director of Social Services. OSM #11 stated that she checked with the business office and found that the facility was not enforcing their bed hold policy because the	F 625		

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F 625	Continued From page 77 census has been low and that the facility always had a bed available. An interview was conducted on 9/7/18 at 9:39 a.m. with OSM #10, the business office manager. OSM #10 stated that they do not provide bed hold information upon transfer to a facility, as the facility census has been "way down for over a year", so they always know they have a bed available for returning residents. On 9/7/18 at 3:26 p.m., ASM (administrative staff member) #1, the Executive Director, and ASM #2, the DON (Director of Nursing) were made aware of the above concerns. No further information was presented prior to exit. (1) Acute renal failure- characterized by sudden loss of the ability of the kidneys to excrete wastes, concentrate urine, conserve electrolytes, and maintain fluid balance. This information was obtained from The National Institutes of Health. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC437979/. 4. The facility staff failed to evidence documentation that a copy of the bed hold policy was provided to Resident # 42 and/or resident representative upon a facility initiated transfer to the hospital on 07/05/18. Resident # 42 was admitted to the facility on 04/03/13 and a readmission of 07/08/18 with diagnoses that included but were not limited to heart failure, gastroesophageal reflux disease (1), atrial fibrillation, (2), and osteoarthritis (3). Resident # 42's most recent MDS (minimum data	F 625		

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F 625	Continued From page 78 set), a quarterly assessment with an ARD (assessment reference date) of 07/11/18, coded Resident # 42 as scoring a 15 on the brief interview for mental status (BIMS) of a score of 0 - 15, 15 - being cognitively intact for making daily decisions. The nurse's "Progress Notes" for Resident # 42 dated 07/05/18 at 4:56 p.m., documented, "Resident with altered mental status, alert but confused and paranoid with visual hallucinations, irregular lab (laboratory) work as of today. VS (vital signs) 98.0 (temperature), 125/68 (125 over 68 -blood pressure), O2 SAT (oxygen saturation) 90% on 2L (two liters). Resque [sic] Squad notified at 1700 (5:00 p.m.). Resident's daughter-in-law, (Name of Daughter-in-law) notified by NP (nurse practitioner), (Name of Nurse Practitioner). Resident did fall out of bed on 7/1/18 without any apparent injuries. Resque [sic] squad here at 1715 (5:15 p.m.), to transport to (Name of Hospital)." On 9/7/18 at 8:39 a.m., an interview was conducted with OSM (other staff member) #12, the social worker, regarding social services role when a resident is transferred to the hospital. OSM #12 stated that her department did not have a role. When asked who was responsible for sending bed hold notifications to residents, OSM #12 stated that the business office was responsible. An interview was conducted on 9/7/18 at 9:39 a.m. with OSM #10, the business office manager. OSM #10 stated that they do not provide bed hold information upon transfer to a facility, as the facility census has been "way down for over a year", so they always know they have a bed	F 625		

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F 625	Continued From page 79 available for returning residents. On 09/06/18 at approximately 3:26 p.m. ASM (administrative staff member) #1, the executive director, ASM #2, the director of nursing, were made aware of the findings. No further information was provided prior to exit. References: (1) Stomach contents to leak back, or reflux, into the esophagus and irritate it. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/gerd.html. (2) A problem with the speed or rhythm of the heartbeat. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/atrialfibrillation.html. (3) The most common form of arthritis. It causes pain, swelling, and reduced motion in your joints. It can occur in any joint, but usually it affects your hands, knees, hips or spine. This information was obtained from the website: https://medlineplus.gov/osteoarthritis.html. 5. The facility staff failed to evidence documentation that a copy of the bed hold policy was provided to the Resident #59 and/or the resident representative upon transfer to the hospital on 7/10/18. Resident #59 was admitted to the facility on 3/25/15, with a most recent readmission of 7/12/18, with diagnoses that included but were not limited to: heart failure, stroke, Bell's palsy	F 625		

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F 625	Continued From page 80	F 625		

(weakness and paralysis of one side of the face) (1), high blood pressure, diabetes, and arthritis.

The most recent MDS (minimum data set) assessment, an annual assessment, with an assessment reference date of 7/20/18, coded the resident as scoring a "15" on the BIMS (brief interview for mental status) score, indicating the resident is cognitively intact for daily decision making.

The physician's note dated 7/10/18 [no time documented] stated, "Patient seen today for follow up on weight increase [and] SOB (shortness of breath) increase."

The nurse practitioner's telephone order dated 7/10/18 [no time documented] stated, "Send Resident to [hospital's name] for eval (evaluation) R/t (related to) SOB (shortness of breath)."

A review of the clinical record failed to evidence that written notification regarding the facility's bed hold policy was provided to Resident #59 and or the Responsible Representative upon the resident's transfer to the hospital on 7/10/11.

On 9/7/18 at 8:39 a.m., an interview was conducted with OSM (other staff member) #12, the social worker, regarding social services role when a resident is transferred to the hospital. OSM #12 stated that her department did not have a role. When asked who was responsible for sending bed hold notifications to residents, OSM #12 stated that the business office was responsible.

An interview was conducted on 9/7/18 at 9:39 a.m. with OSM #10, the business office manager.

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F 625	Continued From page 81 OSM #10 stated that they do not provide bed hold information upon transfer to a facility, as the facility census has been "way down for over a year", so they always know they have a bed available for returning residents. On 9/7/18 at 3:26 p.m., ASM (administrative staff member) #1, the executive director, and ASM #2, the director of nursing, were made aware of the above findings. No further information was provided prior to exit. 1) This information was obtained from the National Institutes of Health at https://medlineplus.gov/bellspalsy.html 6. The facility staff failed to evidence documentation that a copy of the bed hold policy was provided to the Resident #58 and/or the resident representative upon transfer to the hospital on 7/12/18. Resident #58 was admitted to the facility on 3/14/18, with a most recent readmission of 7/12/18, with diagnoses that included but were not limited to: atrial fibrillation (an abnormality of the speed and rhythm of a heart beat) (1), high blood pressure, diabetes, muscle weakness and history of a hip fracture in March 2018. The most recent MDS (minimum data set) assessment, a significant change assessment, with an assessment reference date of 8/20/18, coded the resident as scoring an "8" on the BIMS (brief interview for mental status) score, indicating the resident is moderately impaired for daily decision making. .	F 625		

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F 625	Continued From page 82 The nursing note dated 7/12/18 at 4 p.m. stated, "Resident complains of feeling like he is dying, respirations labored, sat 89 [%] on room air, wheezes noted bilaterally, oxygen applied to [sic] at 2l (liter) per minute. NP (nurse practitioner) was in and recommended [sic] be sent to be evaluated, alert, heart rate regular, son called and informed of situation, pt (patient) to be sent to [hospital's name] via squad." A review of the clinical record failed to evidence that written notification regarding the facility's bed hold policy was provided to Resident #58 and or the Responsible Representative upon the resident's transfer to the hospital on 7/12/18. On 9/7/18 at 8:39 a.m., an interview was conducted with OSM (other staff member) #12, the social worker, regarding social services role when a resident is transferred to the hospital. OSM #12 stated that her department did not have a role. When asked who was responsible for sending bed hold notifications to residents, OSM #12 stated that the business office was responsible. An interview was conducted on 9/7/18 at 9:39 a.m. with OSM #10, the business office manager. OSM #10 stated that they do not provide bed hold information upon transfer to a facility, as the facility census has been "way down for over a year", so they always know they have a bed available for returning residents. On 9/7/18 at 3:26 p.m., ASM (administrative staff member) #1, the executive director, and ASM #2, the director of nursing, were made aware of the above findings.	F 625		

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F 625	Continued From page 83 No further information was provided prior to exit. 1) This information was obtained from the National Institutes of Health at https://medlineplus.gov/atrialfibrillation.html 7. The facility staff failed to evidence documentation that a copy of the bed hold policy was provided to the Resident #88 and/or the resident representative upon transfer to the hospital on 7/21/18. Resident #88 was admitted to the facility on 5/7/16, with a most recent readmission of 7/27/18, with diagnoses that included but were not limited to: stroke, paralysis secondary to stroke, muscle weakness, difficulty speaking, difficulty swallowing, hypertension, and dementia. The most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 8/12/18, coded the resident as rarely- never being able to make himself understood as well as rarely- never understanding others. The nurse practitioner's telephone order dated 7/21/18 [no time documented] stated, "Send Resident to ED (emergency department) for eval (evaluation)/treatment." The nursing note dated 7/21/18 at 12:31 p.m. documented in part, "Resident noted to have diminished respirations, clammy and appears to be in distress. Lung sounds diminished with rhales [sic] (rales are small clicking, bubbling, or rattling sounds in the lungs which could indicate	F 625		

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F 625	Continued From page 84 inflammation of the lungs) (1) bilaterally ...NP (nurse practitioner) notified and new order obtained for resident to be sent to ED for evaluation and treatment." A review of the clinical record failed to evidence that written notification regarding the facility's bed hold policy was provided to the Resident #88 and or the Responsible Representative upon the resident's transfer to the hospital on 7/21/18. On 9/7/18 at 8:39 a.m., an interview was conducted with OSM (other staff member) #12, the social worker, regarding social services role when a resident is transferred to the hospital. OSM #12 stated that her department did not have a role. When asked who was responsible for sending bed hold notifications to residents, OSM #12 stated that the business office was responsible. An interview was conducted on 9/7/18 at 9:39 a.m. with OSM #10, the business office manager. OSM #10 stated that they do not provide bed hold information upon transfer to a facility, as the facility census has been "way down for over a year", so they always know they have a bed available for returning residents. On 9/7/18 at 3:26 p.m., ASM (administrative staff member) #1, the executive director, and ASM #2, the director of nursing, were made aware of the above findings. No further information was provided prior to exit. 1) This information was obtained from the National Institutes of Health at https://medlineplus.gov/ency/article/007535.htm	F 625		

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F 625	Continued From page 85 8. Resident #97 was transferred and admitted to the hospital on 5/23/18, 6/11/18, and 7/28/18. There was no evidence in the clinical record that the resident and/or Resident Representative was provided with a written bed hold notification for either transfer. Resident #97 was admitted to the facility on 4/30/18 with the diagnoses of but not limited to pulmonary embolism, atrial fibrillation, sepsis, congestive heart failure, hypoxemia, and surgical aftercare. The quarterly MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 8/7/18 coded the resident as being cognitively intact in ability to make daily life decisions. The resident was coded as requiring extensive assistance for transfers and toileting; assistance of one person for dressing and hygiene; and was independent for eating. A nurse's note dated 5/23/18 documented, "MD (medical doctor) in room this AM to assess patients. Resident was diaphoretic and SOB (shortness of breath). Lungs with rales and diminished right base. Assessed again by nurse and O2 (oxygen) sats (saturation) were 78% on 2l (two liters) O2 via nasal cannula, O2 was increased to 3l. continues {sic} to be short of breath and complains of dizziness and weakness. (name of son) called and notified of condition and of decision to send patient to hospital. Squad called and resident sent to (name of hospital) for further evaluation." A review of the Nursing Home to Hospital Transfer Form dated 5/23/18 failed to reveal any	F 625		

