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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495255	A. BUILDING _____ B. WING _____	C 09/27/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SKYVIEW SPRINGS REHAB AND NURSING CENTER	30 MONTVUE DRIVE LURAY, VA 22835

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 9/25/18 through 9/27/18. Corrections are required for compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities.	E 000	RECEIVED NOV 0 6 2018 VDH/OLC	
E 001 SS=C	Establishment of the Emergency Program (EP) CFR(s): 483.73 The [facility, except for Transplant Center] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility] must establish and maintain a comprehensive emergency preparedness program that meets the requirements of this section.* The emergency preparedness program must include, but not be limited to, the following elements: *[For hospitals at §482.15:] The hospital must comply with all applicable Federal, State, and local emergency preparedness requirements. The hospital must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach. *[For CAHs at §485.625:] The CAH must comply with all applicable Federal, State, and local emergency preparedness requirements. The CAH must develop and maintain a comprehensive emergency preparedness program, utilizing an all-hazards approach. 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	E 001	A Comprehensive Emergency Preparedness Plan and program was prepared 0n10/16/2018 that meets the requirements. All residents have the potential to be affected by not having the plan in place, Preparing the plan will correct this. The Comprehensive Emergency Preparedness Plan and program was completed per regulations to ensure substantial compliance Staff educated on 10/17/18 by ADON on the Comprehensive Emergency Preparedness Plan And will be given education monthly X 3 months then yearly. QAPI committee will review the plan Annually for completeness and education. Date Of Compliance: 10/30/2018	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Pamela Lee P. Seby — TITLE: Administrator — (X6) DATE: 11/5/2018

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

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E 001	Continued From page 1 preparedness plan. The facility staff failed to establish and maintain a comprehensive emergency preparedness program that meets the requirements of these regulations. The findings include: On 9/27/18 at 8:30 a.m., the facility's emergency preparedness plan was reviewed with OSM (other staff member) #11, the maintenance director, and OSM #7, the maintenance assistant. Review of the facility's emergency preparedness plan failed to evidence a comprehensive plan that meets the requirements of these regulations. OSM #11 and OSM #7 were made aware of this concern. On 9/27/18 at 1:05 p.m., ASM, (administrative staff member), the administrator, #1, was made aware of the above findings. No further information was presented prior to exit.	E 001		
E 004 SS=C	Develop EP Plan, Review and Update Annually CFR(s): 483.73(a) [The [facility] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility] must develop establish and maintain a comprehensive emergency preparedness program that meets the requirements of this section.] * [For hospitals at §482.15 and CAHs at §485.625(a):] The [hospital or CAH] must comply with all applicable Federal, State, and local emergency preparedness requirements. The [hospital or CAH] must develop and maintain a	E 004	A Comprehensive Emergency Preparedness Plan and program was prepared On10/16/2018 that meets the requirements that includes an all hazard approach. All residents have the potential to be affected by not having the plan in place, Preparing the plan will correct this.	

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E 004	Continued From page 2 comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach. The emergency preparedness program must include, but not be limited to, the following elements:] (a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be [reviewed], and updated at least annually. * [For ESRD Facilities at §494.62(a):] Emergency Plan. The ESRD facility must develop and maintain an emergency preparedness plan that must be [evaluated], and updated at least annually. 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 maintain a complete emergency preparedness plan. The facility staff failed to develop and maintain a complete emergency preparedness plan. The findings include: On 9/27/18 at 8:30 a.m., the facility's emergency preparedness plan was reviewed with OSM (other staff member) #11, the maintenance director, and OSM #7, the maintenance assistant. Review of the facility's emergency preparedness plan failed to evidence a complete plan that contained all the required elements. OSM #11 and OSM #7 were made aware of this concern. On 9/27/18 at 1:05 p.m., ASM, (administrative	E 004	The Comprehensive Emergency Preparedness Plan and program was completed per regulations to ensure substantial compliance. Staff educated on 10/17/18 by ADON on the Comprehensive Emergency Preparedness Plan And will be given education monthly X 3 months then yearly. QAPI committee assisted with the Development of the Comprehensive Emergency plan and will review monthly X 3 months then annually. Date of Compliance: 10/30/2018 RECEIVED NOV 0 6 2018 VDH/OLC	

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E 004	Continued From page 3 staff member), the administrator, #1, was made aware of the above findings. No further information was obtained prior to exit.	E 004		
E 006 SS=C	Plan Based on All Hazards Risk Assessment CFR(s): 483.73(a)(1)-(2) [(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do the following:] (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach.* *[For LTC facilities at §483.73(a)(1):] (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing residents. *[For ICF/IIDs at §483.475(a)(1):] (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing clients. (2) Include strategies for addressing emergency events identified by the risk assessment. * [For Hospices at §418.113(a)(2):] (2) Include strategies for addressing emergency events identified by the risk assessment, including the management of the consequences of power failures, natural disasters, and other emergencies that would affect the hospice's ability to provide care. This REQUIREMENT is not met as evidenced by:	E 006	A Comprehensive Emergency Preparedness Plan and program was prepared On10/16/2018 that meets the requirements that includes an all hazards approach including missing clients and addressing emergency events identified by the risk assessment. All residents have the potential to be affected by not having the plan in place, Preparing the plan will correct this. The Comprehensive Emergency Preparedness Plan and program was completed per regulations to ensure substantial compliance. Staff educated on 10/17/18 by ADON on the Comprehensive Emergency Preparedness Plan, Including missing clients and addressing Emergency events identified by the Risk assessment, education will be given monthly X 3 months then yearly.	

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E 006	Continued From page 4 Based on staff interview and facility document review, it was determined that the facility staff failed to develop an emergency preparedness plan based on and including a facility-based and community-based risk assessment, utilizing an all-hazards approach. The facility staff failed to complete a facility-based and community-based risk assessment. The findings include: On 9/27/18 at 8:30 a.m., the facility's emergency preparedness plan was reviewed with OSM (other staff member) #11, the maintenance director, and OSM #7, the maintenance assistant. Review of the facility's emergency preparedness plan failed to evidence a facility-based and community-based risk assessment, utilizing an all-hazards approach. OSM #11 and OSM #7 were made aware of this concern. On 9/27/18 at 1:05 p.m., ASM, (administrative staff member), the administrator, #1, was made aware of the above findings. No further information was obtained prior to exit.	E 006	QAPI committee assisted with the Development of the Comprehensive Emergency plan and will review monthly X 3 months then annually. Date of Compliance: 10/30/2018	
E 007 SS=C	EP Program Patient Population CFR(s): 483.73(a)(3) [(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do the following:] (3) Address patient/client population, including, but not limited to, persons at-risk; the type of services the [facility] has the ability to provide in	E 007	A Comprehensive Emergency Preparedness Plan and program was prepared On10/16/2018 that meets the requirements that addresses resident/client population including persons at-risk, the type of services the(facility) has ability to provide in an emergency and continuity of operations including delegations of authority and succession plans.	

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E 007	Continued From page 5 an emergency; and continuity of operations, including delegations of authority and succession plans.** *Note: ["Persons at risk" does not apply to: ASC, hospice, PACE, HHA, CORF, CMCH, RHC, FQHC, or ESRD facilities.] This REQUIREMENT is not met as evidenced by: Based on 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 the emergency preparedness plan that included the facility's patient population that would be at risk and strategies that the facility put in place to address the needs of at-risk or vulnerable patients. The findings include: On 9/27/18 at 8:30 a.m., the facility's emergency preparedness plan was reviewed with OSM (other staff member) #11, the maintenance director, and OSM #7, the maintenance assistant. Review of the facility's emergency preparedness plan failed to evidence the emergency preparedness plan included the facility's patient population that would be at risk and strategies that the facility put in place to address the needs of at-risk or vulnerable patients. OSM #11 and OSM #7 were made aware of this concern. On 9/27/18 at 1:05 p.m., ASM, (administrative staff member), the administrator, #1, was made aware of the above findings. No further information was obtained prior to exit.	E 007	All residents have the potential to be affected by not having the plan in place, Preparing the plan will correct this. The Comprehensive Emergency Preparedness Plan and program was completed per regulations to ensure substantial compliance. Staff educated on 10/17/18 by ADON on the Comprehensive Emergency Preparedness Plan, Including persons at-risk, the type of services the(facility) has ability to provide in an emergency and continuity of operations and including delegations of authority and succession plans, education will be given monthly X 3 months then yearly. QAPI committee assisted with the Development of the Comprehensive Emergency plan and will review monthly X 3 months then annually. Date of Compliance: 10/30/2018 RECEIVED NOV 06 2018 VDH/OLC	

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E 009 SS=C	Local, State, Tribal Collaboration Process CFR(s): 483.73(a)(4) [(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do the following:] (4) Include a process for cooperation and collaboration with local, tribal, regional, State, and Federal emergency preparedness officials' efforts to maintain an integrated response during a disaster or emergency situation, including documentation of the facility's efforts to contact such officials and, when applicable, of its participation in collaborative and cooperative planning efforts. * [For ESRD facilities only at §494.62(a)(4)]: (4) Include a process for cooperation and collaboration with local, tribal, regional, State, and Federal emergency preparedness officials' efforts to maintain an integrated response during a disaster or emergency situation, including documentation of the dialysis facility's efforts to contact such officials and, when applicable, of its participation in collaborative and cooperative planning efforts. The dialysis facility must contact the local emergency preparedness agency at least annually to confirm that the agency is aware of the dialysis facility's needs in the event of 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. The facility staff failed to include a process for	E 009	A Comprehensive Emergency Preparedness Plan and program was prepared 0n10/16/2018 that meets the requirements including a process for cooperation and collaboration with local, tribal, regional, state and federal emergency preparedness officials 'including documentation of its efforts to maintain an integrated response during a disaster or emergency situation and its efforts to contact such officials when needed of its participation in collaborative and corporative planning efforts. All residents have the potential to be affected by not having the plan in place, Preparing the plan will correct this. The Comprehensive Emergency Preparedness Plan and program was completed per regulations to ensure substantial compliance. Staff educated on 10/17/18 by ADON on the Comprehensive Emergency Preparedness Plan, including a process for cooperation and collaboration with local, tribal, regional, state and federal emergency preparedness officials' including documentation of its efforts to maintain an integrated response during a disaster	

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E 009	Continued From page 7 cooperation and collaboration with local, tribal, regional, State, and Federal emergency preparedness officials' efforts to maintain an integrated response during a disaster or emergency situation, including documentation of the facility's efforts to contact such officials and, when applicable, of its participation in collaborative and cooperative planning efforts. The findings include: On 9/27/18 at 8:30 a.m., the facility's emergency preparedness plan was reviewed with OSM (other staff member) #11, the maintenance director, and OSM #7, the maintenance assistant. Review of the facility's emergency preparedness plan failed to evidence a process for cooperation and collaboration with local, tribal, regional, State, and Federal emergency preparedness officials' efforts to maintain an integrated response during a disaster or emergency situation, including documentation of the facility's efforts to contact such officials and, when applicable, of its participation in collaborative and cooperative planning efforts. OSM #11 and OSM #7 were made aware of this concern. On 9/27/18 at 1:05 p.m., ASM, (administrative staff member), the administrator, #1, was made aware of the above findings. No further information was obtained prior to exit.	E 009	or emergency situation and its efforts to contact such officials when needed of its participation in collaborative and corporative planning efforts. Education will be given monthly X 3 months then yearly. QAPI committee assisted with the Development of the Comprehensive Emergency plan and will review monthly X 3 months then annually. Date of Compliance: 10/30/2018	
E 013 SS=C	Development of EP Policies and Procedures CFR(s): 483.73(b) (b) Policies and procedures. [Facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency	E 013	A Comprehensive Emergency Preparedness Plan and program was prepared On10/16/2018 that meets the requirements that policies and procedures are developed based on the facility-and- community based risk assessment and commination plan, utilizing an all-hazards approach.	

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E 013	Continued From page 8 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. *Additional Requirements for PACE and ESRD Facilities: *[For PACE at §460.84(b):] Policies and procedures. The PACE organization 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 address management of medical and nonmedical emergencies, including, but not limited to: Fire; equipment, power, or water failure; care-related emergencies; and natural disasters likely to threaten the health or safety of the participants, staff, or the public. The policies and procedures must be reviewed and updated at least annually. *[For ESRD Facilities at §494.62(b):] Policies and procedures. The dialysis facility 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. These emergencies include, but are not limited to, fire, equipment or power failures, care-related emergencies, water supply interruption, and natural disasters likely to occur in the facility's	E 013	All residents have the potential to be affected by not having the plan in place, Preparing the plan will correct this. The Comprehensive Emergency Preparedness Plan and program was completed per regulations to ensure substantial compliance. Staff educated on 10/17/18 by ADON on the Comprehensive Emergency Preparedness Plan, on the policies and procedures developed based on the facility-and- community based risk assessment and commination plan, utilizing an all-hazards approach. Education will be given monthly X 3 months then yearly. QAPI committee assisted with the Development of the Comprehensive Emergency plan and will review monthly X 3 months then annually. Date of Compliance: 10/30/2018	

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E 013	Continued From page 9 geographic area. 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. Facility staff failed to provide documentation that the policies and procedures were developed based on the facility-and-community based risk assessment and communication plan, utilizing an all-hazards approach. The findings include: On 9/27/18 at 8:30 a.m., the facility's emergency preparedness plan was reviewed with OSM (other staff member) #11, the maintenance director, and OSM #7, the maintenance assistant. Review of the facility's emergency preparedness plan failed to evidence documentation that the policies and procedures were developed based on a facility-based and community-based risk assessment and utilizing an all-hazards approach. OSM #11 and OSM #7 were made aware of this concern. On 9/27/18 at 1:05 p.m., ASM, (administrative staff member), the administrator, #1, was made aware of the above findings. No further information was obtained prior to exit.	E 013		
E 015 SS=C	Subsistence Needs for Staff and Patients CFR(s): 483.73(b)(1) [(b) Policies and procedures. [Facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency	E 015	A Comprehensive Emergency Preparedness Plan and program was prepared 0n10/16/2018 that meets the requirements that includes the provision of subsistence needs for staff and residents' weather	

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E 015	Continued From page 10 plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually.] At a minimum, the policies and procedures must address the following: (1) The provision of subsistence needs for staff and patients whether they evacuate or shelter in place, include, but are not limited to the following: (i) Food, water, medical and pharmaceutical supplies (ii) Alternate sources of energy to maintain the following: (A) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions. (B) Emergency lighting. (C) Fire detection, extinguishing, and alarm systems. (D) Sewage and waste disposal. *[For Inpatient Hospice at §418.113(b)(6)(iii):] Policies and procedures. (6) The following are additional requirements for hospice-operated inpatient care facilities only. The policies and procedures must address the following: (iii) The provision of subsistence needs for hospice employees and patients, whether they evacuate or shelter in place, include, but are not limited to the following: (A) Food, water, medical, and pharmaceutical supplies. (B) Alternate sources of energy to maintain the following: (1) Temperatures to protect patient health	E 015	they evacuate or shelter in place include, but not limited to the following food, water, medical and pharmaceutical supplies, alternate sources of energy to maintain temperature, emergency lightening, fire detection, extinguishing and alarm systems, sewage and waste disposal. All residents have the potential to be affected by not having the plan in place, Preparing the plan will correct this. The Comprehensive Emergency Preparedness Plan and program was completed per regulations to ensure substantial compliance. Staff educated on 10/17/18 by ADON on the Comprehensive Emergency Preparedness Plan, includes the provision of subsistence needs for staff and residents' weather they evacuate or shelter in place include, but not limited to the following food, water, medical and pharmaceutical supplies, alternate sources of energy to maintain temperature, emergency lightening, fire detection, extinguishing and alarm systems, sewage and waste disposal. Education will be given monthly X 3 months then yearly.	

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E 015	Continued From page 11 and safety and for the safe and sanitary storage of provisions. (2) Emergency lighting. (3) Fire detection, extinguishing, and alarm systems. (C) Sewage and waste disposal. This REQUIREMENT is not met as evidenced by: Based on 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 for the provision of subsistence needs including but not limited to food, water, sewage and waste disposal. The findings include: On 9/27/18 at 8:30 a.m., the facility's emergency preparedness plan was reviewed with OSM (other staff member) #11, the maintenance director, and OSM #7, the maintenance assistant. Review of the facility's emergency preparedness plan failed to evidence documentation of policies and procedures for the provision of subsistence needs including but not limited to food, water, sewage and waste disposal. OSM #11 and OSM #7 were made aware of this concern. On 9/27/18 at 1:05 p.m., ASM, (administrative staff member), the administrator, #1, was made aware of the above findings. No further information was obtained prior to exit.	E 015	QAPI committee assisted with the Development of the Comprehensive Emergency plan and will review monthly X 3 months then annually. Date of Compliance: 10/30/2018	
E 018 SS=C	Procedures for Tracking of Staff and Patients CFR(s): 483.73(b)(2)	E 018	A Comprehensive Emergency Preparedness Plan and program	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495255	A. BUILDING _____ B. WING _____	C 09/27/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SKYVIEW SPRINGS REHAB AND NURSING CENTER	30 MONTVUE DRIVE LURAY, VA 22835

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 018	Continued From page 12 [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually.] At a minimum, the policies and procedures must address the following:] (2) A system to track the location of on-duty staff and sheltered patients in the [facility's] care during an emergency. If on-duty staff and sheltered patients are relocated during the emergency, the [facility] must document the specific name and location of the receiving facility or other location. *[For PRTFs at §441.184(b), LTC at §483.73(b), ICF/IIDs at §483.475(b), PACE at §460.84(b):] Policies and procedures. (2) A system to track the location of on-duty staff and sheltered residents in the [PRTF's, LTC, ICF/IID or PACE] care during and after an emergency. If on-duty staff and sheltered residents are relocated during the emergency, the [PRTF's, LTC, ICF/IID or PACE] must document the specific name and location of the receiving facility or other location. *[For Inpatient Hospice at §418.113(b)(6):] Policies and procedures. (ii) Safe evacuation from the hospice, which includes consideration of care and treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s) and primary and alternate means of communication with external sources of	E 018	was prepared On10/16/2018 that meets the requirements that a system is to be in place to track the location of on-duty staff and sheltered residents in the (facility's) care during an emergency. If on-duty staff are sheltered and residents are relocated during an emergency, the (facility) must document the specific name and location of the receiving facility or other location. All residents have the potential to be affected by not having the plan in place, Preparing the plan will correct this. The Comprehensive Emergency Preparedness Plan and program was completed per regulations to ensure substantial compliance. Staff educated on 10/17/18 by ADON on the Comprehensive Emergency Preparedness Plan a system is to be in place to track the location of on-duty staff and sheltered residents in the (facility's) care during an emergency. If on-duty staff are sheltered and residents are relocated during an emergency, the (facility) must document the specific name and location of the receiving facility or other location. Education will be given monthly X 3 months then yearly.	

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E 018	Continued From page 13 assistance. (v) A system to track the location of hospice employees' on-duty and sheltered patients in the hospice's care during an emergency. If the on-duty employees or sheltered patients are relocated during the emergency, the hospice must document the specific name and location of the receiving facility or other location. *[For CMHCs at §485.920(b):] Policies and procedures. (2) Safe evacuation from the CMHC, which includes consideration of care and treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s); and primary and alternate means of communication with external sources of assistance. *[For OPOs at § 486.360(b):] Policies and procedures. (2) A system of medical documentation that preserves potential and actual donor information, protects confidentiality of potential and actual donor information, and secures and maintains the availability of records. *[For ESRD at § 494.62(b):] Policies and procedures. (2) Safe evacuation from the dialysis facility, which includes staff responsibilities, and needs of the patients. This REQUIREMENT is not met as evidenced by: Based on 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 to include a tracking system for patients and staff.	E 018	QAPI committee assisted with the Development of the Comprehensive Emergency plan and will review monthly X 3 months then annually. Date of Compliance: 10/30/2018	

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E 018	Continued From page 14 The findings include: On 9/27/18 at 8:30 a.m., the facility's emergency preparedness plan was reviewed with OSM (other staff member) #11, the maintenance director, and OSM #7, the maintenance assistant. Review of the facility's emergency preparedness plan failed to evidence policies and procedures to include a tracking system for patients and staff. OSM #11 and OSM #7 were made aware of this concern. On 9/27/18 at 1:05 p.m., ASM, (administrative staff member), the administrator, #1, was made aware of the above findings. No further information was obtained prior to exit.	E 018		
E 020 SS=C	Policies for Evac. and Primary/Alt. Comm. CFR(s): 483.73(b)(3) [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. At a minimum, the policies and procedures must address the following:] Safe evacuation from the [facility], which includes consideration of care and treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s); and primary and alternate means of communication with external sources of assistance.	E 020	A Comprehensive Emergency Preparedness Plan and program was prepared On10/16/2018 that meets the requirements that safe evacuation from the (facility) which includes consideration of care and treatment needs of evacuees; staff responsibilities, transportation; identification of evacuation location(s) and primary and alternate means of communication with external sources of assistance All residents have the potential to be affected by not having the plan in place, Preparing the plan will correct this.	

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E 020	Continued From page 15 *[For RNHCs at §403.748(b)(3) and ASCs at §416.54(b)(2):] Safe evacuation from the [RNHCI or ASC] which includes the following: (i) Consideration of care needs of evacuees. (ii) Staff responsibilities. (iii) Transportation. (iv) Identification of evacuation location(s). (v) Primary and alternate means of communication with external sources of assistance. * [For CORFs at §485.68(b)(1), Clinics, Rehabilitation Agencies, OPT/Speech at §485.727(b)(1), and ESRD Facilities at §494.62(b)(2):] Safe evacuation from the [CORF; Clinics, Rehabilitation Agencies, and Public Health Agencies as Providers of Outpatient Physical Therapy and Speech-Language Pathology Services; and ESRD Facilities], which includes staff responsibilities, and needs of the patients. * [For RHCs/FQHCs at §491.12(b)(1):] Safe evacuation from the RHC/FQHC, which includes appropriate placement of exit signs; staff responsibilities and needs of the patients. This REQUIREMENT is not met as evidenced by: Based on staff interview and facility document review it was determined the facility staff failed to have a complete emergency preparedness plan. The facility staff failed to develop policies and procedures for a safe evacuation from the facility that included care and treatment needs of evacuees, staff responsibilities, transportation; identification of evacuation location(s), and primary and alternate means of communication	E 020	The Comprehensive Emergency Preparedness Plan and program was completed per regulations to ensure substantial compliance. Staff educated on 10/17/18 by ADON on the Comprehensive Emergency Preparedness Plan safe evacuation from the (facility) which includes consideration of care and treatment needs of evacuees; staff responsibilities, transportation; identification of evacuation location(s) and primary and alternate means of communication with external sources of assistance. Education will be given monthly X 3 months then yearly. QAPI committee assisted with the Development of the Comprehensive Emergency plan and will review monthly X 3 months then annually. Date of Compliance: 10/30/2018	

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E 020	Continued From page 16 with external sources of assistance. The findings include: On 9/27/18 at 8:30 a.m., the facility's emergency preparedness plan was reviewed with OSM (other staff member) #11, the maintenance director, and OSM #7, the maintenance assistant. Review of the facility's emergency preparedness plan failed to evidence policies and procedures for a safe evacuation from the facility that included care and treatment needs of evacuees and staff responsibilities. OSM #11 and OSM #7 were made aware of this concern. On 9/27/18 at 1:05 p.m., ASM, (administrative staff member), the administrator, #1, was made aware of the above findings. No further information was provided prior to exit.	E 020		
E 022 SS=C	Policies/Procedures for Sheltering in Place CFR(s): 483.73(b)(4) [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. At a minimum, the policies and procedures must address the following:] (4) A means to shelter in place for patients, staff, and volunteers who remain in the [facility]. [(4) or (2),(3),(5),(6)] A means to shelter in place for patients, staff, and volunteers who remain in the	E 022	A Comprehensive Emergency Preparedness Plan and program was prepared 0n10/16/2018 that meets the requirements that a means to shelter in place for residents, staff and volunteers who remain in the(facility) and how these policies and procedures are aligned with a facility risk assessment. . All residents have the potential to be affected by not having the plan in place, Preparing the plan will correct this.	

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E 022	Continued From page 17 [facility]. *[For Inpatient Hospices at §418.113(b):] Policies and procedures. (6) The following are additional requirements for hospice-operated inpatient care facilities only. The policies and procedures must address the following: (i) A means to shelter in place for patients, hospice employees who remain in the hospice. This REQUIREMENT is not met as evidenced by: Based on 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 of how the facility will provide a means to shelter in place for patients, staff and volunteers who remain in the facility and how those policies and procedures are aligned with a facility risk assessment. The findings include: On 9/27/18 at 8:30 a.m., the facility's emergency preparedness plan was reviewed with OSM (other staff member) #11, the maintenance director, and OSM #7, the maintenance assistant. Review of the facility's emergency preparedness plan failed to evidence documentation of policies and procedures of how the facility will provide a means to shelter in place for patients, staff and volunteers who remain in the facility and how those policies and procedures are aligned with a facility risk assessment. OSM #11 and OSM #7 were made aware of this concern.	E 022	The Comprehensive Emergency Preparedness Plan and program was completed per regulations to ensure substantial compliance. Staff educated on 10/17/18 by ADON on the Comprehensive Emergency Preparedness Plan in means to shelter in place for residents, staff and volunteers who remain in the(facility) and how these policies and procedures are aligned with a facility risk assessment. Education will be given monthly X 3 months then yearly. QAPI committee assisted with the Development of the Comprehensive Emergency plan and will review monthly X 3 months then annually. Date of Compliance: 10/30/2018	

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E 022	Continued From page 18 On 9/27/18 at 1:05 p.m., ASM, (administrative staff member), the administrator, #1, was made aware of the above findings. No further information was obtained prior to exit.	E 022		
E 023 SS=C	Policies/Procedures for Medical Documentation CFR(s): 483.73(b)(5) [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. At a minimum, the policies and procedures must address the following:] (5) A system of medical documentation that preserves patient information, protects confidentiality of patient information, and secures and maintains availability of records. [(5) or (3),(4),(6)] A system of medical documentation that preserves patient information, protects confidentiality of patient information, and secures and maintains availability of records. *[For RNHCIs at §403.748(b):] Policies and procedures. (5) A system of care documentation that does the following: (i) Preserves patient information. (ii) Protects confidentiality of patient information. (iii) Secures and maintains the availability of records. *[For OPOs at §486.360(b):] Policies and procedures. (2) A system of medical	E 023	A Comprehensive Emergency Preparedness Plan and program was prepared On10/16/2018 that meets the requirements that a system of medical documentation that preserves resident information protects confidentiality of resident information, and secures and maintains availability of records. .All residents have the potential to be affected by not having the plan in place, Preparing the plan will correct this. The Comprehensive Emergency Preparedness Plan and program was completed per regulations to ensure substantial compliance. Staff educated on 10/17/18 by ADON on the Comprehensive Emergency Preparedness Plan that a system of medical documentation that preserves resident information protects confidentiality of resident information, and secures and maintains availability of records is in place. Education will be given monthly X 3 months then yearly.	

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E 023	Continued From page 19 documentation that preserves potential and actual donor information, protects confidentiality of potential and actual donor information, and secures and maintains the availability of records. 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 of how the facility preserves patient information, protects confidentiality of patient information, and secures and maintains availability of records. The findings include: On 9/27/18 at 8:30 a.m., the facility's emergency preparedness plan was reviewed with OSM (other staff member) #11, the maintenance director, and OSM #7, the maintenance assistant. Review of the facility's emergency preparedness plan failed to evidence documentation of policies and procedures of how the facility preserves patient information, protects confidentiality of patient information, and secures and maintains availability of records. OSM #11 and OSM #7 were made aware of this concern. On 9/27/18 at 1:05 p.m., ASM, (administrative staff member), the administrator, #1, was made aware of the above findings. No further information was obtained prior to exit.	E 023	QAPI committee assisted with the Development of the Comprehensive Emergency plan and will review monthly X 3 months then annually. Date of Compliance: 10/30/2018	
E 024	Policies/Procedures-Volunteers and Staffing	E 024		

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E 024 SS=C	Continued From page 20 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. The facility staff failed to develop policies and procedures for the use of volunteers in the emergency plan. The findings include: On 9/27/18 at 8:30 a.m., the facility's emergency	E 024	A Comprehensive Emergency Preparedness Plan and program was prepared On10/16/2018 that meets the requirements that addresses the use of volunteers in an emergency and other emergency staffing strategies and to address surge needs during an emergency. All residents have the potential to be affected by not having the plan in place, Preparing the plan will correct this. The Comprehensive Emergency Preparedness Plan and program was completed per regulations to ensure substantial compliance. Staff educated on 10/17/18 by ADON on the Comprehensive Emergency Preparedness Plan that addresses the use of volunteers in an emergency and other emergency staffing strategies to address surge needs during an emergency. Education will be given monthly X 3 months then yearly. QAPI committee assisted with the Development of the Comprehensive Emergency plan and will review monthly X 3 months then annually. Date of Compliance: 10/30/2018	

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E 024	Continued From page 21 preparedness plan was reviewed with OSM (other staff member) #11, the maintenance director, and OSM #7, the maintenance assistant. Review of the facility's emergency preparedness plan failed to evidence documentation of policies and procedures for the use of volunteers in the emergency plan. OSM #11 and OSM #7 were made aware of this concern. On 9/27/18 at 1:05 p.m., ASM, (administrative staff member), the administrator, #1, was made aware of the above findings. No further information was obtained prior to exit.	E 024		
E 026 SS=C	Roles Under a Waiver Declared by Secretary CFR(s): 483.73(b)(8) [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. At a minimum, the policies and procedures must address the following:] (8) [(6), (6)(C)(iv), (7), or (9)] The role of the [facility] under a waiver declared by the Secretary, in accordance with section 1135 of the Act, in the provision of care and treatment at an alternate care site identified by emergency management officials. *[For RNHCIs at §403.748(b):] Policies and procedures. (8) The role of the RNHCI under a waiver declared by the Secretary, in accordance	E 026	A Comprehensive Emergency Preparedness Plan and program was prepared On10/16/2018 that meets the requirements that addresses the role of the facility under a waiver declared by the Secretary, in accordance with section1135 of the Act, in the provision of care and treatment at an alternate care site identified by emergency management officials. All residents have the potential to be affected by not having the plan in place, Preparing the plan will correct this.	