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F 625	Continued From page 86 evidence of a bed hold notice being provided. There was no evidence that the Resident or Resident Representative was provided with a written bed hold notice for the transfer to the hospital on 5/23/18. A review of the clinical record revealed a nurse's note dated 6/11/18 that documented, "Patient felt drowsy, denied any pain, and she stated, "I just don't feel right." Her VS (vital signs) at the beginning of the shift was 98.7-105-16-126/74-96% (temperature-pulse-respirations-blood pressure-oxygen saturation). After making the statement that she did not feel well a new set of VS was obtained at 5:30pm and were 98.2 (temperature)-76/50 (manually) (blood pressure)-26 (respirations)-98% 5L (oxygen saturation on 5 liters). MD notified and assessed patient. He feels that based on her history that she may be presenting with pleural effusions. Order obtained to send patient to the ED (Emergency Department) for evaluation. Son notified." A review of the Nursing Home to Hospital Transfer Form dated 6/11/18 failed to reveal any evidence of a bed hold notice being provided. There was no evidence that the Resident or Resident Representative was provided with a written bed hold notice for the transfer to the hospital on 6/11/18. A review of the nurse's notes revealed one dated 7/28/18 that documented, "This nurse was notified by CNA (certified nursing assistant) that Resident was clammy and not responding. Resident c/o (complained of) dizziness, hard to focus on anything, and nausea. Periods of	F 625		

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F 625	Continued From page 87 hypotension (low blood pressure) this am. MD notified with new orders to send for evaluation. Son (name of son) notified but yet to be contacted. 911 activated." A review of the Nursing Home to Hospital Transfer Form dated 7/28/18 failed to reveal any evidence of a bed hold notice being provided. There was no evidence that the Resident or Resident Representative was provided with a written bed hold notice for the transfer to the hospital on 7/28/18. On 9/7/18 at 8:47 a.m., in an interview with OSM #11, the director of social services, she stated that Admissions provides a written bed hold. At 9:11 a.m., she followed up with "For the bed hold, we were not enforcing it because census has been low enough that we have been able to have a bed available." On 9/7/18 at 9:39 a.m., in an interview with OSM #10, the business office manager, she stated, "We have not been doing bed holds due to census being way down for over a year. We just take everybody back." On 9/7/18 at 3:26 p.m., in a meeting with ASM #1 (Administrative Staff Member - the Executive Director) and ASM #2 (the Director of Nursing) they were made aware of the findings. No further information was provided by the end of the survey. 9. Resident #94 was transferred and admitted to the hospital on 7/27/18 and 8/8/18. There was no evidence in the clinical record that the resident and/or Resident Representative was provided	F 625		

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F 625	Continued From page 88	F 625		

with a written bed hold notification for either transfer.

Resident #94 was admitted to the facility on 6/28/18 with the diagnoses of but not limited to orthopedic aftercare, ischemic heart disease, high blood pressure, and chronic kidney disease. The admission/5-day MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 7/5/18 coded the resident as being cognitively intact in ability to make daily life decisions.

A review of the clinical record revealed the following nurses notes: 7/27/18 at 9:54 a.m., "...Resident was alert and oriented at beginning of shift this AM. Later morning resident became very lethargic and was having a hard time staying awake. MD (medical doctor was notified and resident was assessed. Had started promethazine {1} and Norco {2} this AM. and lethargy was noted to be related to medication changes....Lungs with slight crackles bilaterally. O2 (oxygen) sats (saturations) were 86% on room air. 95% on 2l (two liters of oxygen) via nasal cannula....Addendum: Resident continues with extreme lethargy at this time with continued need for supplemental O2. Reassessed by MD and orders given to sent to ER [emergency room] for further evaluation. Brother was notified. Addendum: Resident was admitted to (hospital) for acute kidney injury."

A review of the Nursing Home to Hospital Transfer Form dated 7/27/18 failed to reveal any evidence of a bed hold notice being provided. There was no evidence that the Resident or Resident Representative was provided with a written bed hold notice for the transfer to the

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F 625	Continued From page 89 hospital on 7/27/18. A nurse's note dated 8/8/18 at 1:30 PM documented, "Resident with increasing tremors throughout today. Temp (temperature) this AM was 98. is {sic} now 102.1. Heart rate of 151. Respirations 32. NP (nurse practitioner) notified of changes. Resident sent to (name of hospital) ER (emergency room). Family notified. Squad arrived at 1:30 PM." A review of the Nursing Home to Hospital Transfer Form dated 8/8/18 failed to reveal any evidence of a bed hold notice being provided. There was no evidence that the Resident or Resident Representative was provided with a written bed hold notice for the transfer to the hospital on 8/18/18. On 9/7/18 at 8:47 a.m., in an interview with OSM #11, the director of social services, she stated that Admissions provides a written bed hold. At 9:11 a.m., she followed up with "For the bed hold, we were not enforcing it because census has been low enough that we have been able to have a bed available." On 9/7/18 at 9:39 a.m., in an interview with OSM #10, the business office manager, she stated, "We have not been doing bed holds due to census being way down for over a year. We just take everybody back." On 9/7/18 at 3:26 p.m., in a meeting with ASM #1 (Administrative Staff Member - the Executive Director) and ASM #2 (the Director of Nursing) they were made aware of the findings. No further information was provided by the end of the	F 625		

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F 625	Continued From page 90 survey. {1} Promethazine - "Promethazine is also used to prevent and control nausea and vomiting that may occur after surgery, and with other medications to help relieve pain after surgery. Promethazine is also used to prevent and treat motion sickness. Promethazine helps control symptoms, but will not treat the cause of the symptoms or speed recovery..." Information obtained from https://medlineplus.gov/druginfo/meds/a682284.html {2} Norco - Hydrocodone and acetaminophen combination is used to relieve moderate to moderately severe pain. Information obtained from https://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0010590/	F 625		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, it was determined the facility staff failed to maintain accurate MDS (minimum data set) assessments for one of 42 residents in the survey sample, Resident #55. The facility staff failed to accurately code Section B0700, B0800 and failed to complete the cognitive interviews for Resident #55's annual	F 641	F 641 1. How will the corrective action be accomplished for those residents found to have been affected by the deficient practice? On 9/19/18, MDS Coordinator corrected the following assessments for resident #55: MDS Assessment Sections B0700, B0800, C0100 and C0500 for annual assessment dated 10/19/17; MDS Assessment Sections C0100 and C0500 for Significant Change Assessment dated 1/15/18;	10/15/18

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F 641	Continued From page 91 MDS assessment, with an assessment reference date of 10/19/17, and failed to complete the interview for the cognitive status for Resident #55's significant change MDS assessment with an assessment reference date of 1/15/18. The facility staff also failed to accurately code Section B0600 Speech Clarity and failed to complete the interviews for the quarterly MDS assessment, with an assessment reference date of 4/17/18 and the quarterly MDS assessment, with an assessment reference date of 7/18/18. The findings include: The facility staff failed to accurately code Section B0700, B0800 and failed to complete the cognitive interviews for Resident #55's annual MDS assessment, with an assessment reference date of 10/19/17, and failed to complete the interview for the cognitive status for Resident #55's significant change MDS assessment with an assessment reference date of 1/15/18. Resident #55 was admitted to the facility in January 2004 with diagnoses that included but were not limited to: Down's Syndrome (A genetic condition in which a person has 47 chromosomes instead of the usual 46. The extra chromosome causes problems with the way the body and brain develop. Down syndrome is one of the most common causes of birth defects.) (1), dementia, and diabetes. The MDS assessment, an annual assessment, with an ARD (assessment reference date) of 10/19/17, in Section B 0700 - Ability to express ideas and wants - coded the resident as understood. In Section B 0800 - Understanding	F 641	Continued from page 91 MDS Assessment Sections B0600, C0100 and C0500 for Quarterly Assessment dated 4/17/18; MDS Assessment Sections B0600, C0100 and C0500 for Quarterly Assessment dated 7/18/18. 2. How will the facility identify other residents having the potential to be affected by the same practice? Any resident with cognitive communication deficits have the potential to be affected by this practice. On 9/19/18, MDS Coordinator and Social Services Director reviewed most recent MDS assessment of all current residents with cognitive communication deficits to ensure accurate coding of Sections B0600, B0700, B0800, C0100 and C0500. Any resident assessment found to be inaccurately coded, assessment was corrected. 3. What measures will be put into place or systematic changes made to ensure the practice will not reoccur.	

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F 641	Continued From page 92 verbal content, however able (with hearing aid or device) - the resident was coded as understands. In Section C- Cognitive Patterns, for should a brief interview for mental status be conducted? The form documented a "No." The "No" indicated that the resident is rarely/never understood. The interview was not completed, though the resident was coded as understands and being understood. The significant change MDS assessment, with an ARD of 1/15/18, coded the resident in Section B 0600 Speech Clarity with unclear speech, sometimes understood, and sometimes understands others. In Section C- Cognitive Patterns, for the question should a brief interview for mental status be conducted? The form documented a "No." The "No" indicated that the resident is rarely/never understood. The interview was not completed, though the resident was coded as sometimes understanding others and sometimes understood. The facility staff also failed to accurately code Section B0600 Speech Clarity, and failed to complete the interviews for Resident #55's quarterly MDS assessment, with an assessment reference date of 4/17/18, and the quarterly MDS assessment, with an assessment reference date of 7/18/18. The quarterly MDS assessment with an ARD of 4/17/18, coded the resident in Section B0600 Speech Clarity as having clear speech. The resident was coded in Section B0700 and B0800 as sometimes understanding and sometimes being understood. In Section C- Cognitive Patterns, for the question should a brief interview for mental status be conducted? The form	F 641	Continued from page 92 By 9/20/18, Staff Development Coordinator will provide written education to current MDS Coordinators, Assistant Director of Nursing, Social Services Director and Social Services Assistant to follow RAI Manual reference tool when completing MDS Assessment to ensure accurate coding. On 9/19/18 MDS Coordinator, Assistant Director of Nursing, Social Services Director participated in company promoted webinar that included updates of Section B and Section C of RAI Manual effective October 1, 2018. Director of Nursing/MDS Coordinator and Social Services Director will review MDS Assessment Sections B0600, B0700, B0800, C0100 and C0500 of residents determined to have cognitive communication deficits to ensure accurate coding prior to transmission one time per week x90 days. 4. How will the facility monitoring the corrective plan to ensure the deficient practice was corrected and not reoccur? Director of nursing will present findings	