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E 026	Continued From page 22 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 alternate care sites under an 1135 waiver. The findings include: On 9/27/18 at 8:30 a.m., the facility's emergency preparedness plan was reviewed with OSM (other staff member) #11, the maintenance director, and OSM #7, the maintenance assistant. Review of the facility's emergency preparedness plan failed to evidence documentation of policies and procedures in the emergency plan that describe the facility's role in providing care and treatment at alternate care sites under an 1135 waiver. OSM #11 and OSM #7 were made aware of this concern. On 9/27/18 at 1:05 p.m., ASM, (administrative staff member), the administrator, #1, was made aware of the above findings. No further information was obtained prior to exit.	E 026	The Comprehensive Emergency Preparedness Plan and program was completed per regulations to ensure substantial compliance. Staff educated on 10/17/18 by ADON on the Comprehensive Emergency Preparedness Plan addresses the role of the facility under a waiver declared by the Secretary, in accordance with section1135 of the Act, in the provision of care and treatment at an alternate care site identified by emergency management officials. Education will be given monthly X 3 months then yearly. QAPI committee assisted with the Development of the Comprehensive Emergency plan and will review monthly X 3 months then annually. Date of Compliance: 10/30/2018	
E 029 SS=C	Development of Communication Plan CFR(s): 483.73(c) (c) The [facility] must develop and maintain an	E 029	A Comprehensive Emergency Preparedness Plan and program was prepared On10/16/2018 that meets the requirements for a complete communication plan.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495255	A. BUILDING _____ B. WING _____	C 09/27/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SKYVIEW SPRINGS REHAB AND NURSING CENTER	30 MONTVUE DRIVE LURAY, VA 22835

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 029	Continued From page 23 emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least annually. 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. Facility staff failed to develop a communication plan. The findings include: On 9/27/18 at 8:30 a.m., the facility's emergency preparedness plan was reviewed with OSM (other staff member) #11, the maintenance director, and OSM #7, the maintenance assistant. Review of the facility's emergency preparedness plan failed to evidence documentation of a communication plan. OSM #11 and OSM #7 were made aware of this concern. On 9/27/18 at 1:05 p.m., ASM, (administrative staff member), the administrator, #1, was made aware of the above findings. No further information was provided prior to exit.	E 029	All residents have the potential to be affected by not having the plan in place, Preparing the plan will correct this. The Comprehensive Emergency Preparedness Plan and program was completed per regulations to ensure substantial compliance. Staff educated on 10/17/18 by ADON on the Comprehensive Emergency Preparedness Plan for a development of a complete Communication plan. Education will be given monthly X 3 months then yearly. QAPI committee assisted with the Development of the Comprehensive Emergency plan and will review monthly X 3 months then annually. Date of Compliance: 10/30/2018	
E 030 SS=C	Names and Contact Information CFR(s): 483.73(c)(1) [(c) The [facility, except RNHCIs, hospices, transplant centers, and HHAs] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and	E 030	A Comprehensive Emergency Preparedness Plan and program was prepared On10/16/2018 that meets the requirements for a complete communication plan that includes all required facility contacts are included in the communication plan.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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E 030	Continued From page 24 updated at least annually. The communication plan must include all of the following:] (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians (iv) Other [facilities]. (v) Volunteers. *[For RNHCIs at §403.748(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Next of kin, guardian, or custodian. (iv) Other RNHCIs. (v) Volunteers. *[For ASCs at §416.45(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians. (iv) Volunteers. *[For Hospices at §418.113(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Hospice employees. (ii) Entities providing services under arrangement.	E 030	All residents have the potential to be affected by not having the plan in place, Preparing the plan will correct this. The Comprehensive Emergency Preparedness Plan and program was completed per regulations to ensure substantial compliance. Staff educated on 10/17/18 by ADON on the Comprehensive Emergency Preparedness Plan for a development of a complete Communication plan that includes all Required facility contacts. Education will be given monthly X 3 months then yearly. QAPI committee assisted with the Development of the Comprehensive Emergency plan and will review monthly X 3 months then annually. Date of Compliance: 10/30/2018	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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E 030	Continued From page 25 (iii) Patients' physicians. (iv) Other hospices. *[For OPOs at §486.360(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Volunteers. (iv) Other OPOs. (v) Transplant and donor hospitals in the OPO's Donation Service Area (DSA). This REQUIREMENT is not met as evidenced by: Based on staff interview and facility document review it was determined that the facility staff failed to have a complete emergency preparedness plan. Facility staff failed to evidence that all required facility contacts were included in the communication plan. The findings include: On 9/27/18 at 8:30 a.m., the facility's emergency preparedness plan was reviewed with OSM (other staff member) #11, the maintenance director, and OSM #7, the maintenance assistant. Review of the facility's emergency preparedness plan failed to evidence that all required facility contacts were included in the communication plan. OSM #11 and OSM #7 were made aware of this concern. On 9/27/18 at 1:05 p.m., ASM, (administrative staff member), the administrator, #1, was made aware of the above findings.	E 030		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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E 030	Continued From page 26 No further information was provided prior to exit.	E 030		
E 031 SS=C	Emergency Officials Contact Information CFR(s): 483.73(c)(2) [(c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least annually.] The communication plan must include all of the following: (2) Contact information for the following: (i) Federal, State, tribal, regional, and local emergency preparedness staff. (ii) Other sources of assistance. *[For LTC Facilities at §483.73(c):] (2) Contact information for the following: (i) Federal, State, tribal, regional, or local emergency preparedness staff. (ii) The State Licensing and Certification Agency. (iii) The Office of the State Long-Term Care Ombudsman. (iv) Other sources of assistance. *[For ICF/IIDs at §483.475(c):] (2) Contact information for the following: (i) Federal, State, tribal, regional, and local emergency preparedness staff. (ii) Other sources of assistance. (iii) The State Licensing and Certification Agency. (iv) The State Protection and Advocacy Agency. 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 031	A Comprehensive Emergency Preparedness Plan and program was prepared 0n10/16/2018 that meets the requirements for a complete communication plan that includes contact information on federal, state, tribal, regional, and local emergency preparedness staff and other sources of assistance. All residents have the potential to be affected by not having the plan in place, Preparing the plan will correct this. The Comprehensive Emergency Preparedness Plan and program was completed per regulations to ensure substantial compliance. Staff educated on 10/17/18 by ADON on the Comprehensive Emergency Preparedness Plan for a complete communication plan that includes contact information on federal, state, tribal, regional, and local emergency preparedness staff and other sources of assistance. Education will be given monthly X 3 months then yearly.	

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E 031	Continued From page 27 Facility staff failed to evidence that all required emergency official's contact information was included in the communication plan. The findings include: On 9/27/18 at 8:30 a.m., the facility's emergency preparedness plan was reviewed with OSM (other staff member) #11, the maintenance director, and OSM #7, the maintenance assistant. Review of the facility's emergency preparedness plan failed to evidence that all required emergency official's contact information was included in the communication plan. OSM #11 and OSM #7 were made aware of this concern. On 9/27/18 at 1:05 p.m., ASM, (administrative staff member), the administrator, #1, was made aware of the above findings. No further information was provided prior to exit.	E 031	QAPI committee assisted with the Development of the Comprehensive Emergency plan and will review monthly X 3 months then annually. Date of Compliance: 10/30/2018	
E 032 SS=C	Primary/Alternate Means for Communication CFR(s): 483.73(c)(3) [(c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least annually.] The communication plan must include all of the following: (3) Primary and alternate means for communicating with the following: (i) [Facility] staff. (ii) Federal, State, tribal, regional, and local emergency management agencies.	E 032	A Comprehensive Emergency Preparedness Plan and program was prepared On10/16/2018 that meets the requirements for a complete communication plan that includes communication plan for primary and alternate means for communication with facility staff, federal, state, tribal, and local emergency management agencies	

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E 032	Continued From page 28 *[For ICF/IIDs at §483.475(c):] (3) Primary and alternate means for communicating with the ICF/IID's staff, Federal, State, tribal, regional, and local emergency management agencies. This REQUIREMENT is not met as evidenced by: Based on 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 evidence of documentation that the communication plan includes primary and alternate means for communicating with facility staff, Federal, State, tribal, and local emergency management agencies by reviewing the communication plan. The findings include: On 9/27/18 at 8:30 a.m., the facility's emergency preparedness plan was reviewed with OSM (other staff member) #11, the maintenance director, and OSM #7, the maintenance assistant. Review of the facility's emergency preparedness plan failed to evidence documentation that the communication plan includes primary and alternate means for communicating with facility staff, Federal, State, tribal, and local emergency management agencies by reviewing the communication plan. OSM #11 and OSM #7 were made aware of this concern. On 9/27/18 at 1:05 p.m., ASM, (administrative staff member), the administrator, #1, was made aware of the above findings. No further information was obtained prior to exit.	E 032	All residents have the potential to be affected by not having the plan in place, Preparing the plan will correct this. The Comprehensive Emergency Preparedness Plan and program was completed per regulations to ensure substantial compliance. Staff educated on 10/17/18 by ADON on the Comprehensive Emergency Preparedness Plan for a complete communication plan that includes communication plan for primary and alternate means for communication with facility staff, federal, state, tribal, and local emergency management agencies assistance. Education will be given monthly X 3 months then yearly. QAPI committee assisted with the Development of the Comprehensive Emergency plan and will review monthly X 3 months then annually. Date of Compliance: 10/30/2018	

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E 033 E 033 SS=C	Continued From page 29 Methods for Sharing Information CFR(s): 483.73(c)(4)-(6) [(c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least annually.] The communication plan must include all of the following: (4) A method for sharing information and medical documentation for patients under the [facility's] care, as necessary, with other health providers to maintain the continuity of care. (5) A means, in the event of an evacuation, to release patient information as permitted under 45 CFR 164.510(b)(1)(ii). [This provision is not required for HHAs under §484.22(c), CORFs under §485.68(c), and RHCs/FQHCs under §491.12(c).] (6) [(4) or (5)]A means of providing information about the general condition and location of patients under the [facility's] care as permitted under 45 CFR 164.510(b)(4). *[For RNHCIs at §403.748(c):] (4) A method for sharing information and care documentation for patients under the RNHCI's care, as necessary, with care providers to maintain the continuity of care, based on the written election statement made by the patient or his or her legal representative. *[For RHCs/FQHCs at §491.12(c):] (4) A means of providing information about the general condition and location of patients under the	E 033 E 033	A Comprehensive Emergency Preparedness Plan and program was prepared On10/16/2018 that meets the requirements for a complete communication plan that includes a method for sharing information and medical documentation for residents under the facility's care as necessary, with other health providers to maintain the continuity of care and that address the means that the facility will use to release resident information to include the general condition and location of residents. All residents have the potential to be affected by not having the plan in place, Preparing the plan will correct this.	

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E 033	Continued From page 30 facility's care as permitted under 45 CFR 164.510(b)(4). 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 evidence of documentation that the communication plan included a method for sharing information and medical documentation for patients under the facility's care, as necessary, with other health providers to maintain the continuity of care by reviewing the communication plan and documentation that the facility has developed. The plan also failed to evidence policies and procedures that address the means the facility will use to release patient information to include the general condition and location of patients by reviewing the communication plan. The findings include: On 9/27/18 at 8:30 a.m., the facility's emergency preparedness plan was reviewed with OSM (other staff member) #11, the maintenance director, and OSM #7, the maintenance assistant. Review of the facility's emergency preparedness plan failed to evidence documentation that the communication plan included a method for sharing information and medical documentation for patients under the facility's care, as necessary, with other health providers to maintain the continuity of care by reviewing the communication plan and documentation that the facility has developed. The plan also failed to evidence policies and procedures that address	E 033	The Comprehensive Emergency Preparedness Plan and program was completed per regulations to ensure substantial compliance. Staff educated on 10/17/18 by ADON on the Comprehensive Emergency Preparedness Plan for a complete communication plan that includes a method for sharing information and medical documentation for residents under the facility's care as necessary, with other health providers to maintain the continuity of care and that address the means that the facility will use to release resident information to include the general condition and location of residents. Education will be given monthly X 3 months then yearly. QAPI committee assisted with the Development of the Comprehensive Emergency plan and will review monthly X 3 months then annually. Date of Compliance: 10/30/2018	

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E 033	Continued From page 31 the means the facility will use to release patient information to include the general condition and location of patients by reviewing the communication plan. OSM #11 and OSM #7 were made aware of this concern. On 9/27/18 at 1:05 p.m., ASM, (administrative staff member), the administrator, #1, was made aware of the above findings. No further information was obtained prior to exit.	E 033		
E 034 SS=C	Information on Occupancy/Needs CFR(s): 483.73(c)(7) [(c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least annually.] The communication plan must include all of the following: (7) [(5) or (6)] A means of providing information about the [facility's] occupancy, needs, and its ability to provide assistance, to the authority having jurisdiction, the Incident Command Center, or designee. *[For ASCs at 416.54(c)]: (7) A means of providing information about the ASC's needs, and its ability to provide assistance, to the authority having jurisdiction, the Incident Command Center, or designee. *[For Inpatient Hospice at §418.113:] (7) A means of providing information about the hospice's inpatient occupancy, needs, and its ability to provide assistance, to the authority having jurisdiction, the Incident Command Center, or	E 034	A Comprehensive Emergency Preparedness Plan and program was prepared On10/16/2018 that meets the requirements for a complete communication plan that includes a means of providing information about the facility needs and its ability to provide assistance, to the authority having jurisdiction, on the occupancy of the facility. All residents have the potential to be affected by not having the plan in place, Preparing the plan will correct this.	

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E 034	Continued From page 32 designee. 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 evidence of documentation that the communication plan includes a means of providing information about the facility's needs, and its ability to provide assistance, to the authority having jurisdiction, the incident Command Center, or designee by reviewing the communication plan and documentation that the communication plan includes a means of providing information about their occupancy. The findings include: On 9/27/18 at 8:30 a.m., the facility's emergency preparedness plan was reviewed with OSM (other staff member) #11, the maintenance director, and OSM #7, the maintenance assistant. Review of the facility's emergency preparedness plan failed to evidence documentation that the communication plan includes a means of providing information about the facility's needs, and its ability to provide assistance, to the authority having jurisdiction, the incident Command Center, or designee by reviewing the communication plan and documentation that the communication plan includes a means of providing information about their occupancy. OSM #11 and OSM #7 were made aware of this concern. On 9/27/18 at 1:05 p.m., ASM, (administrative	E 034	The Comprehensive Emergency Preparedness Plan and program was completed per regulations to ensure substantial compliance. Staff educated on 10/17/18 by ADON on the Comprehensive Emergency Preparedness Plan for a complete communication plan that includes a means of providing information about the facility needs and its ability to provide assistance, to the authority having jurisdiction, on the occupancy of the facility. Education will be given monthly X 3 months then yearly. QAPI committee assisted with the Development of the Comprehensive Emergency plan and will review monthly X 3 months then annually. Date of Compliance: 10/30/2018	

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E 034	Continued From page 33 staff member), the administrator, #1, was made aware of the above findings. No further information was obtained prior to exit.	E 034		
E 035 SS=C	LTC and ICF/IID Sharing Plan with Patients CFR(s): 483.73(c)(8) [(c) The [LTC facility and ICF/IID] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least annually.] The communication plan must include all of the following: (8) A method for sharing information from the emergency plan, that the facility has determined is appropriate, with residents [or clients] and their families or representatives. This REQUIREMENT is not met as evidenced by: Based on 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 evidence of documentation that the communication plan includes a method for sharing information from the emergency plan with residents or clients and their families or representatives. The findings include: On 9/27/18 at 8:30 a.m., the facility's emergency preparedness plan was reviewed with OSM (other staff member) #11, the maintenance director, and OSM #7, the maintenance assistant. Review of the facility's emergency preparedness plan failed	E 035	A Comprehensive Emergency Preparedness Plan and program was prepared On10/16/2018 that meets the requirements for a complete communication plan that includes a method for sharing information from the emergency plan with residents and their families or representatives. All residents have the potential to be affected by not having the plan in place, Preparing the plan will correct this. The Comprehensive Emergency Preparedness Plan and program was completed per regulations to ensure substantial compliance. Staff educated on 10/17/18 by ADON on the Comprehensive Emergency Preparedness Plan for a complete communication plan that includes a method for sharing information from the emergency plan with residents and their families or representatives. Education will be given monthly X 3 months then yearly.	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 035	Continued From page 34 to evidence documentation that the communication plan includes a method for sharing information from the emergency with residents or clients and their families or representatives. OSM #11 and OSM #7 were made aware of this concern. On 9/27/18 at 1:05 p.m., ASM, (administrative staff member), the administrator, #1, was made aware of the above findings. No further information was obtained prior to exit.	E 035	QAPI committee assisted with the Development of the Comprehensive Emergency plan and will review monthly X 3 months then annually. Date of Compliance: 10/30/2018	
E 036 SS=C	EP Training and Testing CFR(s): 483.73(d) (d) Training and testing. The [facility] must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least annually. *[For ICF/IIDs at §483.475(d):] Training and testing. The ICF/IID must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least annually. The ICF/IID must meet the requirements for evacuation drills and training at	E 036	A Comprehensive Emergency Preparedness Plan and program was prepared On 10/16/2018 that meets the requirements that evidence of documentation that the facility has a written training and testing program that meets the requirements of the regulation All residents have the potential to be affected by not having the plan in place, Preparing the plan will correct this.	