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F 641	Continued From page 93 documented a "No." The "No" indicated that the resident is rarely/never understood. The interview was not completed, though the resident was coded as sometimes understanding others and sometimes understood. The quarterly assessment with an ARD of 7/18/18, coded the resident in Section B0600 Speech Clarity as having clear speech. The resident was coded in Section B0700 and B0800 as sometimes understanding and sometimes being understood. In Section C- Cognitive Patterns, for the question should a brief interview for mental status be conducted? The form documented a "No." The "No" indicated that the resident is rarely/never understood). The interview was not completed, though the resident was coded as sometimes understanding others and sometimes understood. The comprehensive care plan dated, 2/20/15 and updated on 8/31/17 documented in part, "Problems: Resident has impaired communication related to expressive problem (difficulty finding right words. Diagnosis/condition - Resident has a DX (diagnosis) Downs Syndrome and Alzheimer's disease." The "Approaches" documented in part, "Use questions that can be answered 'yes' or 'no' with non-verbal signs (head nod, blinking, eye, etc.) if needed." The comprehensive care plan dated, 2/20/18 and revised on 7/30/18, documented in part, ""Problems: Resident has impaired communication related to expressive problem (difficulty finding right words. Diagnosis/condition - Resident has a DX (diagnosis) Downs Syndrome and Alzheimer's disease." The	F 641	Continue from page 93 of audit accurate assessment findings to the Quality Assurance Performance Improvement committee for review and recommendations for 90 days. The QAPI committee consist of Executive Director, Director of Nursing, Assistant Director of Nursing, Social Services, Activities, Dietary Manager, Pharmacy consultant, Medical Director.	

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F 641	Continued From page 94 "Approaches" documented in part, "Use questions that can be answered 'yes' or 'no' with non-verbal signs (head nod, blinking, eye, etc.) if needed." An interview was conducted on 9/7/18 at 8:19 a.m. with LPN (licensed practical nurse) #5, the MDS nurse. When asked who completes Section B of the MDS assessments, LPN #5 stated the MDS nurses do that section. When asked who completes Section C of the MDS assessments, LPN #5 stated the social workers do that section. An interview was conducted with other staff member (OSM) #12, the social services assistant, on 9/7/18 at 8:24 a.m. When asked who completes Section C - Cognitive Patterns, OSM #12 stated that she did that section. Section C of the following MDS assessments were reviewed with OSM #12: Significant change assessment with an ARD of 1/15/18, the quarterly assessment with an ARD of 4/17/18 and the quarterly assessment with an ARD of 7/18/18. When asked why she did not complete the interview for cognitive status, OSM #12 stated the resident is non-verbal and can't complete the interview. When asked if he was rarely/never understood, OSM #12 stated no, he does say "Yeah and No." Section B of the above assessments were reviewed where the resident was coded as sometimes understood on all three assessments. When asked if the interview should be completed, OSM #12 stated she would have to look into that. An interview was conducted with LPN #5 on 9/7/18 at 8:53 a.m. LPN #5 was asked to review Resident #55's MDS assessments from April and July 2018. LPN #5 was then asked if the resident	F 641		

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F 641	Continued From page 95	F 641		

has clear speech. LPN #5 stated that no he doesn't have clear speech. When asked if this section was coded correctly, LPN #5 stated it was not coded correctly. When asked what reference the facility utilizes for completing the MDS assessments, LPN #5 stated, "The RAI (resident assessment instrument) Manual."

An interview was conducted with OSM #11, the director of social services, on 9/7/18 at 8:57 a.m. The MDS assessment with an ARD of 10/19/17 was reviewed with OSM #11. When asked if the interview for cognitive status should have been completed, OSM #11 stated, "Yes, it was coded incorrectly in Section C."

An interview was conducted with administrative staff member (ASM) #3, the assistant director of nursing; on 9/7/18 at approximately 2:30 p.m., ASM #3 was asked to review the MDS assessment, with an ARD of 10/19/18 for Section B0700 and B0800 - being understood and understanding others. The resident was coded as understanding others and being understood. When asked why it was coded like that, ASM #3 stated, "I don't know why I coded that that way. He definitely is not understood and understands. He can communicate but with one-word answers that are normally Yeah and No. I coded that incorrectly."

Copies of the RAI manual was provided by the facility. The manual documented in part, "Section B 0600 - Speech Clarity - the verbal expression of articulate words. Planning for Care: If speech is absent or is not clear enough for the resident to make needs known, other methods of communication should be explored. Lack of

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F 641	Continued From page 96	F 641		

speech clarity or ability to speak should not be mistaken for cognitive impairment. Coding Instructions: Code 0, clear speech if the resident usually utters distinct, intelligible words. Code 1, unclear speech if the resident usually utters slurred or mumbled words. Code 2, no speech if there is absence of spoken words.
B0700 - Makes Self Understood - Code 0 - understood if the resident expresses requests and ideas clearly. Code 1 - usually understood if the resident has difficulty communicating some words or finishing thought but is able if prompted or given time. He or she may have delayed responses or may require some prompting to make self-understood. Code 2 - sometimes understood if the resident has limited ability, but is able to express concrete requests regarding at least basic need (food, drink, sleep toilet). Code 3 - rarely or never understood if, at best, the resident's understanding is limited to staff interpretation of highly individual, resident=specific sounds or body language (indicated presence of pain or need to toilet). B 0800 - Ability to Understand Others - Code 0 if the resident clearly c Code 1, usually understands if the resident misses some part of intent of the message but comprehends most of it. The resident may have periodic difficulties integrating information but generally demonstrates comprehends by responding in words or actions. Code 2 - sometimes understands if the resident demonstrates frequent difficulties integrating information, and responds adequately only to simple and direct questions or instructions. When staff rephrase or simplify the message and/or uses gestures, the resident's comprehension is enhanced. Code 3 - rarely/never understands if the resident demonstrates very limited ability to understand

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F 641	Continued From page 97	F 641		

communication. Or, if staff have difficulty determining whether or not the resident comprehends messages, based on verbal and non verbal responses. Or, the resident can hear sounds but does not understand messages. Section C - Cognitive Patterns - Record whether the cognitive interview should be attempted with the resident. Code 0, no if the interview should not be attempted because the resident rarely/never understood, cannot respond verbally or in writing or an interpreter is needed but not available. Code 1, Yes if the interview should be attempted because the resident is at least sometimes understood verbally or in writing and if an interpreter is needed, one is available...Code 99, unable to complete interview if the resident chooses not to participated in the BIMS (brief interview for mental status); if four or more items were coded 0 because the resident chose not to answer or gave a nonsensical response or if any of the BIMS items is coded with a dash. A zero score does not mean the BIMS was incomplete. To be incomplete, a resident had to choose not to answer or give completely unrelated, nonsensical responses to four or more items."

Administrative staff member (ASM) #1, the executive director and ASM #2, the director of nursing, were made aware of the above findings on 9/7/18 at 3:26 p.m.

No further information was provided prior to exit.

(1) This information was obtained from the following website: https://medlineplus.gov/ency/article/000997.htm.

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F 645	Continued From page 98	F 645		
F 645 SS=D	PASARR Screening for MD & ID CFR(s): 483.20(k)(1)-(3) §483.20(k) Preadmission Screening for individuals with a mental disorder and individuals with intellectual disability. §483.20(k)(1) A nursing facility must not admit, on or after January 1, 1989, any new residents with: (i) Mental disorder as defined in paragraph (k)(3)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission, (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services; or (ii) Intellectual disability, as defined in paragraph (k)(3)(ii) of this section, unless the State intellectual disability or developmental disability authority has determined prior to admission- (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services for intellectual disability. §483.20(k)(2) Exceptions. For purposes of this section- (i)The preadmission screening program under paragraph(k)(1) of this section need not provide	F 645	F 645 1. How will the corrective action be accomplished for those residents found to have been affected by the deficient practice? Our policy at Life Care Centers of America is to ensure a Preadmission Screening and Resident Review (PASRR) is completed so that individuals are not inappropriately placed in nursing homes for long term care. Federal requirements state PASRR requires 1) all applicants to a Medicaid-certified nursing facility be evaluated for serious mental illness (SMI) and/or intellectual disability; 2) be offered the most appropriate and least restrictive setting for their needs (in the community, a nursing facility, or acute care settings); and 3) receive the services they need in those settings. When concern was identified Social Services and Admissions Director collaborated to obtain Level 1 PASRR screening tool. On 9/21/18, Level 1 PASRR was completed on resident #48, #88, and #40.	10/15/18

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F 645	Continued From page 99 for determinations in the case of the readmission to a nursing facility of an individual who, after being admitted to the nursing facility, was transferred for care in a hospital. (ii) The State may choose not to apply the preadmission screening program under paragraph (k)(1) of this section to the admission to a nursing facility of an individual- (A) Who is admitted to the facility directly from a hospital after receiving acute inpatient care at the hospital, (B) Who requires nursing facility services for the condition for which the individual received care in the hospital, and (C) Whose attending physician has certified, before admission to the facility that the individual is likely to require less than 30 days of nursing facility services. §483.20(k)(3) Definition. For purposes of this section- (i) An individual is considered to have a mental disorder if the individual has a serious mental disorder defined in 483.102(b)(1). (ii) An individual is considered to have an intellectual disability if the individual has an intellectual disability as defined in §483.102(b)(3) or is a person with a related condition as described in 435.1010 of this chapter. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, it was determined that the facility staff failed to ensure a level one PASARR (Preadmission Screening and Resident Review) was completed for three of 42 residents in the survey sample, Residents # 48, 88, and 40. 1. The facility staff failed to ensure Resident	F 645	Continued from page 99 2. How will the facility identify other residents having the potential to be affected by the same practice? All residents have the potential to be affected if they are admitted to facility without having Level 1 PASRR. On 9/7/18, Admission Directors were made aware to verify each potential admission had Level 1 PASRR on file prior to admission to facility. On 9/20/18, all current resident medical records were reviewed by Social Services Director, Health Information Management, and Unit Manager. Any resident found to not have a Level 1 PASRR present in their medical record will have a screening completed by qualified associate before 9/28/18. 3. What measures will be put into place or systematic changes made to ensure the practice will not reoccur? Staff Development Coordinator provided written education and policy to Admission Directors, Social Services Director, and Social Services Assistant on 9/24/18.	

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F 645	Continued From page 100 #48's level one PASARR was completed to ensure the resident was evaluated and receiving care and services in the most integrated setting appropriate for the resident's needs. 2. The facility staff failed to ensure Resident #88's level one PASARR (preadmission screening and resident review) was completed to ensure the resident was evaluated and receiving care and services in the most integrated setting appropriate for the resident's needs. 3. The facility staff failed to ensure Resident #40's level one PASARR was completed to ensure the resident was evaluated and receiving care and services in the most integrated setting appropriate for the resident's needs. The findings include: 1. Resident #48 was admitted to the facility on 8/20/07, with a most recent readmission of 3/20/18, with diagnoses that included but were not limited to: chronic obstructive pulmonary disorder (a lung disorder that makes it hard to breath) (1), multiple strokes, high blood pressure, anxiety, and bipolar disorder (a serious mental illness which causes people who have it go through unusual mood changes. They go from very happy, "up," and active to very sad and hopeless, "down," and inactive, and then back again) (2). The most recent MDS (minimum data set) assessment, a significant change in status assessment, with an assessment reference date of 7/05/18, coded the resident as scoring a "9" on the BIMS (brief interview for mental status) score,	F 645	Continued from page 100 Admission Directors will verify Level 1 PASRR is present and complete prior to accepting any new admission to facility. Social Services Director will validate presence of Level 1 PASRR on all new admissions 5 times a week x4 weeks, 3 times a week x4 weeks, 1 time a week x 4 weeks. 4. How will the facility monitoring the corrective plan to ensure the deficient practice was corrected and not reoccur? Social Services Director will present findings of audit accurate assessment findings to the Quality Assurance Performance Improvement committee for review and recommendations for 90 days. The QAPI committee consist of Executive Director, Director of Nursing, Assistant Director of Nursing, Social Services, Activities, Dietary Manager, Pharmacy consultant, Medical Director.	

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F 645	Continued From page 106 member) #1, the Executive Director, and ASM #2, the DON (Director of Nursing) were made aware of the above concerns. No further information was presented prior to exit. (1) Depressive Disorder- Depression (major depressive disorder or clinical depression) is a common but serious mood disorder. It causes severe symptoms that affect how you feel, think, and handle daily activities, such as sleeping, eating, or working. To be diagnosed with depression, the symptoms must be present for at least two weeks. This information was obtained from The National Institutes of Health. https://www.nimh.nih.gov/health/topics/depression/index.shtml. (2) Anxiety Disorder- Anxiety is feelings of fear, dread, and uneasiness that is a reaction to stress. Anxiety disorder is a category of disorders characterized as feelings of anxiety and fear. Feelings may cause physical symptoms such as racing heart, shakiness. Anxiety disorder is when anxiety and worry become excessive. This information was obtained from The National Institutes of Health. https://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0024920/.	F 645		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that	F 657	F 657 1. How will the corrective action be accomplished for those residents found to have been affected by the deficient practice? On 9/7/18, MDS Coordinator reviewed and revised the comprehensive care plan for resident #55. A patient centered care plan for Seizure Activity was implemented that	10/15/18

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F 657	Continued From page 107 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 interview, facility document review and clinical record review, it was determined the facility staff failed to review and revise the comprehensive care plan for one of 42 residents in the survey sample, Resident #55. The facility staff failed to review and revise Resident #55's comprehensive care plan after the most recent MDS was completed, to address the resident's new diagnosis of and medication prescribed for seizures. The findings include: Resident #55 was admitted to the facility in	F 657	Continued from page 107 that included prescribed seizure medication with measurable goals, approaches and target dates. 2. How will the facility identify other residents having the potential to be affected by the same practice? All residents with a diagnosis of seizures has the potential to be affected by this practice. On 9/19/18, Director of Nursing reviewed all residents with diagnosis of seizures for comprehensive care plans addressing Seizure Activity and seizure medication use. Any resident found not to have a current comprehensive care plan for Seizure Activity and/or medication for seizures, their care plan was updated and implemented by Director of Nursing. 3. What measures will be put into place or systematic changes made to ensure the practice will not reoccur. By 10/8/18, Staff Development Coordinator/ Director of Nursing/Assistant Director of Nursing or MDS Coordinator will educate on implementing and revising care plans for seizure activity and/or medication for seizures along with approaches for care. Any Licensed Nurse that has not been in-serviced by 10/8/18 will not be allowed to provide direct care until in-service is completed.	

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F 657	Continued From page 108 January 2004 with diagnoses that included but were not limited to: Down's Syndrome (A genetic condition in which a person has 47 chromosomes instead of the usual 46. The extra chromosome causes problems with the way the body and brain develop. Down syndrome is one of the most common causes of birth defects.) (1), dementia, and diabetes. The most recent MDS (minimum data set) assessment, a quarterly assessment, with an ARD (assessment reference date) of 7/18/18, coded the resident as having short-term memory difficulties and no long term memory difficulties. The resident was coded as being severely impaired to make daily cognitive decisions. Resident #55 was coded as requiring extensive assistance of one or more staff members for all of his activities of daily living. In Section I - Active Diagnoses, the resident was coded as having a seizure disorder. The nurse's note dated, 9/5/17 at 5:20 a.m. documented in part, "At 5:00 a.m. while receiving breathing tx (treatment), I entered the resident's room to find him with red face, grunting respirations, and his extremities with decorticate posturing. He was noted to have some light bleeding coming from his mouth. Breathing tx (treatment) stopped. Resident's normal skin tone returned to his face and he began to take deep breaths. Eyes were crossed and not focusing on anything. No response to verbal stimuli from resident. Cleansed outer lips, but resident wouldn't open his mouth so I could check for the source of bleeding. After a few minutes his eyes returned to their normal and resident closed his eyes and began with normal respirations. Before I left the room, the resident was smiling and	F 657	Continued from page 108 All newly hired nurses will receive education on implementing and revising care plans in orientation. All new admissions/readmissions and telephone orders will be reviewed in grand rounds (daily clinical meeting) by Director of Nursing/Unit Manager/MDS Coordinator to determine if resident has diagnosis of seizures and/or receives medications for seizures to ensure a patient centered care plan has been implemented to reflect Seizure Activity and/or medication for seizures with approaches 5 times a week x30 days, 3 times a week x30 days, 1 time a week x30 days. 4. How will the facility monitoring the corrective plan to ensure the deficient practice was corrected and not reoccur? Director of nursing will present findings of audit accurate care plan findings to the Quality Assurance Performance Improvement committee for review and recommendations for 90 days. The QAPI committee consist of Executive Director, Director of Nursing, Assistant Director of Nursing, Social Services, Activities, Dietary Manager, Pharmacy consultant, Medical Director.	

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F 657	Continued From page 109 moving his arms about normally." The nurse's note dated, 9/5/17 at 6:19 pm. documented, "7a-7p (7:00 a.m. to 7:00 p.m.) nursing note: Resident was observed with seizure like activity this morning lasting approximately 5-7 minutes. Resident was unresponsive, with no pupillary reflex, with abdominal breath at 32 breaths per minute. Resident was placed on side to prevent any further complications. Post seizure VS (vital signs) 120/55 (blood pressure) 93 (heart rate), 22 (respirations) O2 (Oxygen) sat (saturation) on RA (room Air). Resident was transported via ambulance to (initials of hospital) ER (emergency room) for evaluation. Residents brother stated resident should have been taking Keppra 500 mg BID after previous discharge from (initials of hospital). Oder for Keppra 500 mg BID obtained, faxed to Pharmacy and is pending in delivery. Residents brother stated that resident has not eaten anything all day and has maintained a 'decent blood glucose.' Resident arrived back from (initials of hospital) at 5:15 p.m. with a blood glucose of 327, no insulin given. All meds (medications) from 7 am until 4 p.m. have not been given due to resident being OOF (out of facility). Resident is currently in bed resting with eyes closed, with respiration being even and unlabored. Call bell is within reach." Review of the active care plan dated, 2/20/15, reprinted, and revised on 7/30/18, failed to evidence documentation related to seizures. The care plan documented in part, "At risk for fall related injury - disease process - Hx (history) of seizure disorder." On 9/7/18, at approximately 9:15 a.m., an interview was conducted with RN (registered	F 657		

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F 657	Continued From page 110 nurse) #3, a.m. RN #3 was asked if there be a care plan to address seizures for a resident diagnosed as having seizures, who is on anti-seizure medication. RN #3 stated, "Yes, I believe so." RN #3 was asked to review nurse's notes from September 2017 for Resident #55 as documented above and the current care plan to see if it addresses the resident's seizures. RN #3 stated, "There isn't one here." When asked if there should be one, RN #3 stated, "Yes, you have to keep the resident safe during a seizure." An interview was conducted with LPN (licensed practical nurse) #3 on 9/7/18 at 12:13 p.m. LPN #3 was asked if a resident with a new diagnosis of seizures, would have a care plan addressing the diagnosis and care required. LPN #3 stated, "Yes, once they have a diagnosis of seizures, their care plan should be updated for it." When asked the purpose of the care plan, LPN #3 stated, "It lays out their plan of care, their goals and the steps to reach that goal." An interview was conducted with administrative staff member (ASM) #3, the assistant director of nursing, on 9/7/18 at 2:30 p.m. When asked the purpose of the care plan, ASM #3 stated, "It's to give that patient, patient centered care. It's how we know their goals and approaches." The facility policy, "Resident Assessment Instrument & Care Plan," documented in part, "The information identified using the MDS and Care Area Assessment process is used to develop an individualized person=centered Care Plan that includes the patient's voice, the patient's goals while resident in the facility and for discharge that assist the patient to attain and/or maintain their highest level of well-being."	F 657		

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F 657	Continued From page 111 Administrative staff member (ASM) #1, the executive director and ASM #2, the director of nursing, were made aware of the above findings on 9/7/18 at 3:26 p.m. No further information was provided prior to exit. (1) This information was obtained from the following website: https://medlineplus.gov/ency/article/000997.htm.	F 657		
F 658 SS=G	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on family interview, staff interview, facility document review and clinical record review, it was determined the facility staff failed to ensure a resident was free of a significant medication error for one of 42 residents in the survey sample, Resident #55. The facility staff failed to ensure a complete review of hospital discharge orders for Resident #55, and failed transcribe an order for an anti-seizure medication upon Resident #55's readmission to the facility on 8/31/17. The resident was not administered the anti-seizure medication from 9/1 through 9/5/17 and on 9/5/17, Resident #55 had a seizure, resulting in harm and transfer to a local emergency room.	F 658	Past noncompliance: no plan of correction required.	