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	495255	A. BUILDING _____ B. WING _____	C 09/27/2018

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E 036	Continued From page 35 §483.470(h). *[For ESRD Facilities at §494.62(d):] Training, testing, and orientation. The dialysis facility must develop and maintain an emergency preparedness training, testing and patient orientation program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training, testing and orientation program must be reviewed and updated at least annually. This REQUIREMENT is not met as evidenced by: Based on 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 evidence of documentation that the facility has a written training and testing program that meets the requirements of the regulation. The findings include: On 9/27/18 at 8:30 a.m., the facility's emergency preparedness plan was reviewed with OSM (other staff member) #11, the maintenance director, and OSM #7, the maintenance assistant. Review of the facility's emergency preparedness plan failed to evidence documentation that the facility has a written training and testing program that meets the requirements of the regulation. OSM #11 and OSM #7 were made aware of this concern. On 9/27/18 at 1:05 p.m., ASM, (administrative	E 036	The Comprehensive Emergency Preparedness Plan and program was completed per regulations to ensure substantial compliance. Staff educated on 10/17/18 by ADON on the Comprehensive Emergency Preparedness Plan for evidence of documentation that the facility has a written training and testing program that meets the requirements of the regulation. Education will be given monthly X 3 months then yearly. QAPI committee assisted with the Development of the Comprehensive Emergency plan and will review monthly X 3 months then annually. Date of Compliance: 10/30/2018	

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E 036	Continued From page 36 staff member), the administrator, #1, was made aware of the above findings. No further information was obtained prior to exit.	E 036		
E 037 SS=C	EP Training Program CFR(s): 483.73(d)(1) (1) Training program. The [facility, except CAHs, ASCs, PACE organizations, PRTFs, Hospices, and dialysis facilities] must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected role. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. *[For Hospitals at §482.15(d) and RHCs/FQHCs at §491.12:] (1) Training program. The [Hospital or RHC/FQHC] must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing on-site services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. *[For Hospices at §418.113(d):] (1) Training. The hospice must do all of the following: (i) Initial training in emergency preparedness	E 037	A Comprehensive Emergency Preparedness Plan and program was prepared On 10/16/2018 that meets the requirements that evidence of documentation that the facility has initial emergency preparedness training and annual emergency preparedness training offerings for volunteers and documentation that facility volunteers have received initial and annual emergency preparedness training. All residents have the potential to be affected by not having the plan in place, Preparing the plan will correct this. The Comprehensive Emergency Preparedness Plan and program was completed per regulations to ensure substantial compliance. Staff educated on 10/17/18 by ADON on the Comprehensive Emergency Preparedness Plan for facility has the initial emergency preparedness training and annual emergency preparedness training offerings for volunteers and documentation that facility	

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E 037	Continued From page 37 policies and procedures to all new and existing hospice employees, and individuals providing services under arrangement, consistent with their expected roles. (ii) Demonstrate staff knowledge of emergency procedures. (iii) Provide emergency preparedness training at least annually. (iv) Periodically review and rehearse its emergency preparedness plan with hospice employees (including nonemployee staff), with special emphasis placed on carrying out the procedures necessary to protect patients and others. *[For PRTFs at §441.184(d):] (1) Training program. The PRTF must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) After initial training, provide emergency preparedness training at least annually. (iii) Demonstrate staff knowledge of emergency procedures. (iv) Maintain documentation of all emergency preparedness training. *[For PACE at §460.84(d):] (1) The PACE organization must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing on-site services under arrangement, contractors, participants, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least annually.	E 037	volunteers have received initial and annual emergency preparedness training. Education will be given monthly X 3 months then yearly. QAPI committee assisted with the Development of the Comprehensive Emergency plan and will review monthly X 3 months then annually. Date of Compliance: 10/30/2018	

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E 037	Continued From page 38 (iii) Demonstrate staff knowledge of emergency procedures, including informing participants of what to do, where to go, and whom to contact in case of an emergency. (iv) Maintain documentation of all training. *[For CORFs at §485.68(d):](1) Training. The CORF must do all of the following: (i) Provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. All new personnel must be oriented and assigned specific responsibilities regarding the CORF's emergency plan within 2 weeks of their first workday. The training program must include instruction in the location and use of alarm systems and signals and firefighting equipment. *[For CAHs at §485.625(d):] (1) Training program. The CAH must do all of the following: (i) Initial training in emergency preparedness policies and procedures, including prompt reporting and extinguishing of fires, protection, and where necessary, evacuation of patients, personnel, and guests, fire prevention, and cooperation with firefighting and disaster authorities, to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at	E 037		

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E 037	Continued From page 39 least annually. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. *[For CMHCs at §485.920(d):] (1) Training. The CMHC must provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles, and maintain documentation of the training. The CMHC must demonstrate staff knowledge of emergency procedures. Thereafter, the CMHC must provide emergency preparedness training at least annually. This REQUIREMENT is not met as evidenced by: Based on 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 evidence of documentation of the facility's initial emergency preparedness training and annual emergency preparedness training offerings for volunteers and documentation that facility volunteers have received initial & annual emergency preparedness training. The findings include: On 9/27/18 at 8:30 a.m., the facility's emergency preparedness plan was reviewed with OSM (other staff member) #11, the maintenance director, and OSM #7, the maintenance assistant. Review of the facility's emergency preparedness plan failed	E 037		

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E 037	Continued From page 40 to evidence documentation of the facility's initial emergency preparedness training and annual emergency preparedness training offerings for volunteers and documentation that facility volunteers have received initial & annual emergency preparedness training. OSM #11 and OSM #7 were made aware of this concern. On 9/27/18 at 1:05 p.m., ASM, (administrative staff member), the administrator, #1, was made aware of the above findings. No further information was obtained prior to exit.	E 037		
E 039 SS=C	EP Testing Requirements CFR(s): 483.73(d)(2) (2) Testing. The [facility, except for LTC facilities, RNHCIs and OPOs] must conduct exercises to test the emergency plan at least annually. The [facility, except for RNHCIs and OPOs] must do all of the following: *[For LTC Facilities at §483.73(d):] (2) Testing. The LTC facility must conduct exercises to test the emergency plan at least annually, including unannounced staff drills using the emergency procedures. The LTC facility must do all of the following:] (i) Participate in a full-scale exercise that is 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	E 039	A Comprehensive Emergency Preparedness Plan and program was prepared On 10/16/2018 that meets the requirements that evidence of documentation that the facility has annual tabletop and full scale exercises and document of how the facility's exercise analysis, response and how the facility updated its emergency program based on the exercise analysis. All residents have the potential to be affected by not having the plan in place, Preparing the plan will correct this.	

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E 039	Continued From page 41 the actual event. (ii) Conduct an additional exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, facility-based. (B) A tabletop exercise that includes a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed. *[For RNHCIs at §403.748 and OPOs at §486.360] (d)(2) Testing. The [RNHCI and OPO] must conduct exercises to test the emergency plan. The [RNHCI and OPO] must do the following: (i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group discussion led by a facilitator, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (ii) Analyze the [RNHCI's and OPO's] response to and maintain documentation of all tabletop 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.	E 039	The Comprehensive Emergency Preparedness Plan and program was completed per regulations to ensure substantial compliance. Staff educated on 10/17/18 by ADON on the Comprehensive Emergency Preparedness Plan for evidence of documentation that the facility has annual tabletop and full scale exercises and document of how the facility's exercise analysis, response and how the facility updated its emergency program based on the exercise analysis. Education will be given monthly X 3 months then yearly. QAPI committee assisted with the Development of the Comprehensive Emergency plan and will review monthly X 3 months then annually. Date of Compliance: 10/30/2018	

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E 039	Continued From page 42 The facility staff failed to provide evidence of documentation of the annual tabletop and full-scale exercises and documentation of the facility's exercise analysis, response, and how the facility updated its emergency program based on the exercise analysis. The findings include: On 9/27/18 at 8:30 a.m., the facility's emergency preparedness plan was reviewed with OSM (other staff member) #11, the maintenance director, and OSM #7, the maintenance assistant. Review of the facility's emergency preparedness plan failed to evidence documentation of the annual tabletop and 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. OSM #11 and OSM #7 were made aware of this concern. On 9/27/18 at 1:05 p.m., ASM, (administrative staff member), the administrator, #1, was made aware of the above findings. No further information was obtained prior to exit.	E 039		
E 041 SS=C	Hospital CAH and LTC Emergency Power CFR(s): 483.73(e) (e) Emergency and standby power systems. The hospital must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section and in the policies and procedures plan set forth in paragraphs (b)(1)(i) and (ii) of this section. §483.73(e), §485.625(e)	E 041	A Comprehensive Emergency Preparedness Plan and program was prepared On 10/16/2018 that meets the requirements that evidence of documentation that the facility has the required emergency power systems or plans in place to maintain safe operations while sheltering in place and a plan of how to keep the generator operational during an emergency.	

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E 041	Continued From page 43 (e) Emergency and standby power systems. The [LTC facility and the CAH] must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section. §482.15(e)(1), §483.73(e)(1), §485.625(e)(1) Emergency generator location. The generator must be located in accordance with the location requirements found in the Health Care Facilities Code (NFPA 99 and Tentative Interim Amendments TIA 12-2, TIA 12-3, TIA 12-4, TIA 12-5, and TIA 12-6), Life Safety Code (NFPA 101 and Tentative Interim Amendments TIA 12-1, TIA 12-2, TIA 12-3, and TIA 12-4), and NFPA 110, when a new structure is built or when an existing structure or building is renovated. 482.15(e)(2), §483.73(e)(2), §485.625(e)(2) Emergency generator inspection and testing. The [hospital, CAH and LTC facility] must implement the emergency power system inspection, testing, and maintenance requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code. 482.15(e)(3), §483.73(e)(3), §485.625(e)(3) Emergency generator fuel. [Hospitals, CAHs and LTC facilities] that maintain an onsite fuel source to power emergency generators must have a plan for how it will keep emergency power systems operational during the emergency, unless it evacuates. *[For hospitals at §482.15(h), LTC at §483.73(g), and CAHs §485.625(g):] The standards incorporated by reference in this section are approved for incorporation by	E 041	All residents have the potential to be affected by not having the plan in place, Preparing the plan will correct this. The Comprehensive Emergency Preparedness Plan and program was completed per regulations to ensure substantial compliance. Staff educated on 10/17/18 by ADON on the Comprehensive Emergency Preparedness Plan for evidence of documentation that the facility has the required emergency power systems or plans in place to maintain safe operations while sheltering in place and a plan of how to keep the generator operational during an emergency. Education will be given monthly X 3 months then yearly. QAPI committee assisted with the Development of the Comprehensive Emergency plan and will review monthly X 3 months then annually. Date of Compliance: 10/30/2018	

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E 041	Continued From page 44 reference by the Director of the Office of the Federal Register in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. You may obtain the material from the sources listed below. You may inspect a copy at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html. If any changes in this edition of the Code are incorporated by reference, CMS will publish a document in the Federal Register to announce the changes. (1) National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02169, www.nfpa.org, 1.617.770.3000. (i) NFPA 99, Health Care Facilities Code, 2012 edition, issued August 11, 2011. (ii) Technical interim amendment (TIA) 12-2 to NFPA 99, issued August 11, 2011. (iii) TIA 12-3 to NFPA 99, issued August 9, 2012. (iv) TIA 12-4 to NFPA 99, issued March 7, 2013. (v) TIA 12-5 to NFPA 99, issued August 1, 2013. (vi) TIA 12-6 to NFPA 99, issued March 3, 2014. (vii) NFPA 101, Life Safety Code, 2012 edition, issued August 11, 2011. (viii) TIA 12-1 to NFPA 101, issued August 11, 2011. (ix) TIA 12-2 to NFPA 101, issued October 30, 2012. (x) TIA 12-3 to NFPA 101, issued October 22, 2013. (xi) TIA 12-4 to NFPA 101, issued October 22, 2013.	E 041		

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E 041	Continued From page 45 (xiii) NFPA 110, Standard for Emergency and Standby Power Systems, 2010 edition, including TIAs to chapter 7, issued August 6, 2009. This REQUIREMENT is not met as evidenced by: Based on staff interview and facility document review it was determined that the facility staff failed to have a complete emergency preparedness plan. Facility staff failed to evidence documentation that the facility has the required emergency and standby power systems, has emergency power systems or plans in place to maintain safe operations while sheltering in place and a plan of how to keep the generator operational during an emergency unless they plan to evacuate. The findings include: On 9/27/18 at 8:30 a.m., the facility's emergency preparedness plan was reviewed with OSM (other staff member) #11, the maintenance director, and OSM #7, the maintenance assistant. Review of the facility's emergency preparedness plan failed evidence documentation that the facility has the required emergency and standby power systems, has emergency power systems or plans in place to maintain safe operations while sheltering in place and a plan of how to keep the generator operational during an emergency unless they plan to evacuate. OSM #11 and OSM #7 were made aware of this concern. On 9/27/18 at 1:05 p.m., ASM, (administrative staff member), the administrator, #1, was made aware of the above findings. No further information was provided prior to exit.	E 041		

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E 042 SS=C	Integrated EP Program CFR(s): 483.73(f) (e) [or (f)]Integrated healthcare systems. If a [facility] is part of a healthcare system consisting of multiple separately certified healthcare facilities that elects to have a unified and integrated emergency preparedness program, the [facility] may choose to participate in the healthcare system's coordinated emergency preparedness program. If elected, the unified and integrated emergency preparedness program must- [do all of the following:] (1) Demonstrate that each separately certified facility within the system actively participated in the development of the unified and integrated emergency preparedness program. (2) Be developed and maintained in a manner that takes into account each separately certified facility's unique circumstances, patient populations, and services offered. (3) Demonstrate that each separately certified facility is capable of actively using the unified and integrated emergency preparedness program and is in compliance [with the program]. (4) Include a unified and integrated emergency plan that meets the requirements of paragraphs (a)(2), (3), and (4) of this section. The unified and integrated emergency plan must also be based on and include the following: (i) A documented community-based risk assessment, utilizing an all-hazards approach. (ii) A documented individual facility-based risk	E 042	A Comprehensive Emergency Preparedness Plan and program was prepared On 10/16/2018 that meets the requirements that the facility has evidence has or has not opted to be part of its healthcare system's unified and integrated emergency preparedness program. All residents have the potential to be affected by not having the plan in place, Preparing the plan will correct this. The Comprehensive Emergency Preparedness Plan and program was completed per regulations to ensure substantial compliance. Staff educated on 10/17/18 by ADON on the Comprehensive Emergency Preparedness Plan for evidence that the facility has or has not opted to be part of its healthcare system's unified and integrated emergency preparedness program. Education will be given monthly X 3 months then yearly. QAPI committee assisted with the Development of the Comprehensive Emergency plan and will review monthly X 3 months then annually. Date of Compliance: 10/30/2018	

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E 042	Continued From page 47 assessment for each separately certified facility within the health system, utilizing an all-hazards approach. (5) Include integrated policies and procedures that meet the requirements set forth in paragraph (b) of this section, a coordinated communication plan, and training and testing programs that meet the requirements of paragraphs (c) and (d) of this section, respectively. 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. Facility staff failed to evidence that the facility has or has not opted to be part of its healthcare system's unified and integrated emergency preparedness program. The findings include: On 9/27/18 at 8:30 a.m., the facility's emergency preparedness plan was reviewed with OSM (other staff member) #11, the maintenance director, and OSM #7, the maintenance assistant. Review of the facility's emergency preparedness plan failed to evidence that the facility has or has not opted to be part of its healthcare system's unified and integrated emergency preparedness program. OSM #11 and OSM #7 were made aware of this concern. On 9/27/18 at 1:05 p.m., ASM, (administrative staff member), the administrator, #1, was made aware of the above findings.	E 042		

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E 042	Continued From page 48 No further information was provided prior to exit.	E 042		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 9/25/18 through 9/27/18. Complaints were investigated during the survey. 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 120 certified bed facility was 119 at the time of the survey. The survey sample consisted of 39 current resident reviews (Residents #24, #17, #22, #27, #64, #111, #36, #94, #103, #38, #106, #55, #97, #2, #53, #90, #102, #8, #20, #79, #88, #57, #45, #31, #56, #30, #44, #29, #14, #100, #42, #99, #92, #23, #118, #83, #87, #85 and #48) and four closed record reviews (Residents #119, #121, #169 and #117).	F 000		
F 584 SS=E	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.	F 584	Residents #103 room will be Repaired and painted by the Maintenance department By 10/30/18. Resident #27 fan Was cleaned on 09/26/18. Resident # 97 will be served Food in day room without trays. Stained dishware removed from Service. A room rounds will be conducted By the Administrator by 10/18/18 to observe for any more rooms that may be need of repair due to torn wall paper, or scratches.	