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F 658	Continued From page 112 The findings include: Resident #55 was admitted to the facility in January 2004 with diagnoses that included but were not limited to: Down's Syndrome (A genetic condition in which a person has 47 chromosomes instead of the usual 46. The extra chromosome causes problems with the way the body and brain develop. Down syndrome is one of the most common causes of birth defects.) (1), dementia, and diabetes. The most recent MDS (minimum data set) assessment, a quarterly assessment, with an ARD (assessment reference date) of 7/18/18, coded the resident as having short term memory difficulties and no long term memory difficulties. The resident was coded as being severely impaired to make daily cognitive decisions. Resident #55 was coded as requiring extensive assistance of one or more staff members for all of his activities of daily living. The MDS assessment, close to the date of the medication error, an annual assessment, with an ARD of 10/19/17, coded the resident as having both short and long term memory difficulties and being severely impaired to make daily cognitive decisions. Resident #55 was coded as requiring extensive assistance of one or more staff members for all of his activities of daily living. The Facility Reported Incident (FRI) dated 9/5/17, documented in part, "Injuries: yes, seizure, bit tongue with laceration. Prescribed medication (Keppra*) omitted from 9/1/17 - 9/4/17, resulting in seizure activity in a.m.(morning) of 9/5/18. Resident was sent to Emergency Room for evaluation and was not admitted and is returning	F 658		

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F 658	Continued From page 113 to facility on 9/5/17. *Keppra- is used to treat certain types of seizures in the treatment of epilepsy. This medication cannot cure epilepsy and will only work to control seizures as long as you continue to use it.(2) The pharmacokinetics of levetiracetam have been studied in healthy adult subjects, adults and pediatric patients with epilepsy, elderly subjects and subjects with renal and hepatic impairment. Keppra (Levetiracetam) is rapidly and almost completely absorbed after oral administration. Keppra (Levetiracetam) plasma half-life in adults is 7 ± 1 hour. (4) The letter dated 9/8/17 to the state agency documented in part the following: "It was reported to Unit Manager on 9/5/17 that above resident (Resident #55) had a seizure on the morning of 9/5/17 and was transferred to the hospital as a precautionary measure and resident returned from the same day,... Resident had been readmitted from the hospital on 9/1/17. In reviewing the discharge orders from the hospital on 9/1/17 to this resident's previous orders, there were not any new orders noted by the Nurse or Physician or staff for a seizure medicine. This resident also was not on any seizure medication prior to his hospital stay. After this resident returned to the facility [on 9/1/17], the facility received by fax, the After Discharge Summary. This was reviewed by Physician and forwarded to nursing unit with no new orders. Upon review of both documents it was noted that the After Discharge Summary, did contain a seizure medication, which this resident was not on prior to hospital stay. Nursing staff will be educated that all documents coming in for	F 658		

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F 658	Continued From page 114 residents from the hospital or outside physician visits need to be reviewed for any changes and appropriate follow taken as needed." The physician orders dated 8/31/17 failed to evidence documentation of a physician order for Keppra. A telephone order dated, 9/5/17 documented, "Keppra 500 mg (milligrams) po (by mouth) take 1 tab (tablet) po BID (twice a day) for seizures." The nurse's note dated, 9/5/17 at 5:20 a.m. documented in part, "At 5:00 a.m. while receiving breathing tx (treatment), I entered the resident's room to find him with red face, grunting respirations, and his extremities with decorticate posturing. He was noted to have some light bleeding coming from his mouth. Breathing tx (treatment) stopped. Resident's normal skin tone returned to his face and he began to take deep breaths. Eyes were crossed and not focusing on anything. No response to verbal stimuli from resident. Cleansed outer lips, but resident wouldn't open his mouth so I could check for the source of bleeding. After a few minutes his eyes returned to their normal and resident closed his eyes and began with normal respirations. Before I left the room, the resident was smiling and moving his arms about normally." The nurse's note dated, 9/5/17 at 6:19 p.m., documented, "7a-7p (7:00 a.m. to 7:00 p.m.) nursing note: Resident was observed with seizure like activity this morning lasting approximately 5-7 minutes. Resident was unresponsive, with no pupillary reflex, with abdominal breath at 32 breaths per minute. Resident was placed on side to prevent any further complications. Post seizure VS (vital signs) 120/55 (blood pressure) 93 (heart	F 658		

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rate), 22 (respirations) O2 (Oxygen) sat (saturation) on RA (room Air). Resident was transported via ambulance to (initials of hospital) ER (emergency room) for evaluation. Residents brother stated resident should have been taking Keppra 500 mg BID after previous discharge from (initials of hospital). Order for Keppra 500 mg BID obtained, faxed to Pharmacy and is pending in delivery. Residents brother stated that resident has not eaten anything all day and has maintained a 'decent blood glucose.' Resident arrived back from (initials of hospital) at 5:15 p.m. with a blood glucose of 327, no insulin given. All meds (medications) from 7 am until 4 p.m. have not been given due to resident being OOF (out of facility). Resident is currently in bed resting with eyes closed, with respiration being even and unlabored. Call bell is within reach."

The comprehensive care plan dated, 2/5/15 and revised on 8/31/17, failed to evidence documentation of the new diagnosis of seizures on the care plan.

The "Discharge Summary Notes" dated, 8/31/17, documented in part, "START taking these medications: Levetiracetam, Keppra 500 mg PO TABS- take 1 tab by mouth every 12 hours."

An interview was conducted with Resident #55's family member on 9/6/18 at 4:00 p.m. the family member explained to this surveyor that when Resident #55 returned from the hospital on 8/31/17, from being treated for a UTI (urinary tract infection), the facility staff didn't have an order for the Keppra. The family member explained that during his stay at the hospital Resident #55 was observed to have a grand mal seizure while in the emergency room. He was

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started on Keppra in the hospital for seizures. Upon his return to the facility, the family member asked a nurse, twice, about the order for Keppra. Each time the nurse told him he (Resident #55) didn't have an order for Keppra. After Resident #55 returned from the ER on 9/5/17, a nurse (no longer employed at the facility) pulled him aside and told him that ... the order (for Keppra) was here all the time.

On 9/6/18 at 6:08 p.m. administrative staff member (ASM) #1, the executive director, and ASM #2, the director of nursing, were made aware of the concern for harm.

An interview was conducted with LPN (licensed practical nurse) #4, the nurse whom the family member asked twice about the order for Keppra; on 9/6/18 at 6:41 p.m., LPN #4 was asked about the process staff follows for physician orders when a resident is admitted or on a readmission. LPN #4 stated, "Normally the physician gets the order from the hospital. They (the orders) are brought to us by (name of director of business development). The orders are on the top with the discharge summary stapled to the back. We take them to the doctor, he will write the diagnoses for the medication, and he can add or subtract medications. The doctor signed the bottom of each page. After they sing them, we fax them to the pharmacy. After they go to the pharmacy, we call the pharmacy to verify that they received the orders. One nurse will import the physician orders and initiate the fixed order set in the computer. After that is printed, another nurse compares and verify every order is correct. Both nurses sign the updated sheets. After that we print up the MARs (medication administration records) and TARs (treatment administration records), we both verify

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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 658	Continued From page 117 the MARs with the orders." LPN #4 was asked what she recalled from when Resident #55 returned to the facility on 9/1/17. LPN #4 stated she took care of Resident #55 on the second or third day he was back. When asked if she remembered the family asking about Keppra, LPN #4 stated, "No, I remember (name of family member) saying (Resident #55) received a medication for seizures. That triggered me to look at the chart. I looked at hospital records and our orders; there was no orders for Keppra. Then I looked at the discharge packet, I noted that the resident had received Ativan*. He asked me twice and I looked at the exact same spot. I then went on vacation. I came back and found out he had a new order for Keppra. *(Lorazepam [Ativan] is used to relieve anxiety. Lorazepam is in a class of medications called benzodiazepines. It works by slowing activity in the brain to allow for relaxation. (3) An interview was conducted with administrative staff member (ASM) #4, the medical director; on 9/6/18 at 6:51 p.m., ASM #4 stated the facility has had difficulty with obtaining the correct orders for residents transferred to the facility. He stated the facility goes by the AVS (after visit summary) to get the medications in the facility. Sometimes the facility receives a second and third AVS. He stated he has spoken to the hospital after this occurred and they are only sending one AVS. ASM #4 stated, The hospital sent the AVS (for Resident #55) and the Keppra was not on it. It was reviewed by (ASM #5), the covering physician as ASM #4 stated he was out of town. Somehow, another AVS [for Resident #55] came in that same day, it was not signed by the	F 658		

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	495139	A. BUILDING _____ B. WING _____	09/07/2018

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F 658	Continued From page 118 physician and it was kept somewhere else. ASM #4 stated, now the process is if there is a change from what they originally sent, the hospital has to call us. ASM #4 stated that upon his return from vacation, we went through the entire paper record. The second AVS was there and had the order for the Keppra. When asked who is ultimately responsible, ASM #4 stated, "We are." An interview was conducted with RN (registered nurse) #3, the interim director of nursing at the time of the incident, on 9/7/18 at 9:15 a.m. When asked her knowledge of the incident, RN #3 stated, "I know that there was an order set that had come in. A piece was out of it. We didn't have the page with the Keppra. The family told us he was supposed to be on Keppra. We couldn't find the order for it. We were missing a page of the orders." When asked if the order was found in the facility, RN #3 stated, "Yes, (ASM #4 [medical director]) went through the record, page by page and found the order." An interview was conducted with other staff member (OSM) #17, the director of business development; on 9/7/18 at 9:23 a.m., OSM #17 was asked about the process in place during September 2017, for reciving information from the hospital for an admission. OSM #17 stated, "My process hasn't really changed. I will review the information in the computer program from the hospital. I print it out and hand it to the physician directly. That's the end of my involvement." When asked about the process in place now, OSM #17 stated, the hospital has an upgraded system and that the facility has access to the system. I still print the information and hand it to the medical provider. The AVS (after visit summary) is what the hospital sends. It used to be called discharge	F 658		

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F 658	Continued From page 119	F 658		

orders. It's essentially the medication list. I print the H&P (history and physical) and that set of orders. Then I hand it to (ASM #4) or (ASM #5). The papers go straight into the hands of the physician or nurse practitioner."