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F 584	Continued From page 49 (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, 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 observation, resident interview, staff interview, facility policy review and clinical record review and it was determined, the facility staff failed to maintain a clean comfortable homelike environment for three of 43 residents in the survey sample (Resident #103, Resident #27 and Resident #97), and in one of 5 dining rooms (south wing day area) and in the kitchen. 1. The facility staff failed to maintain Resident #103's room in good repair, multiple scratch marks, torn wallpaper, and indentations were observed on the wall behind the resident's bed.	F 584	All fans being utilized in facility were Checked on 09/26/18 by unit managers To ensure cleanness. Staff educated on 09/26/18 that meals served in day room Can not be on trays. An audit completed By dietary manager on stained dishware And will be replaced with new. Maintenance Department will conduct Room rounds quarterly to ensure that Rooms are kept in good repair. Housekeeping will put fans on a Weekly cleaning schedule to ensure Free of dust. Residents will not be served On trays in day room. Staff educated on 10/18/18 by ADON on this. Dishware will Be replaced and a water softener will be Purchased for the dish machine to keep Dishware free of lime stains. Results of room rounds will be taken To the QAPI for review and recommendations. Management staff will conduct rounds 5 x week and observe fans for cleanness, Dietary manager will notify Administrator of need for new dishware when stains noted. Administrator will observe weekly dishware for any stains and replace as needed. Management staff will monitor 5 x week dayroom meal service to ensure compliance. Results of observations will be taken to QAPI meeting for review and recommendations. Date of Compliance: 10/30/2018	

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F 584	Continued From page 50 2. The facility staff failed to maintain Resident # 27's room in a sanitary, homelike environment; gray dust was observed coating the fan blades and the front and rear finger guard setting of a 12-inch tabletop fan pointed towards and blowing in the direction of Resident # 27's bed. 3. The facility staff failed to serve residents meals in a homelike manner in the south wing, day area. 4. a. The facility staff failed to ensure that the residents were served meals with dishware that was homelike and not heavily worn stained in appearance. 4.b. The facility staff failed to ensure that Resident #97 was served her meal in dishware that was home like and not heavily stained and unsightly. The findings include: 1. Resident #103 was admitted to the facility on 2/6/14, and readmitted to the facility on 9/4/18, with diagnoses that included, but were not limited to: chronic obstructive pulmonary disease (COPD) (1), acute and chronic respiratory failure (2), major depressive disorder, generalized anxiety disorder, atrial fibrillation (3) and high blood pressure. The most recent MDS (minimum data set), a five day assessment, with an ARD (assessment reference date) of 9/8/18 coded the resident as having a score of 15 out of 15 on the BIMS (brief interview for mental status); indicating the resident was cognitively intact to make daily decisions.	F 584		

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F 584	Continued From page 51 On 09/25/18 at approximately 12:33 p.m., an observation was made of Resident #103's room. The room was observed with multiple scratch marks, torn wallpaper, and indentations in the wall measuring approximately 24 x 6 inches behind the resident's bed. On 09/26/18 at approximately 3:00 p.m., a second observation was made of Resident #103's room. The room was observed with multiple scratch marks, torn wallpaper, and indentations in the wall measuring approximately 24 x 6 inches behind the resident's bed. On 09/27/18 at approximately 12:50 p.m., a third observation was made of Resident #103's room with OSM (other staff member) #11, the Maintenance Director. When asked what he observed, OSM #11 replied, "The wall paper behind the bed is torn and the wall is scratched." On 09/25/18 at approximately 12:33 p.m., an interview was conducted with Resident #103. When asked if the condition of the walls in her room is something that she would have fixed at home, the resident responded "Yes." On 09/27/18 at approximately 12:18 p.m., an interview was conducted with CNA (certified nursing assistant) #4. CAN #4 was asked about the procedure staff follows if repair is needed in a resident's room. CNA #4 stated, "There is a maintenance slip at the nursing station we fill it out and leave it in a box at the nursing station that maintenance checks 3-4 times per day." On 09/27/18 at approximately 12:31 p.m., an interview was conducted with LPN (Licensed	F 584		

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practical nurse) #1, the Unit Manager. When asked if a maintenance request had been made to repair the wall behind Resident #103's bed, LPN #1 stated that she was not aware of one.

On 09/27/18 at approximately 12:50 p.m., and interview was conducted with OSM #11. When asked about the condition of the wall in Resident #103's room, OSM #11 stated, "Yes sir. It should have been fixed immediately. The housekeeper should have seen this while cleaning the room and put in a work order and then we would come fixed it." When asked is there a work order to repair this wall, OSM #11 responded "No."

The facility was unable to locate the policy regarding maintaining a homelike environment.

On 09/27/18 at approximately 3:30 p.m., ASM (administrative staff member) #1, the Administrator and ASM #2, the Director of Nursing were made aware of the findings.

No further information was provided prior to exit.

1. A disease that makes it difficult to breath that can lead to shortness of breath. The two main types are chronic bronchitis and emphysema. The main cause of COPD is long-term exposure to substances that irritate and damage the lungs. This is usually cigarette smoke. Air pollution, chemical fumes, or dust can also cause it. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/copd.html.

2. A condition in which not enough oxygen passes from your lungs into your blood. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/respiratoryfa

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F 584	Continued From page 53 ilure.html. 3. 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. 2. The facility staff failed to maintain Resident # 27's room in a sanitary, homelike environment; gray dust was observed coating the fan blades and the front and rear finger guard setting of a 12-inch tabletop fan pointed towards and blowing in the direction of Resident # 27's bed. Resident # 27 was admitted to the facility on 06/28/2016 with diagnoses that included but were not limited to: atrial fibrillation (1), heart failure (2), dyspnea (3) and hypertension (4). Resident # 27's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 07/03/18, coded Resident # 27 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. Resident # 27 was coded as requiring extensive assistance of one staff member for activities of daily living. On 09/25/18 at approximately 12:00 p.m., an observation of Resident # 27's room revealed she was not in her room. Further observation of the room revealed a 12-inch tabletop fan setting on the sink counter in the room, pointed toward and blowing in the direction of Resident # 27's bed. Observation of the fan revealed gray dust coating the fan blades and the front and rear finger guards.	F 584		

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F 584	Continued From page 54 On 09/25/18 at approximately 2:19 p.m., and at 2:22 p.m., observations of Resident # 27's room revealed she was not in her room. Further observation of the room revealed a 12-inch tabletop fan setting on the sink counter in the room, pointed toward and blowing in the direction of Resident # 27's bed. Observation of the fan revealed gray dust coating the fan blades and the front and rear finger guards. On 09/25/18 at approximately 5:11 p.m., during an interview with Resident # 27 in her room, observation of the room revealed a 12-inch tabletop fan setting on the sink counter in the room, pointed toward and blowing in the direction of Resident # 27's bed. Observation of the fan revealed gray dust coating the fan blades and the front and rear finger guards. When asked about the fan Resident # 27 stated it kept her cool. On 09/26/18 at approximately 8:25 a.m., and at approximately 1:22 p.m., observations of Resident # 27's room revealed she was not in her room. Further observations of the room revealed a 12-inch tabletop fan setting on the sink counter in the room, pointed toward and blowing in the direction of Resident # 27's bed. Observation of the fan revealed gray dust coating the fan blades and the front and rear finger guards. On 09/26/18 at approximately 2:59 p.m., an interview and observation of Resident # 27's room was conducted with LPN (licensed practical nurse) # 2, north wing, unit manager. After observing the fan blowing toward Resident # 27's bed, LPN # 2 acknowledged the fan was dirty and stated, "Maintenance is responsible for checking	F 584		

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and cleaning the fan. It should be checked daily during room rounds." LPN # 2 then removed the fan from Resident # 27's room.

On 09/26/18 at approximately 5:50 p.m., ASM (administrative staff member) # 1, the administrator and ASM # 2, director of nursing were made aware of the findings.

No further information was provided prior to exit.

References:
(1) 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.

(2) A condition in which the heart is no longer able to pump oxygen-rich blood to the rest of the body efficiently. This causes symptoms to occur throughout the body. This information was obtained from the website: https://medlineplus.gov/ency/article/000158.htm.

(3) When you're short of breath, it's hard or uncomfortable for you to take in the oxygen your body needs. You may feel as if you're not getting enough air. Sometimes you can have mild breathing problems because of a stuffy nose or intense exercise. But shortness of breath can also be a sign of a serious disease. This information was obtained from the website: https://medlineplus.gov/breathingproblems.html.

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

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3. The facility staff failed to serve residents in a homelike manner in the south wing, day area, residents were served the lunch meal on trays, in a cafeteria, institutional like manner.

A dining observation was conducted on 09/26/18 at 12:32 p.m. in the south wing, day area. There were four residents seated at two tables; two residents at one table and two residents at another table and one resident seated in a Gerri chair. All of the residents were served their lunches on trays.

On 09/25/18 at approximately 2:59 p.m., an interview was conducted with OSM (other staff member) # 3, dietary manager. When asked to describe the dining process for the residents OSM # 3 stated, "In the dining room we try to set up the tables with table clothes or place mat, we don't serve the meal on the trays, the plates are taken off the trays and placed in front of the residents, like a restaurant. In the day room we do not set up like the dining room, we don't take the items off the trays. When asked is there a reason why the residents ate their meals on trays OSM # 3 stated, "No specific reason, it has never been brought up. It would probably be more home like. Just because they don't want to come to the dining room doesn't mean it can't be homelike."

On 09/25/18 at approximately 3:22 p.m., an interview was conducted with CNA (certified nursing assistant) # 4. When asked if she served lunch to the residents in the south wing day room today CNA # 4 stated, "Yes." When asked to describe how the meal was served to the residents CNA # 4 stated, "I put the trays with the

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food on it in front of the residents. Set up the residents by opening drinks, cutting up the food, and provided clothing protector for those who wanted them." When asked what the facility was to the residents CNA # 4 stated, "The resident's home." When asked if she considered homelike for the residents to be serve and eat meals on a tray CNA # 4 stated, "Not really but now that you say that, no. This is always how it's done. We never gave it a thought."

On 09/26/18 at approximately 9:52 a.m., an interview was conducted with OSM (other staff member) # 15, hospitality aide. When asked to describe her responsibilities OSM # 15 stated, "I pass coffee, fill water pitchers, and get supplies for the nutrition rooms, pass breakfast and lunch trays, set up the residents by cutting up food and opening containers. I pick up trays after meals. I do not feed or provide resident care, no hands on care." When asked if she served lunch to the residents in the south wing day room yesterday on 09/25/18, OSM # 15 stated, "Yes." When asked to describe how the meal was served to the residents OSM # 15 stated, "I set up the meal by opening containers, cutting up food if needed and made sure items were accessible. When asked what the facility was to the residents OSM # 15 stated, "It's their home." When asked if she considered it homelike for the residents to serve and eat meals on a tray OSM # 15 stated, "I don't know. It would make it nicer to serve the meals on the table instead of on the trays. I was trained to serve the meals on the trays in the day areas."

On 09/26/18 at approximately 5:50 p.m., ASM (administrative staff member) # 1, the administrator and ASM # 2, director of nursing were made aware of the findings.

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F 584	Continued From page 58 No further information was provided prior to exit. 4. a. The facility staff failed to ensure that the residents were served meals with dishware that was homelike and not heavily worn stained in appearance. On 9/26/18 at 11:23 AM, an observation was made of the lunch meal tray-line service in the kitchen. It was noted that the dark blue hard-type plastic dome covers used to cover each plate of food for serving the residents in the dining room and on the units were heavily stained and discolored on the outside with a white substance, giving the appearance of being unclean, and worn. An observation was then made of a rack of facility coffee cups that were cleaned and stored for use. Every cup was observed with brown residue (coffee) stains on the entire inside surface of the cups. The residue could be scraped with a fingernail. On 9/26/18 at 12:50 p.m., in an interview with OSM #3 (Other Staff Member) and OSM #4, both dietary managers, they agreed that the condition of the coffee cups and dome covers were unsightly and that residents should not be served food in dishware of the condition observed on these items. OSM #3 stated she "had been fighting with management for years to replace them." On 9/26/18 at approximately 1:30 p.m., ASM #1 (Administrative Staff Member) the Administrator, was made aware of the findings. ASM #1 stated she had been at the facility since February 2018, and that dietary had never asked her about	F 584		

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replacing these items. When asked, if she had ever noticed the coffee cups and dome covers during meal times, since being at facility for approximately 7 months, ASM #1 stated she had not. She stated she had seen the dome covers stacked on top of the food carts on the units but did not notice that they were heavily stained with a white, residue.

A review of the facility policy, "Serving of Meals" documented, "3. Appearance of the Tray: a. Use attractive china, clean, matched and not chipped...c. Have glasses sparkling clean and free of stains and spots."

On 9/27/18 at 9:30 a.m., ASM #1 was made aware of the findings. No further information was provided by the end of the survey.

4. b. The facility staff failed to ensure that Resident #97 was served her meal in dishware that was home like and not heavily stained and unsightly.

Resident #97 was admitted to the facility on 2/22/18 with the diagnoses of but not limited to Alzheimer's disease, osteoarthritis, cardiac pacemaker, pain, dementia, and nutritional deficiency. The most recent MDS (Minimum Data Set) was a quarterly assessment with an ARD (Assessment Reference Date of 9/1/18). The resident was coded as being severely impaired in ability to make daily life decisions. The resident required total care for bathing and hygiene; extensive assistance for transfers, dressing, and toileting; limited assistance for eating.

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A review of the clinical record revealed a physician's order dated 3/21/18 for regular diet, liquid pureed consistency, and may have finger foods.

On 9/26/18 at 11:23 a.m., an observation was made of the lunch meal tray-line service in the kitchen. During tray-line, observation was made of the meal preparation for Resident #97's meal. Resident #97's meal was liquid puree texture. The food for Resident #97 was prepared by putting pureed variation of turkey with gravy, mashed potatoes, and zucchini, each into individual hard-type plastic dark blue coffee cups. Hot water was observed being added to each cup and mixed with the pureed food, reducing the texture to more of a liquid consistency, than standard pureed food. Lids were then placed on each cup and the cups placed on the tray for Resident #97. The coffee cups used were observed with heavy brown residue (coffee) staining on the entire inside surface of the cups. The cups were unsightly and the residue could be scraped with a fingernail.

On 9/26/18 at 1:45 p.m., in an interview with CNA #5 (Certified Nursing Assistant) she stated that Resident #97 drinks her food from the coffee cups, and she is given them one at a time. CNA #5 stated she never noticed if they were stained. CNA #5 stated food should not be served to residents in stained coffee cups.

On 9/26/18 at 12:50 p.m., in an interview with OSM #3 (Other Staff Member) and OSM #4, both dietary managers, they agreed that the condition of the coffee cups were unsightly and that residents should not be served food in dishware of the condition observed on these items. OSM

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F 584	Continued From page 61 #3 stated she "had been fighting with management for years to replace them." A review of the facility policy, "Serving of Meals" documented, "3. Appearance of the Tray: a. Use attractive china, clean, matched and not chipped....c. Have glasses sparkling clean and free of stains and spots." On 9/27/18 at 9:30 AM, ASM #1 (Administrative Staff Member) the Administrator, was made aware of the findings. No further information was provided by the end of the survey.	F 584		
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 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	F 622	Resident #79, #119, #56, #103, and # 87 cannot be corrected as they were discharged without the Care Plan goals and returned to facility. Residents who have been discharged have been affected by this deficient practice and cannot be corrected at this time. Education was given to Licensed Nurses on the requirement of sending the care plan goals with resident while being discharged by the Administrator on 10/18/18.	

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F 622	Continued From page 62 payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or (F) The facility ceases to operate. (ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose. §483.15(c)(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care 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)	F 622	All discharged residents will be audited by the Administration Team within 24 hours to ensure Compliance. Results will be taken To the QAPI committee for review And recommendations. Date of Compliance: 10/31/2018	

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F 622	Continued From page 63 (2)(i) of this section must be made by- (A) The resident's physician when transfer or discharge is necessary under paragraph (c) (1) (A) or (B) of this section; and (B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, it was determined that the facility staff failed to meet the appropriate transfer requirements for five of 43 residents in the survey sample, Residents #79, #119, #56, #103, and #87. 1. The facility staff failed to evidence that the comprehensive care plan goals were provided to the receiving provider for a facility initiated transfer of Resident # 79 on 09/08/18. 2. The facility staff failed to provide evidence that the comprehensive care plan goals were sent with the resident upon a transfer to the hospital	F 622		

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on 8/23/18, for Resident #119.

3. The facility staff failed to provide the required documentation to the receiving provider for a facility-initiated transfer of Resident #56 on 6/18/18.

4. The facility staff failed to evidence that the comprehensive care plan goals were provided to the receiving provider for a facility initiated transfer of Resident #103 on 8/30/18.

5. The facility staff failed to provide evidence that the comprehensive care plan goals and other required documents were sent with the resident upon a transfer to the hospital on 7/17/18 for Resident #87.

The findings include:

1. Resident # 79 was admitted to the facility on 09/30/2017 with diagnoses that included but were not limited to: dementia with behavioral disturbances (1), respiratory failure (2), depressive disorder (3) and anxiety (4).

Resident # 79's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 08/21/18, coded Resident # 79 as scoring a 4 (four) on the brief interview for mental status (BIMS) of a score of 0 - 15, 4 (four) - being severely impaired of cognition for making daily decisions.

The nurse's "Progress Notes" for Resident #79 dated 09/08/18 documented, "6:44 a.m. CNA (certified nursing assistant) was talking to resident when resident began shaking and drooling-NP (nurse practitioner) notified, ER

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F 622	Continued From page 65 (emergency room) and 911 called. Msg (message) left for granddaughter to call." The nurse's "Progress Notes" for Resident #79 dated 09/08/18 documented, "3:26 p.m. This nurse spoke with (Name of Hospital) and was informed that resident was being admitted for LLL PNA (left lower lobe pneumonia). NP and DON (director of nursing) aware." Review of the EHR (electronic health record) for Resident # 79 failed to evidence that Resident #79's comprehensive care plan goals were provided to the receiving facility upon her facility-initiated transfer to the hospital on 09/08/18. On 9/27/18 at 8:31 a.m., an interview was conducted with LPN (licensed practical nurse) #7. When asked to describe the process for sending a resident to the hospital for an acute change in condition, LPN #7 stated that first she would assess the resident before making the determination to send the resident out. LPN #7 stated that she would then print out the resident's face sheet, medication list, advanced directives, nursing notes, recent vital signs, and a transfer form. LPN #7 stated that once she had everything together, she would call 911 and send all the printed information with the resident. LPN #7 stated she would then notify the family and medical doctor. LPN #7 was asked if the transfer form included comprehensive care plan goals or if nursing sent the comprehensive care plan with the resident to the hospital. LPN #7 stated, "No." On 09/26/18 at approximately 5:50 p.m., ASM (administrative staff member) # 1, the administrator and ASM # 2, director of nursing	F 622		

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F 622	Continued From page 66 were made aware of the findings. No further information was provided prior to exit. References: (1) Psychological symptoms and behavioral abnormalities are common and prominent characteristics of dementia. They include symptoms such as depression, anxiety psychosis, agitation, aggression, disinhibition, and sleep disturbances. Approximately 30% to 90% of patients with dementia suffer from such behavioral disorders. There are complex interactions between cognitive deficits, psychological symptoms, and behavioral abnormalities. This information was obtained from the website: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3181717/. (2) When not enough oxygen passes from your lungs into your blood. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/respiratoryfailure.html. (3) Depression may be described as feeling sad, blue, unhappy, miserable, or down in the dumps. Most of us feel this way at one time or another for short periods. Clinical depression is a mood disorder in which feelings of sadness, loss, anger, or frustration interfere with everyday life for weeks or more. This information was obtained from the website: https://medlineplus.gov/ency/article/003213.htm. (4) Fear. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/anxiety.html	F 622		

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F 622	Continued From page 67 #summary. 2. The facility staff failed to provide evidence that the comprehensive care plan goals were sent with the resident upon a transfer to the hospital on 8/23/18, for Resident #119. Resident #119 was admitted to the facility on 9/2/14, with diagnoses that included but were not limited to: left sided weakness due to a stroke, dementia, high blood pressure, diabetes, and muscle spasms. The most recent MDS (minimum data set) assessment, an annual assessment, with an assessment reference date of 8/5/18, coded the resident as scoring a "9" on the BIMS (brief interview for mental status) score, indicating he has moderate cognitive impairment for daily decision making. The nurse's note dated 8/23/18 at 2:19 p.m. documented in part, "This nurse was called to residents [sic] room, resident was complaining SOB (shortness of breath) with pain radiating to back, diaphoresis (sweating). Unable to obtain BP (blood pressure) [sic] temp (temperature)-101.5, pulse 60, finger stick (to check blood sugar)-388. NP (nurse practitioner) notified and gave order to send to ER (emergency room) for evaluation. PO (power of attorney) notified." Review of the clinical record failed to evidence that Resident #119's comprehensive care plan or comprehensive care plan goals were sent with him upon transfer to the hospital. On 9/27/18 at 8:31 a.m., an interview was conducted with LPN (licensed practical nurse) #7. When asked about the process staff follows for sending a resident to the hospital for an acute	F 622		

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change in condition, LPN #7 stated that first she would assess the resident before making the determination to send the resident out. LPN #7 stated that she would then print out the resident's face sheet, medication list, advanced directives, nursing notes, recent vital signs, and a transfer form. LPN #7 stated that once she had everything together, she would call 911 and send all the printed information with the resident. LPN #7 stated she would then notify the family and medical doctor. When asked if the transfer form included comprehensive care plan goals, or if nursing sent the comprehensive care plan with the resident to the hospital, LPN #7 stated, "No."

On 9/27/18 at 11:56 a.m., an interview was conducted with LPN #2. LPN #2 stated that the facility started using the transfer sheets on August 24th of this year (2018).

On 9/27/18 at 1:05 p.m., ASM, (administrative staff member), the administrator, #1, was made aware of the above findings. ASM #1 was asked if it was possible that a transfer form was filled out for Resident #119 since he was transferred on 8/23/18. ASM #1 stated, "No, as I have all of the completed ones and there is no transfer sheet for him (Resident #119)."

No further information was provided prior to exit.
3. The facility staff failed to provide the required documentation to the receiving provider for a facility-initiated transfer of Resident #56 on 6/18/18.

Resident #56 was admitted to the facility on 1/23/18 and readmitted on 6/20/18 with diagnoses that included but were not limited to type two diabetes, unspecified dementia without

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F 622	Continued From page 69 behavioral disturbance, high blood pressure, chronic heart failure, and major depressive disorder. Resident #56's most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 8/2/18. Resident #56 was coded as being cognitively intact scoring 11 out of 15 on the BIMS (Brief Interview for Mental Status) exam. Review of Resident #56's clinical record revealed that he was sent out to the hospital on 6/18/18. The following nursing note was documented: "VS (vital signs): T (temperature): 99.0, P (pulse): 76, BP (blood pressure): 128/70. While resident was being transferred this am, foley catheter came out. Foley catheter has been attempted to be replaced x 2 along with caude catheter (1) attempt by NP (nurse practitioner) with no results. Obtained orders to send resident out to have catheter placed due to history of muscular dysfunction, BPH (Benign Prostatic Hyperplasia) (enlarged prostate) (2), and urinary retention. RP (responsible party) made aware." The next nursing note dated 6/18/18 documented the following: "Resident transferred to (Name of hospital)." There was no evidence that the required documentation; contact information of the practitioner responsible for the care of the resident, resident representative information including contact information, Advance Directive information, All special instructions or precautions for ongoing care, as appropriate and comprehensive care plan goals were sent with the resident upon transfer to the hospital. This information would be documented on a hospital transfer sheet that was missing from Resident	F 622		

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F 622	Continued From page 70 #56's clinical record. On 9/26/18 at the end of day meeting at approximately 6 p.m., Administration was asked to evidence Resident #56's transfer sheet dated 6/18/18, or any documentation evidencing all required information was provided to the receiving hospital when Resident #56 was transferred to the hospital on 6/18/18. On 9/27/18 at 8:31 a.m., an interview was conducted with LPN (licensed practical nurse) #7, Resident #56's nurse. When asked about the process staff follows for sending a resident to the hospital for an acute change in condition, LPN #7 stated that first she would assess the resident before making the determination to send the resident out. LPN #7 stated that she would then print out the resident's face sheet, medication list, advanced directives, nursing notes, recent vital signs, and a transfer form. LPN #7 stated that once she had everything together, she would call 911 and send all the printed information with the resident. LPN #7 stated she would then notify the family and medical doctor. When asked if the transfer form included comprehensive care plan goals, or if nursing sent the comprehensive care plan with the resident to the hospital, LPN #7 stated, "No." On 9/27/18 at 11:56 a.m., an interview was conducted with LPN #2. LPN #2 stated that the facility started using the transfer sheets on August 24th of this year. LPN #2 stated that she would not have a transfer sheet for Resident #56. On 9/27/18 at approximately 12:30 p.m., ASM (administrative staff member) #1, the administrator was made aware of the above	F 622		

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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 622	Continued From page 71 concerns. No further information was provided prior to exit. (1) Caude or Coudé catheter is a reinforced tip catheter that is recommended when one encounters difficulty placing a catheter using the regular technique. This information was obtained from The National Institutes of Health. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2692169/. (2) This information was obtained from The National Institutes of Health. https://medlineplus.gov/enlargedprostatebph.html . 4. The facility staff failed to evidence that the comprehensive care plan goals were provided to the receiving provider for a facility initiated transfer of Resident #103 on 8/30/18. Resident #103 was admitted to the facility on 2/6/14 and readmitted on 9/4/18, with diagnoses that included but were not limited to: chronic obstructive pulmonary disease (COPD) (1), acute and chronic respiratory failure (2), major depressive disorder, generalized anxiety disorder, atrial fibrillation (3) and high blood pressure. The most recent MDS (minimum data set), a five day assessment, with an ARD (assessment reference date) of 9/8/18 coded the resident as having a score of 15 of 15 on the BIMS (brief interview for mental status) indicating the resident was cognitively intact to make daily decisions. Review of Resident #103's clinical record revealed that she had been sent to the hospital on 8/30/18. A nursing note dated 8/30/18 at 8:00 a.m. documented, "Resident found to be	F 622		

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	495255	A. BUILDING _____ B. WING _____	C 09/27/2018

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F 622	Continued From page 72 lethargic, responsive and breathing heavily in respiratory distress, NP (Nurse Practitioner) informed, 911 called and resident was sent to ER (emergency room)." There was no documented evidence in the clinical record that Resident #103's comprehensive care plan goals were sent to the receiving provider for this facility- initiated transfer of the residents to the hospital on 8/30/18. On 9/27/18 at 8:31 a.m., an interview was conducted with LPN (licensed practical nurse) #7. When asked if the transfer documents included comprehensive care plan goals, LPN #7 stated, "No." On 09/27/18 at approximately 9:43 a.m., an interview was conducted with LPN #2, Unit Manager. When asked if the comprehensive care plan goals were sent with a resident being transferred to the hospital, LPN #2 responded "No". On 09/27/18 at approximately 3:30 p.m., ASM (administrative staff member) #1, the Administrator and ASM #2, the Director of Nursing were made aware of the findings. No further information was provided prior to exit. 1. A disease that makes it difficult to breath that can lead to shortness of breath. The two main types are chronic bronchitis and emphysema. The main cause of COPD is long-term exposure to substances that irritate and damage the lungs. This is usually cigarette smoke. Air pollution, chemical fumes, or dust can also cause it. This information was obtained from the website:	F 622		

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F 622	Continued From page 73 https://www.nlm.nih.gov/medlineplus/copd.html. 2. A condition in which not enough oxygen passes from your lungs into your blood. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/respiratoryfailure.html. 3. A problem with the speed or rhythm of the heartbeat. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/atrialfibrillation.html. 5. The facility staff failed to provide evidence that the comprehensive care plan goals and other required documents were sent with the resident upon a transfer to the hospital on 7/17/18 for Resident #87. Resident #87 was admitted to the facility on 8/31/16 with a recent readmission on 7/30/18, with diagnoses that included but were not limited to: cancer of the colon, retention of urine, high blood pressure, dementia, and depression. The most recent MDS (minimum data set) assessment, a Medicare 30 day assessment, with an assessment reference date of 8/25/18, coded the resident as scoring a "4" on the BIMS (brief interview for mental status) score, indicating the resident was severely impaired to make cognitive daily decisions. The nurse's note dated, 7/17/18 at 9:21 a.m. documented, "It was reported to this nurse by night shift that resident had vomited several times on the night shift. Resident awake and alert, however stating that he 'feels bad.' Resident's stomach distended. Staff attempted ordered lab	F 622		

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F 622	Continued From page 74	F 622		

[laboratory] work, unable to obtain. NP (nurse practitioner) informed unit supervisor and administrator and it was agreed that resident be sent out to ER (emergency room) for eval (evaluation)."

The physician order dated, 7/17/18, documented, "Send to ER to eval and treat."

Further review of the clinical record failed to reveal any documentation evidencing the required documents were sent to the receiving hospital on 7/17/18.

On 09/27/18 at 7:29 a.m., an interview was conducted with LPN #2, the unit manager. When asked to describe the paperwork that is sent with a resident for a facility-initiated transfer, LPN # stated, "We sends copies of any nursing and physician progress notes, physician's orders, list of the resident's medications, the code status, face sheet and the transfer form."

On 09/27/18 at approximately 7:55 a.m., LPN #2 was asked for a copy of the facility's transfer form for Resident # 87.

On 09/27/18 at approximately 8:05 a.m., LPN #2 stated, "We don't have a transfer form for (name of Resident # 87)".