When asked her knowledge of what happened with Resident #55 last September, OSM #17 stated that the first set of orders came in around 2:00 p.m. I took them down to the unit. A second set came over the fax around 4:00 p.m. It was a second document but an AVS (after visit summary). The hospital has up to 72 hours to provide a discharge summary but the AVS is what the doctors go by for the orders, and it was two hours before the second one arrived here." When asked why the documents at 2:00 p.m. didn't match the documents at 4:00 p.m., OSM #17 stated, "Sometimes it doesn't the AVS is the one that the patient is walking in the door with. Discharge summaries are unpredictable they are late. The process for the admission steps is the same today as it was in September, last year. We still print the same documents and hand them to the physician directly."

An interview was conducted with ASM #1, the executive director, on 9/7/18 at 9:55 a.m. When asked about his knowledge of the incident with Resident #55 on 9/5/17, ASM #1 stated the order had come into the facility. The doctor (ASM #5) reviewed the orders and then gave the orders to the nurse. It wasn't until he went out with the seizure that (ASM #4) the medical director, went through the clinical record, page by page, and found the order in the hospital paperwork." When asked who is ultimately responsible, ASM #1 stated, "We are." ASM #1 stated there is now a double check system by two nurses that was put

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F 658	Continued From page 120 in place after this happened." A request was made at this time, for any documentation of the new process that the facility put into place after the incident. The facility policy, "Physician Order Processing Procedure" dated, 11/19/16, documented in part, "Admission orders are written prior to or upon each admission or readmission. Or written by the physician, nurse practitioner or physician's assistant; obtained via telephone by the nursing staff from the physician, or transcribed from the transfer orders. A copy of the admitting orders will be faxed to the pharmacy as soon as possible. An initial set of Medication and Treatment Administration records will be created and placed in the appropriate medication/treatment books. " On 9/7/18 at 11:51 a.m., ASM #1 presented a copy of the "Quality Assurance and Performance Improvement Plan" dated, 9/5/17, which documented "Observation: Resident did not have Keppra on admission orders from hospital." The "Actions" documented, "Resident was assessed. MD (medical doctor) and responsible party was notified of seizure possible missing medications. Resident was sent to ER for evaluation. Resident was sent back to facility." All residents admitted since (ASM #5) had been assisting admission orders will be reviewed for any missing orders or transcription errors. Nursing will be educated when orders are completed prior to resident arriving they must compare to orders received when resident arrives for any changes made prior to leaving hospital. Two nurses will review all new admissions. Nursing administration will review 5 days a week. All nurses not receiving in service training will not work until education is completed. Education will be added to orientation packet.	F 658		

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F 658	Continued From page 121 DON (director of nursing) to report finding of daily audit 5 days a week to PI (performance improvement) for review and recommendations." Interviews were conducted with six current nurses. The nurses interviewed had been in the facility before the incident and two nurses had just started working at the facility a few months ago. All of the nurses could correctly state the double check system for admission/readmission orders and following physician orders. No further information was provided prior to exit. PAST NON-COMPLIANCE (1) This information was obtained from the following website: https://medlineplus.gov/ency/article/000997.htm. (2) This information was obtained from the following website: https://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0010898/?report=details (3) This information was obtained from the following website: https://medlineplus.gov/druginfo/meds/a682053.html. (4) This information was obtained from the website: https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=d1329893-a8bc-4f31-a31b-76690d111035	F 658		
F 679 SS=E	Activities Meet Interest/Needs Each Resident CFR(s): 483.24(c)(1) §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on	F 679	F 679 1. How will the corrective action be accomplished for those residents found to have been affected by deficient practice?	10/15/18

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F 679	Continued From page 122 the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review and clinical record review, it was determined that the facility staff failed to provide a complete activity program for one of 42 residents in the survey sample, Resident # 75. The facility staff failed to provide evidence staff offered and engaged Resident #42 in an ongoing program of activities. The findings include: Resident # 75 was admitted to the facility on 07/25/18 with diagnoses that included but were not limited to anemia (1), hypertension (2), diabetes mellitus (3), and dementia (4). Resident # 75's most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 08/01/18, coded Resident # 75 as scoring a three (3) on the brief interview for mental status (BIMS) of a score of 0 - 15, three (3) - being severely impaired of cognition for making daily decisions. Resident # 75 was coded as requiring extensive assistance of one staff member for activities of daily living. Section F "Preferences for Customary Routine and Activities" coded Resident # 75 as "Very	F 679	Continued from page 122 Our facility policy states we must provide, based on comprehensive assessment and care plan and the preferences of each patient, an ongoing program to support patients in their choice of activities, both facility sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well- being of each patient, encouraging both independence and interaction in the community. When Activity Director was notified on 9/6/18 of concern for resident #75 she immediately assessed resident room and placed a music player with resident preference of radio station. Comprehensive care plan goals and approaches for activities were reviewed and revised for resident #75 to indicate one-to one activities. 2. How will the facility identify other residents having the potential to be affected by the same practice?	

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F 679	Continued From page 123 important for having family or a close friend involved in discussion about your care" and "Somewhat important for going outside to get fresh air when the weather is good." On 09/05/18 at approximately 1:43 p.m., Resident # 75 was observed lying in bed, with the bed positioned was low to floor. Observation of Resident # 75's room failed to evidence a radio, music playing or a television. On 09/05/18 at approximately 3:00 p.m., Resident # 75 was observed lying in bed, with the bed positioned was low to floor. Observation of the Resident # 75's room failed to evidence a radio, music playing or a television. On 09/06/18 at approximately 11:00 a.m., Resident # 75 was observed lying in bed, with the bed positioned was low to floor. Observation of the Resident # 75's room failed to evidence a radio, music playing or a television. On 09/06/18 at approximately 3:30 p.m., Resident # 75 was observed lying in bed, with the bed positioned was low to floor. Observation of the Resident # 75's room failed to evidence a radio, music playing or a television. The "Activities Evaluation" for Resident # 75 dated 08/01/18 was reviewed. Under "Activity Pursuit Patterns And Preferences" it documented a check mark next to "Family/Friends Visits, Music and Radio." The comprehensive care plan for Resident # 75 documented, "Problems: 08/02/2018. Resident may need assistance and encouragement to attend activities. Resident at this time is unable	F 679	Continued from page 123 All residents other than independent residents are at risk to be potentially affected by this practice. Activities Director and Assistant Activities Director will identify all residents other than independent residents from 9/1/18, review their comprehensive care plan goals and approaches to ensure activity preferences are being met and available. 3. What measures will be put into place or systematic changes made to ensure the practice will not reoccur? On 9/25/18, Activities Director will provide written education to Assistant Activities Director on policy we must provide, based on comprehensive assessment and care plan and the preferences of each patient, an ongoing program to support patients in their choice of activities, both facility sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each patient,	

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F 679	Continued From page 124 to attend activities per family member. 08/02/2018. Resident needs to be reminded to attend activities of choice." Under "Approaches" it documented, "Encourage, assist and remind resident to attend activities of interest. Invite/encourage the resident's family members to attend activities with resident in order to support participation. Monitor for family visits and self initiated activities. Post calendar in room so she can choose events to attend. Thank resident for attendance at activity function." On 09/06/18 interview was conducted at 2:45 p.m., with OSM (other staff member) # 18, assistant activities director. When asked to describe the process for providing one-to-one activities for residents, OSM # 18 stated, "We get input from the nursing staff and therapy if the resident needs one-to-one activities." When asked if they take the initiate for offering one-to-one activities, OSM # 18 stated, "No, we wait for the referral from nursing and/or therapy." OSM #18 was asked if Resident # 75 was receiving any one-to-one activities or if Resident # 75 has been offered to attend any group activities. OSM # 18 stated, "She (Resident # 75) is not on the list for one-to-one activities." When asked to provide evidence that Resident # 75 has been offered to attend group activities, OSM # 18 was unable to provide any documentation. 09/06/18 interview was conducted at 5:40 p.m., with OSM # 16, activities director. When asked to describe the process for providing activities to the residents, OSM # 16 stated, "Start with the interview, part of the comprehensive assessment and based on the answers they may or may not want to be involved in group activities and may prefer self-directed activities. If the resident is	F 679	Continued from page 124 encouraging both independence and interaction in the community. Education will include guidelines of initiating one-to-one activities for Low-function, Bed-bound Residents. Activities Director will review activity comprehensive care plan and activity preferences to validate needs of resident are being met through activities. Audit will consist of 10 residents a week x 90 days with 50% of sample to include Low-function, Bed-bound Residents. On 9/25/18, Executive Director will provide written education to Activities Director and Assistant Activities Director on documentation necessary to support residents were offered and engaged in an ongoing activities program. Activities Director will review Resident Daily Activity Attendance Record 5 times a week x4 weeks, 3 times a week x4 weeks, weekly x4 weeks to ensure documentation supports residents were offered and engaged in an ongoing activities program.	

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F 679	Continued From page 125 unable to answer the questions, we get the information from the family. If they have dementia we try to get them involved in one-to-one activities or get them to come to group activities or a combination of both." When asked to describe the process for providing one-to-one activities, OSM # 16 stated, "We go into the room and provide whatever the resident wants, it could be conversation, prayer, singing, going outside or anything the family has requested." When asked how often one-to-one activities are provided to residents, OSM # 16 stated, "Two to three times a week." OSM # 16 was asked to review Resident # 75's admission MDS with an ARD (assessment reference date) of 08/01/18, and the care plan dated 08/02/2018. When asked about providing Resident # 75 activities, OSM # 16 stated, she should be on the one-to-one list and getting one-to-one activities." When asked to provide documentation of Resident # 75 receiving activities, OSM # 16 stated, "There's no documentation of activities being offered." At 5:55 p.m., OSM # 16 was asked to accompany this surveyor to Resident # 75's room. Upon entering and observing Resident # 75's room OSM # 16 agreed the room did not have a television, radio or CD (compact disk) player. OSM # 16 stated, "I'm going to correct this right now." On 09/07/18 at 8:25 a.m., an interview was conducted with OSM # 16, activities director. When asked about the "Activities Evaluation" for Resident # 75 dated 08/01/18, OSM # 16 stated, "The evaluation is completed by the seven day look back period. I try to complete it within two to three days." After reviewing the "Activities Evaluation" for Resident # 75 dated 08/01/18, OSM # 16 stated, "Input from the family and	F 679	Continued from page 125 4. How will the facility monitoring the corrective plan to ensure the deficient practice was corrected and not reoccur? Activities Director will present findings of audits accurate assessment findings to the Quality Assurance Performance Improvement committee for review and recommendations for 90 days. The QAPI committee consist of Executive Director, Director of Nursing, Assistant Director of Nursing, Social Services, Activities, Dietary Manager, Pharmacy consultant, Medical Director.	