On 9/27/18 at 8:31 a.m., an interview was conducted with LPN (licensed practical nurse) #7. LPN #7 was asked if nursing sent the comprehensive care plan with the resident to the hospital. LPN #7 stated, "No."

Administrative staff member (ASM) #1, the administrator, and ASM #2, the director of

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F 622	Continued From page 75 nursing, were made aware of the above concern on 9/27/18 at 10:43 a.m. No further information was provided prior to exit.	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 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;	F 623	623 Resident #79, #117, #119, #56, #103 and #87 cannot be corrected as they were discharged without the proper notice and returned to the facility. Residents who have been discharged have been affected by this deficient practice and cannot be corrected at this time. Residents who potential can be discharged will be reviewed for correct discharge notification and notification to state ombudsman. Education was given to Licensed Nurses on the proper discharge notice to resident or responsible representative prior to discharge SSD/Designee was given education on notification to the State Ombudsman when a resident is discharged by the Administrator on 10/18/18.	

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F 623	Continued From page 76 (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 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	F 623	All discharged residents will be audited by the Administration Team within 24 hours to ensure Compliance for proper discharge notice and notice to state Ombudsman. Results will be taken To the QAPI committee for review And recommendations. Date of Compliance: 10/30/2018	

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F 623	Continued From page 77 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 provide written notification to the resident and / or the resident's representative of a facility initiated transfer for six of 43 residents in the survey sample, Residents # 79, #117, #119, #56, #103 and #87. 1. The facility staff failed to provide Resident # 79 or the resident's representative and the ombudsman written notification when the resident was transferred to the hospital on 09/08/18. 2. The facility staff failed to provide Resident #	F 623		

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F 623	Continued From page 78 117 or the resident's representative and the ombudsman written notification when the resident was transferred to the hospital on 09/19/18. 3. The facility staff failed to provide written notification to Resident/Responsible Representative and the ombudsman of a transfer to the hospital on 8/23/18, for Resident #119. 4. The facility staff failed to evidence that Resident #56, and or the responsible party and long term care ombudsmen received written notification documenting reason for hospital transfer on 6/18/18. 5. The facility staff failed to provide ombudsman with written notification of a facility initiated transfer dated 8/30/18 for Resident #103. 6. The facility staff failed to provide written documentation to the resident and/or resident representative for a facility initiated transfer and failed to notify the ombudsman of a facility initiated transfer on 7/17/18 for Resident #87. The findings include: 1. The facility staff failed to provide Resident # 79 or the resident's representative and the ombudsman written notification when the resident was transferred to the hospital on 09/08/18. Resident # 79's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 08/21/18, coded Resident # 79 as scoring a 4 (four) on the brief interview for mental status (BIMS) of a score of 0 - 15, 4 (four) - being severely impaired of cognition for making daily decisions.	F 623		

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F 623	Continued From page 79 The nurse's "Progress Notes" for Resident #79 dated 09/08/18 documented, "6:44 a.m. CNA (certified nursing assistant) was talking to resident when resident began shaking and drooling-NP (nurse practitioner) notified, ER (emergency room) and 911 called. Msg (message) left for granddaughter to call." The nurse's "Progress Notes" for Resident #79 dated 09/08/18 documented, "3:26 p.m. This nurse spoke with (Name of Hospital) and was informed that resident was being admitted for LLL PNA (left lower lobe pneumonia). NP and DON (director of nursing) aware." Review of the EHR (electronic health record) for Resident # 79 failed to evidence Resident # 79 or the resident's representative and the ombudsman were provided written notification when the resident was transferred to the hospital on 09/08/18. On 09/27/18 at 7:29 a.m., an interview was conducted with LPN (licensed practical nurse) # 2, unit manager. When asked if they provide written notification to the resident or resident representative of a resident's transfer to the hospital, LPN # 2 stated, "No, just by phone." On 09/27/18 at approximately 10:35 a.m., an interview was conducted with OSM (other staff member) # 1, social worker. When asked if they notify the ombudsman of a resident's transfer to the hospital, OSM # 1 stated, "The previous social worker emailed the ombudsman at the end of each month with a list of residents who were discharged from the facility but not those who were transferred."	F 623		

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F 623	Continued From page 80 The facility's policy "Resident Transfers and Discharges" documented, "Standard: Transfers and discharges of residents between distinct parts of the same facility or out of the facility will occur for the right reason, with proper notice and orientation to facilitate adjustment." On 09/26/18 at approximately 5:50 p.m., ASM (administrative staff member) # 1, the administrator and ASM # 2, director of nursing were made aware of the findings. When asked to identify the standard of practice the nursing staff follows ASM # 2 stated that they follow the facility's policies. No further information was provided prior to exit. References: (1) Psychological symptoms and behavioral abnormalities are common and prominent characteristics of dementia. They include symptoms such as depression, anxiety psychosis, agitation, aggression, disinhibition, and sleep disturbances. Approximately 30% to 90% of patients with dementia suffer from such behavioral disorders. There are complex interactions between cognitive deficits, psychological symptoms, and behavioral abnormalities. This information was obtained from the website: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3181717/. (2) When not enough oxygen passes from your lungs into your blood. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/respiratoryfailure.html.	F 623		

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F 623	Continued From page 81 (3) Depression may be described as feeling sad, blue, unhappy, miserable, or down in the dumps. Most of us feel this way at one time or another for short periods. Clinical depression is a mood disorder in which feelings of sadness, loss, anger, or frustration interfere with everyday life for weeks or more. This information was obtained from the website: https://medlineplus.gov/ency/article/003213.htm. (4) Fear. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/anxiety.html #summary. 2. The facility staff failed to provide Resident # 117 or the resident's representative and the ombudsman written notification when the resident was transferred to the hospital on 09/19/18. Resident # 117 was admitted to the facility on 07/19/2018 with diagnoses that included but were not limited to: atrial fibrillation (1), hemiplegia (2), depressive disorder (3) and hypertension (4). Resident # 117's most recent MDS (minimum data set), a 5 (five)-Day assessment with an ARD (assessment reference date) of 07/26/18, coded Resident # 117 as scoring a 7 (seven) on the brief interview for mental status (BIMS) of a score of 0 - 15, 7 (seven) - being severely impaired of cognition for making daily decisions. The nurse's "Progress Notes" for Resident # 117 dated 09/19/18 documented, "8:50 a.m. res (Resident) eating breakfast in back day room. CNA (certified nursing assistant) yelled for help.	F 623		

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F 623	Continued From page 82 Res thought to be choking, this nurse starting Heimlich Maneuver when res became unresponsive, Res breathing and being transported to ER (emergency room) for eval (evaluation) and Treat (treatment), NP (nurse practitioner) notified and daughter notified." Review of the EHR (electronic health record) for Resident # 117 failed to evidence Resident # 117 or the resident's representative and the ombudsman were provided written notification when the resident was transferred to the hospital on 09/19/18. On 09/27/18 at 7:29 a.m., an interview was conducted with LPN (licensed practical nurse) # 2, unit manager. When asked if they provide written notification of a resident's transfer to the hospital, LPN # 2 stated, "No, just by phone." On 09/27/18 at approximately 10:35 a.m., an interview was conducted with OSM (other staff member) # 1, social worker. When asked if they notify the ombudsman of a resident's transfer to the hospital, OSM # 1 stated, "The previous social worker emailed the ombudsman at the end of each month with a list of residents who were discharged from the facility but not those who were transferred." On 09/26/18 at approximately 5:50 p.m., ASM (administrative staff member) # 1, the administrator and ASM # 2, director of nursing were made aware of the findings. No further information was provided prior to exit. References: (1) A problem with the speed or rhythm of the	F 623		

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F 623	Continued From page 83 heartbeat. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/atrialfibrillation.html. (2) Also called: Hemiplegia, Palsy, Paraplegia, Quadriplegia. Paralysis is the loss of muscle function in part of your body. It happens when something goes wrong with the way messages pass between your brain and muscles. Paralysis can be complete or partial. It can occur on one or both sides of your body. It can also occur in just one area, or it can be widespread. This information was obtained from the website: https://medlineplus.gov/paralysis.html. (3) Depression may be described as feeling sad, blue, unhappy, miserable, or down in the dumps. Most of us feel this way at one time or another for short periods. Clinical depression is a mood disorder in which feelings of sadness, loss, anger, or frustration interfere with everyday life for weeks or more. This information was obtained from the website: https://medlineplus.gov/ency/article/003213.htm. (4) High blood pressure. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/highbloodpressure.html. 3. The facility staff failed to provide written notification to Resident/Responsible Representative and the ombudsman of a transfer to the hospital on 8/23/18, for Resident #119. Resident #119 was admitted to the facility on 9/2/14, with diagnoses that included but were not limited to: left sided weakness due to a stroke, dementia, high blood pressure, diabetes, and	F 623		

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muscle spasms. The most recent MDS (minimum data set) assessment, an annual assessment, with an assessment reference date of 8/5/18, coded the resident as scoring a "9" on the BIMS (brief interview for mental status) score, indicating he has moderate cognitive impairment for daily decision making.

The nurse's note dated 8/23/18 at 2:19 p.m. documented in part, "This nurse was called to residents [sic] room, resident was complaining SOB (shortness of breath) with pain radiating to back, diaphoresis (sweating). Unable to obtain BP (blood pressure) [sic] temp (temperature)-101.5, pulse 60, finger stick (to check blood sugar)-388. NP (nurse practitioner) notified and gave order to send to ER (emergency room) for evaluation. PO (power of attorney) notified."

On 09/27/18 at 7:29 a.m., an interview was conducted with LPN (licensed practical nurse) # 2, unit manager. When asked if they provide written notification to the resident, resident representative or Ombudsman for a facility initiated transfer to the hospital LPN # 2 stated, "No, just by phone."

On 09/27/18 at approximately 10:35 a.m., an interview was conducted with OSM (other staff member) #1, the social worker. When asked if they notify the Ombudsman of a resident's transfer to the hospital, OSM #1 stated, "The previous social worker emailed the Ombudsman at the end of each month with a list of residents who were discharged from the facility but not those who were transferred." OSM #1 failed to provide evidence that the ombudsman was notified in writing of Resident #119's transfer to

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F 623	Continued From page 85 the hospital on 8/23/18. On 9/27/18 at 1:05 p.m., ASM, (administrative staff member), the administrator, #1, was made aware of the above findings. No further information was provided prior to exit. 4. The facility staff failed to evidence that Resident #56, and or the responsible party and long term care ombudsmen received written notification documenting reason for hospital transfer on 6/18/18. Resident #56 was admitted to the facility on 1/23/18 and readmitted on 6/20/18 with diagnoses that included but were not limited to type two diabetes, unspecified dementia without behavioral disturbance, high blood pressure, chronic heart failure, and major depressive disorder. Resident #56's most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 8/2/18. Resident #56 was coded as being cognitively intact scoring 11 out of 15 on the BIMS (Brief Interview for Mental Status) exam. Review of Resident #56's clinical record revealed that he was sent out to the hospital on 6/18/18. The following nursing note was documented: "VS (vital signs): T (temperature): 99.0, P (pulse): 76, BP (blood pressure): 128/70. While resident was being transferred this am, foley catheter came out. Foley catheter has been attempted to be replaced x 2 along with caude catheter (1) attempt by NP (nurse practitioner) with no results. Obtained orders to send resident out to have catheter placed due to history of muscular dysfunction, BPH (Benign Prostatic Hyperplasia)	F 623		

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F 623	Continued From page 86 (2), and urinary retention. RP (responsible party) made aware." The next nursing note dated 6/18/18 documented the following: "Resident transferred to (Name of hospital)." There was no evidence in the clinical record that the responsible party and long term care ombudsman received written notification documenting the reason for Resident #56's transfer on 6/18/18. On 9/27/18 at 8:31 a.m., an interview was conducted with LPN (licensed practical nurse) #7, Resident #56's nurse. When asked how the responsible party was notified of a residents transfer to the hospital, LPN #7 stated that nursing notified the family verbally. When asked if nurses were supposed to provide written notification to the responsible party documenting the reason for transfer, LPN #7 stated that nursing could provide a copy of the nursing note to the family if they request it. LPN #7 stated that most of the time notification is done over the phone. When asked if nursing notified the long term care ombudsman when a resident was transferred to the hospital, LPN #7 stated that nursing did not. On 09/27/18 at approximately 10:35 a.m., an interview was conducted with OSM (other staff member) # 1, social worker. When asked if they notify the Ombudsman of a resident's transfer to the hospital. OSM # 1 stated, "The previous social worker emailed the Ombudsman at the end of each month with a list of residents who were discharged from the facility but not those who were transferred." Ombudsman notification for	F 623		

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F 623	Continued From page 87 Resident #56's transfer to the hospital on 6/18/18 could not be provided. On 9/27/18 at approximately 12:30 p.m., ASM (administrative staff member) #1, the administrator was made aware of the above concerns. No further information was presented prior to exit. (1) Caude or Coudé catheter is a reinforced tip catheter that is recommended when one encounters difficulty placing a catheter using the regular technique. This information was obtained from The National Institutes of Health. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2692169/. (2) This information was obtained from The National Institutes of Health. https://medlineplus.gov/enlargedprostatebph.html . 5. The facility staff failed to provide ombudsman with written notification of a facility initiated transfer dated 8/30/18 for Resident #103. Resident #103 was admitted to the facility on 2/6/14 and readmitted on 9/4/18, with diagnoses that included but were not limited to: chronic obstructive pulmonary disease (COPD) (1), acute and chronic respiratory failure (2), major depressive disorder, generalized anxiety disorder, atrial fibrillation (3) and high blood pressure. The most recent MDS (minimum data set), a five day assessment, with an ARD (assessment reference date) of 9/8/18 coded the resident as having a score of 15 of 15 on the BIMS (brief interview for mental status) indicating the resident was cognitively intact to make daily decisions.	F 623		

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F 623	Continued From page 88 Review of Resident #103's clinical record revealed that she had been sent to the hospital on 8/30/18. A nursing note dated 8/30/18 at 8:00 a.m. documented, "Resident found to be lethargic, responsive and breathing heavily in respiratory distress, NP (Nurse Practitioner) informed, 911 called and resident was sent to ER (emergency room)." Further review of the clinical record failed to evidence that the Ombudsman was provided a written notice of Resident #103's transfer to the hospital on 8/30/18. On 09/27/18 at approximately 8:08 a.m., an interview was conducted with LPN (licensed practical nurse) #7. LPN #7 was asked if notification was sent to the ombudsman regarding Resident #103's transfer dated 8/30/18, LPN #7 responded "Not to my knowledge." On 09/27/18 at approximately 10:37 a.m., an interview was conducted with OSM (other staff member) #1, Social Worker. OSM #1 was asked, if notification was sent to the ombudsman regarding Resident #103's transfer dated 8/30/18, OSM #1 stated, "No, the previous social worker would email the ombudsman at the end of the month with discharges but not transfers." On 09/27/18 at approximately 3:30 p.m., ASM (administrative staff member) #1, the Administrator and ASM #2, the Director of Nursing were made aware of the findings. No further information was provided prior to exit. 1. A disease that makes it difficult to breath that	F 623		

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F 623	Continued From page 89 can lead to shortness of breath. The two main types are chronic bronchitis and emphysema. The main cause of COPD is long-term exposure to substances that irritate and damage the lungs. This is usually cigarette smoke. Air pollution, chemical fumes, or dust can also cause it. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/copd.html. 2. A condition in which not enough oxygen passes from your lungs into your blood. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/respiratoryfailure.html. 3. 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. 6. The facility staff failed to provide written documentation to the resident and/or resident representative for a facility initiated transfer and failed to notify the ombudsman of a facility initiated transfer on 7/17/18 for Resident #87. Resident #87 was admitted to the facility on 8/31/16 with a recent readmission on 7/30/18, with diagnoses that included but were not limited to: cancer of the colon, retention of urine, high blood pressure, dementia, and depression. The most recent MDS (minimum data set) assessment, a Medicare 30 day assessment, with an assessment reference date of 8/25/18, coded the resident as scoring a "4" on the BIMS (brief interview for mental status) score, indicating the resident was severely impaired to make cognitive daily decisions.	F 623		