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F 679	Continued From page 126 anything checked under "Preferences" should be provided and even if an item is not checked I will ask the resident if they would like to try it." The facility's "Activity & Recreation Services Manual, Suggested Activity Program, Chapter 3" documented, "Examples of Bed-bound / Room-bound Activities: Arts and Crafts, Bedside Music, Correspondence, Games/Exercises, Reality Orientation and Religious Activities." On 09/06/18 at approximately 3:26 p.m. ASM (administrative staff member) #1, the executive director, ASM #2, the director of nursing, were made aware of the findings. No further information was provided prior to exit. References: (1) Low iron. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/anemia.html . (2) High blood pressure. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/highbloodpressure.html. (3) A chronic disease in which the body cannot regulate the amount of sugar in the blood. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/ency/article/001214.htm. (4) A loss of brain function that occurs with certain diseases. It affects memory, thinking, language, judgment, and behavior. This information was obtained from the website:	F 679		

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F 679	Continued From page 127 https://medlineplus.gov/ency/article/000739.htm.	F 679		
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, resident interview, staff interview, facility document review, and clinical record review it was determined, that the facility staff failed to provide respiratory care consistent with professional standards of practice for one of 42 residents in the survey sample, Residents #60. The facility staff failed to store Resident #60's CPAP (continuous positive airway pressure) mask in a manner to prevent infection. The findings include: Resident #60 was admitted to the facility on 4/13/2018 with diagnosis that included but were not limited to: obstructive sleep apnea (Obstructive sleep apnea [OSA] is a problem in which your breathing pauses during sleep. This occurs because of narrowed or blocked airways) (1), chronic obstructive pulmonary disease (COPD- is a general term for chronic, nonreversible lung disease that is usually a	F 695	F 695 1. How will the corrective action be accomplished for those residents found to have been affected by the deficient practice? On 9/6/18, Unit Manager approached resident #60 to clean and properly store CPAP mask and tubing. Resident #60 declined Unit Manager to perform task. Unit Manager provided education for resident #60 including increased risk of respiratory infection related to resident declining to store CPAP mask in storage bag while not in use. Unit Manager reviewed and revised comprehensive care plan to reflect resident preferences and approaches. Resident #60 is independent with care of her CPAP and she wishes to leave CPAP mask to air dry on her nightstand; she does not want to place her mask in the provided storage bag. Most recent resident assessment dated 7/21/18 reflected BIMS 15.	10/15/18

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F 695	Continued From page 128 combination of emphysema and chronic bronchitis) (2) and congestive heart failure (CHF is a condition in which the heart can't pump enough blood to meet the body's needs. Heart failure does not mean that your heart has stopped or is about to stop working. It means that your heart is not able to pump blood the way it should. It can affect one or both sides of the heart.) (3) The minimum data set (MDS), a quarterly assessment, with an assessment reference date (ARD) of 7/21/18, coded the resident as scoring a 15 on the BIMS (brief interview for mental status) score, indicating she was capable of making cognitive daily decisions. The physician order dated 8/17/2018 documented "CPAP/BiPAP* settings 5-20 (mmHg or millimeters of mercury) with 3L (liters) oxygen while sleeping every shift". A second physician order on 9/6/2018 documented "Change CPAP storage bag q (every) week (Sunday). Place CPAP mask in storage bag when not in use". *Positive airway pressure (PAP) "uses a machine to pump air under pressure into the airway of the lungs. This helps keep the windpipe open during sleep. The forced air delivered by CPAP (continuous positive airway pressure) prevents episodes of airway collapse that block the breathing in people with obstructive sleep apnea and other breathing problems." (4). On 09/05/18 at 12:11 p.m., an initial observation of Resident #60's room was conducted. Resident #60's CPAP mask was observed on the resident's nightstand uncovered. On 09/06/18, at 9:00 a.m. a second observation was made, again the CPAP mask was observed on the resident's nightstand	F 695	Continued from page 128 2. How will the facility identify other residents having the potential to be affected by the same practice? All residents using a CPAP/BiPAP have the potential to be affected by this practice. On 9/6/18, Unit Managers evaluated all residents with CPAP/BiPAP and all other masks were stored properly at that time. On 9/19/18, Unit Manager and Director of Nursing evaluated all residents with CPAP/BiPAP orders to ensure proper storage of mask. Any CPAP/BiPAP mask found to be stored improperly was wiped down, air dried, then stored properly at bedside. 3. What measures will be put into place or systematic changes made to ensure the practice will not reoccur? By 10/8/18, Staff Development Coordinator/Director of Nursing or Unit Manager will educate on proper cleaning, air dry, and storage of BiPAP/CPAP mask and tubing.	

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F 695	Continued From page 129 uncovered. A third observation was made on 09/06/18 at 3:27 p.m. with Registered Nurse (RN) #5 who noted the CPAP mask was on the nightstand uncovered. An interview was conducted with RN #5 at that time. When asked how a CPAP mask is stored when not in use, RN #5 responded "In plastic bags". When asked why a CPAP mask should be covered, RN #5 responded "For cleanliness to keep from getting dirty." When asked how Resident #60's CPAP mask is being stored, RN #5 stated, "The CPAP mask is not in a bag". Review of Resident #60's care plan dated 7/24/2018, documented CPAP to be used every night. The Medication Administration Record for August 2018 and September 2018, for Resident #60 documented the CPAP was being used nightly. According to the facility's "BiPAP/CPAP administration policy" documents "Upon removal, mask should be properly wiped down with a facility approved disinfectant. Mask and tubing should be allowed to air dry. Once dry they should be bagged/ stored properly at bedside." In Fundamentals of Nursing" 7th edition, 2009: Patricia A. Potter and Anne Griffin Perry: Mosby, Inc.; Page 648. Box 34-2 states, "Sites for and Causes of Health Care-Associated Infections under Respiratory Tract -- Contaminated respiratory therapy equipment." On 09/07/18 at 3:27 p.m., the ASM (administrative staff member) #1, the	F 695	Continued from page 129 Any Licensed Nurse that has not been in-serviced by 10/8/18 will not be allowed to provide direct care until in-service is completed. All newly hired nurses will receive education on proper cleaning, air dry, and storage of BiPAP/CPAP mask and tubing on orientation. Director of Nursing/Unit Manager/Staff Development Coordinator will evaluate proper storage of BiPAP/CPAP mask and tubing 5 times a week x30 days, 3 times a week x30 days, 1 time a week x30 days. 4. How will the facility monitoring the corrective plan to ensure the deficient practice was corrected and not reoccur? Director of nursing will present findings of audit accurate assessment to the QAPI committee for review and recommendations for 90 days. The QAPI committee consist of Executive Director, Director of Nursing, Assistant Director of Nursing, Social Services, Activities, Dietary Manager, Pharmacy consultant, Medical Director.	

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F 695	Continued From page 130 administrator and ASM#2 the director of nursing were notified of above concerns. No further information was provided prior to exit. 1. This information was obtained from the website: https://medlineplus.gov/ency/article/000811.htm. 2. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/copd.html. 3. This information was obtained from the website: https://medlineplus.gov/heartfailure.html 4. This information was obtained from the website: https://medlineplus.gov/ency/article/001916.htm	F 695		
F 760 SS=G	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on family interview, staff interview, facility document review and clinical record review, it was determined the facility staff failed to ensure one of 42 residents in the survey sample, Resident #55, was free of a significant medication error. Upon Resident #55's readmission to the facility, from the hospital on 8/31/17, the facility staff failed to administer a newly prescribed medication for seizures from 9/1 through 9/5/17, Resident #55 had a seizure on 9/5/17, resulting in harm, and transfer to a local emergency room.	F 760	Past noncompliance: no plan of correction required.	

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F 760	Continued From page 131 The findings include: Resident #55 was admitted to the facility in January 2004 with diagnoses that included but were not limited to: Down's Syndrome (A genetic condition in which a person has 47 chromosomes instead of the usual 46. The extra chromosome causes problems with the way the body and brain develop. Down syndrome is one of the most common causes of birth defects.) (1), dementia, and diabetes. The most recent MDS (minimum data set) assessment, a quarterly assessment, with an ARD (assessment reference date) of 7/18/18, coded the resident as having short term memory difficulties and no long term memory difficulties. The resident was coded as severely impaired for make daily cognitive decisions. Resident #55 was coded as requiring extensive assistance of one or more staff members for all of his activities of daily living. The MDS assessment, close to the date of the medication error, an annual assessment, with an ARD of 10/19/17, coded the resident as having both short and long term memory difficulties and as severely impaired to make daily cognitive decisions. Resident #55 was coded as requiring extensive assistance of one or more staff members for all of his activities of daily living. The Facility Reported Incident (FRI) dated 9/5/17, documented in part, "Injuries: yes, seizure, bit tongue with laceration. Prescribed medication (Keppra*) omitted from 9/1/17 - 9/4/17, resulting in seizure activity in a.m.(morning) of 9/5/18. Resident was sent to Emergency Room for evaluation and was not admitted and is returning	F 760		

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F 760	Continued From page 132 to facility on 9/5/17. *Keppra- is used to treat certain types of seizures in the treatment of epilepsy. This medication cannot cure epilepsy and will only work to control seizures as long as you continue to use it. (2) The pharmacokinetics of levetiracetam have been studied in healthy adult subjects, adults and pediatric patients with epilepsy, elderly subjects and subjects with renal and hepatic impairment. Keppra (Levetiracetam) is rapidly and almost completely absorbed after oral administration. Keppra (Levetiracetam) plasma half-life in adults is 7 ± 1 hour. (4) The letter dated 9/8/17 to the state agency documented in part the following: "It was reported to Unit Manager on 9/5/17 that above resident (Resident #55) had a seizure on the morning of 9/5/17 and was transferred to the hospital as a precautionary measure and resident returned from the same day,... Resident had been readmitted from the hospital on 9/1/17. In reviewing the discharge orders from the hospital on 9/1/17 to this resident's previous orders, there were not any new orders noted by the Nurse or Physician or staff for a seizure medicine. This resident also was not on any seizure medication prior to his hospital stay. After this resident returned to the facility [on 9/1/17], the facility received by fax, the After Discharge Summary. This was reviewed by Physician and forwarded to nursing unit with no new orders. Upon review of both documents it was noted that the After Discharge Summary, did contain a seizure medication, which this resident was not on prior to hospital stay. Nursing staff will be educated that all documents coming in for	F 760		

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residents from the hospital or outside physician visits need to be reviewed for any changes and appropriate follow taken as needed."

The physician orders dated 8/31/17 failed to evidence documentation of a physician order for Keppra.
A telephone order dated, 9/5/17 documented, "Keppra 500 mg (milligrams) po (by mouth) take 1 tab (tablet) po BID (twice a day) for seizures."

The nurse's note dated, 9/5/17 at 5:20 a.m. documented in part, "At 5:00 a.m. while receiving breathing tx (treatment), I entered the resident's room to find him with red face, grunting respirations, and his extremities with decorticate posturing. He was noted to have some light bleeding coming from his mouth. Breathing tx (treatment) stopped. Resident's normal skin tone returned to his face and he began to take deep breaths. Eyes were crossed and not focusing on anything. No response to verbal stimuli from resident. Cleansed outer lips, but resident wouldn't open his mouth so I could check for the source of bleeding. After a few minutes his eyes returned to their normal and resident closed his eyes and began with normal respirations. Before I left the room, the resident was smiling and moving his arms about normally."

The nurse's note dated, 9/5/17 at 6:19 p.m., documented, "7a-7p (7:00 a.m. to 7:00 p.m.) nursing note: Resident was observed with seizure like activity this morning lasting approximately 5-7 minutes. Resident was unresponsive, with no pupillary reflex, with abdominal breath at 32 breaths per minute. Resident was placed on side to prevent any further complications. Post seizure VS (vital signs) 120/55 (blood pressure) 93 (heart

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rate), 22 (respirations) O2 (Oxygen) sat (saturation) on RA (room Air). Resident was transported via ambulance to (initials of hospital) ER (emergency room) for evaluation. Residents brother stated resident should have been taking Keppra 500 mg BID after previous discharge from (initials of hospital). Order for Keppra 500 mg BID obtained, faxed to Pharmacy and is pending in delivery. Residents brother stated that resident has not eaten anything all day and has maintained a 'decent blood glucose.' Resident arrived back from (initials of hospital) at 5:15 p.m. with a blood glucose of 327, no insulin given. All meds (medications) from 7 am until 4 p.m. have not been given due to resident being OOF (out of facility). Resident is currently in bed resting with eyes closed, with respiration being even and unlabored. Call bell is within reach."

The comprehensive care plan dated, 2/5/15 and revised on 8/31/17, failed to evidence documentation of the new diagnosis of seizures on the care plan.

The "Discharge Summary Notes" dated, 8/31/17, documented in part, "START taking these medications: Levetiracetam, Keppra 500 mg PO TABS- take 1 tab by mouth every 12 hours."

An interview was conducted with Resident #55's family member on 9/6/18 at 4:00 p.m. the family member explained to this surveyor that when Resident #55 returned from the hospital on 8/31/17, from being treated for a UTI (urinary tract infection), the facility staff didn't have an order for the Keppra. The family member explained that during his stay at the hospital Resident #55 was observed to have a grand mal seizure while in the emergency room. He was

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F 760	Continued From page 135 started on Keppra in the hospital for seizures. Upon his return to the facility, the family member asked a nurse, twice, about the order for Keppra. Each time the nurse told him he (Resident #55) didn't have an order for Keppra. After Resident #55 returned from the ER on 9/5/17, a nurse (no longer employed at the facility) pulled him aside and told him that ... the order (for Keppra) was here all the time. On 9/6/18 at 6:08 p.m. administrative staff member (ASM) #1, the executive director, and ASM #2, the director of nursing, were made aware of the concern for harm. An interview was conducted with LPN (licensed practical nurse) #4, the nurse whom the family member asked twice about the order for Keppra; on 9/6/18 at 6:41 p.m., LPN #4 was asked about the process staff follows for physician orders when a resident is admitted or on a readmission. LPN #4 stated, "Normally the physician gets the order from the hospital. They (the orders) are brought to us by (name of director of business development). The orders are on the top with the discharge summary stapled to the back. We take them to the doctor, he will write the diagnoses for the medication, and he can add or subtract medications. The doctor signed the bottom of each page. After they sing them, we fax them to the pharmacy. After they go to the pharmacy, we call the pharmacy to verify that they received the orders. One nurse will import the physician orders and initiate the fixed order set in the computer. After that is printed, another nurse compares and verify every order is correct. Both nurses sign the updated sheets. After that we print up the MARs (medication administration records) and TARs (treatment administration records), we both verify	F 760		

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F 760	Continued From page 136 the MARs with the orders." LPN #4 was asked what she recalled from when Resident #55 returned to the facility on 9/1/17. LPN #4 stated she took care of Resident #55 on the second or third day he was back. When asked if she remembered the family asking about Keppra, LPN #4 stated, "No, I remember (name of family member) saying (Resident #55) received a medication for seizures. That triggered me to look at the chart. I looked at hospital records and our orders; there was no orders for Keppra. Then I looked at the discharge packet, I noted that the resident had received Ativan*. He asked me twice and I looked at the exact same spot. I then went on vacation. I came back and found out he had a new order for Keppra. *(Lorazepam [Ativan] is used to relieve anxiety. Lorazepam is in a class of medications called benzodiazepines. It works by slowing activity in the brain to allow for relaxation. (3) An interview was conducted with administrative staff member (ASM) #4, the medical director; on 9/6/18 at 6:51 p.m., ASM #4 stated the facility has had difficulty with obtaining the correct orders for residents transferred to the facility. He stated the facility goes by the AVS (after visit summary) to get the medications in the facility. Sometimes the facility receives a second and third AVS. He stated he has spoken to the hospital after this occurred and they are only sending one AVS. ASM #4 stated, The hospital sent the AVS (for Resident #55) and the Keppra was not on it. It was reviewed by (ASM #5), the covering physician as ASM #4 stated he was out of town. Somehow, another AVS [for Resident #55] came in that same day, it was not signed by the	F 760		

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physician and it was kept somewhere else. ASM #4 stated, now the process is if there is a change from what they originally sent, the hospital has to call us. ASM #4 stated that upon his return from vacation, we went through the entire paper record. The second AVS was there and had the order for the Keppra. When asked who is ultimately responsible, ASM #4 stated, "We are."

An interview was conducted with RN (registered nurse) #3, the interim director of nursing at the time of the incident, on 9/7/18 at 9:15 a.m. When asked her knowledge of the incident, RN #3 stated, "I know that there was an order set that had come in. A piece was out of it. We didn't have the page with the Keppra. The family told us he was supposed to be on Keppra. We couldn't find the order for it. We were missing a page of the orders." When asked if the order was found in the facility, RN #3 stated, "Yes, (ASM #4 [medical director]) went through the record, page by page and found the order."

An interview was conducted with other staff member (OSM) #17, the director of business development; on 9/7/18 at 9:23 a.m., OSM #17 was asked about the process in place during September 2017, for reciving information from the hospital for an admission. OSM #17 stated, "My process hasn't really changed. I will review the information in the computer program from the hospital. I print it out and hand it to the physician directly. That's the end of my involvement." When asked about the process in place now, OSM #17 stated, the hospital has an upgraded system and that the facility has access to the system. I still print the information and hand it to the medical provider. The AVS (after visit summary) is what the hospital sends. It used to be called discharge

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orders. It's essentially the medication list. I print the H&P (history and physical) and that set of orders. Then I hand it to (ASM #4) or (ASM #5). The papers go straight into the hands of the physician or nurse practitioner."

When asked her knowledge of what happened with Resident #55 last September, OSM #17 stated that the first set of orders came in around 2:00 p.m. I took them down to the unit. A second set came over the fax around 4:00 p.m. It was a second document but an AVS (after visit summary). The hospital has up to 72 hours to provide a discharge summary but the AVS is what the doctors go by for the orders, and it was two hours before the second one arrived here." When asked why the documents at 2:00 p.m. didn't match the documents at 4:00 p.m., OSM #17 stated, "Sometimes it doesn't the AVS is the one that the patient is walking in the door with. Discharge summaries are unpredictable they are late. The process for the admission steps is the same today as it was in September, last year. We still print the same documents and hand them to the physician directly."

An interview was conducted with ASM #1, the executive director, on 9/7/18 at 9:55 a.m. When asked about his knowledge of the incident with Resident #55 on 9/5/17, ASM #1 stated the order had come into the facility. The doctor (ASM #5) reviewed the orders and then gave the orders to the nurse. It wasn't until he went out with the seizure that (ASM #4) the medical director, went through the clinical record, page by page, and found the order in the hospital paperwork." When asked who is ultimately responsible, ASM #1 stated, "We are." ASM #1 stated there is now a double check system by two nurses that was put

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in place after this happened." A request was made at this time, for any documentation of the new process that the facility put into place after the incident.

The facility policy, "Physician Order Processing Procedure" dated, 11/19/16, documented in part, "Admission orders are written prior to or upon each admission or readmission. Or written by the physician, nurse practitioner or physician's assistant; obtained via telephone by the nursing staff from the physician, or transcribed from the transfer orders. A copy of the admitting orders will be faxed to the pharmacy as soon as possible. An initial set of Medication and Treatment Administration records will be created and placed in the appropriate medication/treatment books. "

On 9/7/18 at 11:51 a.m., ASM #1 presented a copy of the "Quality Assurance and Performance Improvement Plan" dated, 9/5/17, which documented "Observation: Resident did not have Keppra on admission orders from hospital." The "Actions" documented, "Resident was assessed. MD (medical doctor) and responsible party was notified of seizure possible missing medications. Resident was sent to ER for evaluation. Resident was sent back to facility." All residents admitted since (ASM #5) had been assisting admission orders will be reviewed for any missing orders or transcription errors. Nursing will be educated when orders are completed prior to resident arriving they must compare to orders received when resident arrives for any changes made prior to leaving hospital. Two nurses will review all new admissions. Nursing administration will review 5 days a week. All nurses not receiving in service training will not work until education is completed. Education will be added to orientation packet.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF NEW MARKET	315 EAST LEE HIGHWAY NEW MARKET, VA 22844

(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 760	Continued From page 140 DON (director of nursing) to report finding of daily audit 5 days a week to PI (performance improvement) for review and recommendations." Interviews were conducted with six current nurses. The nurses interviewed had been in the facility before the incident and two nurses had just started working at the facility a few months ago. All of the nurses could correctly state the double check system for admission/readmission orders and following physician orders. No further information was provided prior to exit. PAST NON-COMPLIANCE (1) This information was obtained from the following website: https://medlineplus.gov/ency/article/000997.htm. (2) This information was obtained from the following website: https://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0010898/?report=details (3) This information was obtained from the following website: https://medlineplus.gov/druginfo/meds/a682053.html. (4) This information was obtained from the website: https://dailymed.nlm.nih.gov/dailymed/druginfo.cfm?setid=d1329893-a8bc-4f31-a31b-76690d111035	F 760		