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F 623	Continued From page 90 The nurse's note dated, 7/17/18 at 9:21 a.m. documented, "It was reported to this nurse by night shift that resident had vomited several times on the night shift. Resident awake and alert, however stating that he 'feels bad.' Resident's stomach distended. Staff attempted ordered lab [laboratory] work, unable to obtain. NP (nurse practitioner) informed unit supervisor and administrator and it was agreed that resident be sent out to ER (emergency room) for eval (evaluation)." The physician order dated, 7/17/18, documented, "Send to ER to eval and treat." There was no evidence in the clinical record that the responsible party and long term care ombudsman received written notification documenting the reason for Resident #87's transfer on 7/17/18. On 09/27/18 at 7:29 a.m., an interview was conducted with LPN #2, the unit manager. When asked to describe the paperwork that is sent with a resident for a facility-initiated transfer, LPN # stated, "We sends copies of any nursing and physician progress notes, physician's orders, list of the resident's medications, the code status, face sheet and the transfer form." When asked if they provide written notification to the resident and the resident's representative of the transfer, LPN # stated, "We use the transfer form." On 09/27/18 at approximately 7:55 a.m., LPN #2 was asked for a copy of the facility's transfer form for Resident # 87. On 09/27/18 at approximately 8:05 a.m., LPN #2 stated, "We don't have a transfer form for (Resident # 87)."	F 623		

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F 623	Continued From page 91 On 9/27/18 at 8:31 a.m., an interview was conducted with LPN (licensed practical nurse) #7. LPN #7 stated she would then notify the family and medical doctor. When asked how the responsible party was notified, LPN #7 stated that nursing notified the family verbally. When asked if nurses were supposed to provide written notification to the responsible party documenting the reason for transfer, LPN #7 stated that nursing could provide a copy of the nursing note to the family if they request it. LPN #7 stated that most of the time notification is done over the phone. When asked if nursing notified the long term care ombudsman when a resident was transferred to the hospital, LPN #7 stated that nursing did not. An interview was conducted with administrative staff member (ASM) #1 on 9/27/18 at 10:40 a.m. ASM #1 stated the facility did not use a transfer form until she came as the administrator and that the ombudsman notification was completed monthly, per the ombudsman. The previous social worker would send the notification via email. ASM #1 stated I do not have access to her email account as she is no longer employed here and I can't get into it. Administrative staff member (ASM) #1, the administrator, and ASM #2, the director of nursing, were made aware of the above concern on 9/27/18 at 10:43 a.m. No further information was provided prior to exit.	F 623		
F 625 SS=E	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2)	F 625	Resident #79, #117, #56, #103, and #87 cannot be corrected as they were discharged without the bed hold policy being given to them per regulation.	

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F 625	Continued From page 92 §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing 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 and clinical record review, it was determined that facility staff failed to provide a bed hold policy to the resident or the resident's representative upon a facility initiated transfer for five of 43 residents in the survey sample, Residents #79, #117, #56, #103 and #87. 1. The facility staff failed to provide Resident # 79 or the resident's representative written notification	F 625	Residents who have been discharged have been affected by this deficient practice and cannot be corrected at this time. Residents who potential can be discharged will be reviewed for bed hold policy if discharged. Education was given to Licensed Nurses on the proper bed hold notice to resident or responsible representative prior to discharge by the Administrator on 10/18/18. All discharged residents will be audited by the Administration Team within 24 hours to ensure compliance for bed hold policy. Results will be taken to the QAPI committee for review and recommendations. Date of Compliance: 10/30/2018	

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F 625	Continued From page 93 of the bed hold policy when the resident was transferred to the hospital on 09/08/18. 2. The facility staff failed to provide Resident # 117 or the resident's representative written notification of the bed hold policy when the resident was transferred to the hospital on 09/19/18. 3. The facility staff failed to evidence that written bed hold notification was provided to the Resident #56 or the responsible party at the time of a facility initiated transfer to the hospital on 6/18/18. 4. The facility staff failed to provide Resident #103 and or the resident's representative with a the bed-hold policy upon a facility initiated transfer to the hospital on 8/30/18. 5. The facility staff failed to evidence documentation that a copy of the bed hold policy was provided to the resident and/or resident representative upon a facility initiated transfer to the hospital on 7/17/18 for Resident #87. The findings include: 1. The facility staff failed to provide Resident # 79 or the resident's representative written notification of the bed hold policy when the resident was transferred to the hospital on 09/08/18. Resident # 79 was admitted to the facility on 09/30/2017 with diagnoses that included but were not limited to: dementia with behavioral disturbances (1), respiratory failure (2), depressive disorder (3) and anxiety (4). Resident # 79's most recent MDS (minimum data	F 625		

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set), a quarterly assessment with an ARD (assessment reference date) of 08/21/18, coded Resident # 79 as scoring a 4 (four) on the brief interview for mental status (BIMS) of a score of 0 - 15, 4 (four) - being severely impaired of cognition for making daily decisions.

The nurse's "Progress Notes" for Resident #79 dated 09/08/18 documented, "6:44 a.m. CNA (certified nursing assistant) was talking to resident when resident began shaking and drooling-NP (nurse practitioner) notified, ER (emergency room) and 911 called. Msg (message) left for granddaughter to call."

The nurse's "Progress Notes" for Resident #79 dated 09/08/18 documented, "3:26 p.m. This nurse spoke with (Name of Hospital) and was informed that resident was being admitted for LLL PNA (left lower lobe pneumonia). NP and DON (director of nursing) aware."

Review of the EHR (electronic health record) for Resident # 79 failed to evidence documentation of written notification of the bed hold policy being provided to Resident # 79 or Resident # 79' s representative for a facility-initiated transfer on 09/08/18.

On 09/27/18 at 10:19 a.m., an interview was conducted with OSM (other staff member) # 1, admissions director. OSM # 1 stated, "When the patient is admitted to the hospital we will give them the bed hold policy if they are their own responsible party, if the resident is not then we call the resident's representative and ask if they wanted to hold the bed. It is documented in the nurse's notes." When asked if the bed hold policy was provided to the resident or resident's

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representative at the time of the facility-initiated transfer, OSM # 1 stated, "No. Nobody sends the bed hold policy at the time of transfer."

On 09/26/18 at approximately 5:50 p.m., ASM (administrative staff member) # 1, the administrator and ASM # 2, director of nursing were made aware of the findings. When asked to identify the standard of practice the nursing staff follows ASM # 2 stated that they follow the facility's policies.

No further information was provided prior to exit.

References:
(1) Psychological symptoms and behavioral abnormalities are common and prominent characteristics of dementia. They include symptoms such as depression, anxiety psychosis, agitation, aggression, disinhibition, and sleep disturbances. Approximately 30% to 90% of patients with dementia suffer from such behavioral disorders. There are complex interactions between cognitive deficits, psychological symptoms, and behavioral abnormalities. This information was obtained from the website: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3181717/.

(2) When not enough oxygen passes from your lungs into your blood. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/respiratoryfailure.html.

(3) Depression may be described as feeling sad, blue, unhappy, miserable, or down in the dumps. Most of us feel this way at one time or another for

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short periods. Clinical depression is a mood disorder in which feelings of sadness, loss, anger, or frustration interfere with everyday life for weeks or more. This information was obtained from the website: https://medlineplus.gov/ency/article/003213.htm.

(4) Fear. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/anxiety.html #summary.

2. The facility staff failed to provide Resident # 117 or the resident's representative written notification of the bed hold policy when the resident was transferred to the hospital on 09/19/18.

Resident # 117 was admitted to the facility on 07/19/2018 with diagnoses that included but were not limited to: atrial fibrillation (1), hemiplegia (2), depressive disorder (3) and hypertension (4).

Resident # 117's most recent MDS (minimum data set), a 5 (five)-Day assessment with an ARD (assessment reference date) of 07/26/18, coded Resident # 117 as scoring a 7 (seven) on the brief interview for mental status (BIMS) of a score of 0 - 15, 7 (seven) - being severely impaired of cognition for making daily decisions.

The nurse's "Progress Notes" for Resident # 117 dated 09/19/18 documented, "8:50 a.m. Res (Resident) eating breakfast in back day room. CNA (certified nursing assistant) yelled for help. Res thought to be choking, this nurse starting Heimlich Maneuver when res became unresponsive, Res breathing and being transported to ER (emergency room) for eval

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F 625	Continued From page 97 (evaluation) and Treat (treatment), NP (nurse practitioner) notified and daughter notified." Review of the EHR (electronic health record) for Resident # 117 failed to evidence documentation of written notification of the bed hold policy being provided to Resident # 117 or Resident # 117's representative for a facility-initiated transfer on 09/19/18. On 09/26/18 at approximately 5:50 p.m., ASM (administrative staff member) # 1, the administrator and ASM # 2, director of nursing were made aware of the findings. No further information was provided prior to exit. References: (1) 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. (2) Also called: Hemiplegia, Palsy, Paraplegia, Quadriplegia. Paralysis is the loss of muscle function in part of your body. It happens when something goes wrong with the way messages pass between your brain and muscles. Paralysis can be complete or partial. It can occur on one or both sides of your body. It can also occur in just one area, or it can be widespread. This information was obtained from the website: https://medlineplus.gov/paralysis.html. (3) Depression may be described as feeling sad, blue, unhappy, miserable, or down in the dumps. Most of us feel this way at one time or another for short periods. Clinical depression is a mood	F 625		

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F 625	Continued From page 98 disorder in which feelings of sadness, loss, anger, or frustration interfere with everyday life for weeks or more. This information was obtained from the website: https://medlineplus.gov/ency/article/003213.htm. (4) High blood pressure. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/highbloodpressure.html. 3. The facility staff failed to evidence that written bed hold notification was provided to the Resident #56 or the responsible party at the time of a facility initiated transfer to the hospital on 6/18/18. Resident #56 was admitted to the facility on 1/23/18 and readmitted on 6/20/18 with diagnoses that included but were not limited to type two diabetes, unspecified dementia without behavioral disturbance, high blood pressure, chronic heart failure, and major depressive disorder. Resident #56's most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 8/2/18. Resident #56 was coded as being cognitively intact scoring 11 out of 15 on the BIMS (Brief Interview for Mental Status) exam. Review of Resident #56's clinical record revealed that he was sent out to the hospital on 6/18/18. The following nursing note was documented: "VS (vital signs): T (temperature): 99.0, P (pulse): 76, BP (blood pressure): 128/70. While resident was being transferred this am, foley catheter came out. Foley catheter has been attempted to be replaced x 2 along with caude catheter (1) attempt by NP (nurse practitioner) with no results. Obtained orders to send resident out to have catheter placed due to history of muscular	F 625		

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dysfunction, BPH (Benign Prostatic Hyperplasia) (2), and urinary retention. RP (responsible party) made aware."

The next nursing note dated 6/18/18 documented the following: "Resident transferred to (Name of hospital)."

There was no evidence in the clinical record that the resident and/or responsible party received written bed hold notification at the time of transfer on 6/18/18.

Further review of Resident #56's clinical record revealed that he was readmitted to the facility on 6/20/18.

On 9/27/18 at 8:31 a.m., an interview was conducted with LPN (licensed practical nurse) #7, Resident #56's nurse. LPN #7 stated that nurses did not provide written bed hold notification to the resident or responsible party. LPN #7 stated that she thought admissions was responsible for that.

On 9/27/18 at 10:25 a.m., an interview was conducted with OSM (other staff remember) #10, the admissions director. When asked about the process followed for written bed hold notification for a transfer to the hospital, OSM #10 stated that when a resident is transferred to the hospital, an outside marketer would visit the resident in the hospital. OSM #10 stated that the outside marketer is the liaison for the nursing home. OSM #10 stated that outside marketer would ask the resident at the hospital about holding their bed. OSM #10 stated that if the resident is not their own RP (responsible party), she (OSM #10), would call the RP and ask about holding the bed over the phone. OSM #10 stated that if the

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resident or family member want to hold the bed, they would fill out the appropriate paperwork. OSM #10 stated that she also documents in a nursing note if the resident or RP wanted a bed hold. OSM #10 stated that the bed hold policy is not sent with the resident or RP at the time of transfer. OSM #10 stated that she did not have evidence of written bed hold notification for Resident #56.

On 9/27/18 at approximately 12:30 p.m., ASM (administrative staff member) #1, the administrator was made aware of the above concerns. No further information was provided prior to exit.

(1) Caude or Coudé catheter is a reinforced tip catheter that is recommended when one encounters difficulty placing a catheter using the regular technique. This information was obtained from The National Institutes of Health. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2692169/.

(2) This information was obtained from The National Institutes of Health. https://medlineplus.gov/enlargedprostatebph.html .

4. The facility staff failed to provide Resident #103 and or the resident's representative with a the bed-hold policy upon a facility initiated transfer to the hospital on 8/30/18.

Resident #103 was admitted to the facility on 2/6/14 and readmitted on 9/4/18, with diagnoses that included but were not limited to: chronic obstructive pulmonary disease (COPD) (1), acute

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and chronic respiratory failure (2), major depressive disorder, generalized anxiety disorder, atrial fibrillation (3) and high blood pressure. The most recent MDS (minimum data set), a five day assessment, with an ARD (assessment reference date) of 9/8/18 coded the resident as having a score of 15 of 15 on the BIMS (brief interview for mental status) indicating the resident was cognitively intact to make daily decisions.

Review of Resident #103's clinical record revealed that she was sent to the hospital on 8/30/18. A nursing note dated 8/30/18 at 8:00 a.m. documented, "Resident found to be lethargic, responsive and breathing heavily in respiratory distress, NP (Nurse Practitioner) informed, 911 called and resident was sent to ER (emergency room)."

Further review of the clinical record failed to evidence that written notification of bed-hold policy was provided to Resident #103 or the resident's representative at the time of Resident #103's facility initiated transfer to the hospital on 8/30/18.

On 9/27/18 at 10:25 a.m., an interview was conducted with OSM (other staff remember) #10, the admissions director. When asked about the process followed for written bed hold notification for a transfer to the hospital, OSM #10 stated that when a resident is transferred to the hospital, an outside marketer will visit the resident in the hospital. OSM #10 stated that the outside marketer is the liaison for the nursing home. OSM #10 stated that outside marketer would ask the resident at the hospital about holding their bed. OSM #10 stated that if the resident is not their own RP (responsible party), she (OSM #10), will

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F 625	Continued From page 102 call the RP and ask about holding the bed over the phone. OSM #10 stated that if the resident or family member want to hold the bed, they would fill out the appropriate paperwork. OHM #10 stated that she also documents in a nursing note if the resident or RP wanted a bed hold. OSM #10 stated that the bed hold policy is not sent with the resident or RP at the time of transfer. On 09/27/18 at approximately 10:37 a.m., an interview was conducted with OSM (other staff member) #1, Social Worker. OSM #1 was asked if a written notification of the bed-hold policy was given to Resident #103 or her representative at the time of transfer to the hospital on 8/30/18, OSM #1 replied "I don't know." On 09/27/18 at approximately 3:30 p.m., ASM (administrative staff member) #1, the Administrator and ASM #2, the Director of Nursing were made aware of the findings. No further information was provided prior to exit. 1. A disease that makes it difficult to breath that can lead to shortness of breath. The two main types are chronic bronchitis and emphysema. The main cause of COPD is long-term exposure to substances that irritate and damage the lungs. This is usually cigarette smoke. Air pollution, chemical fumes, or dust can also cause it. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/copd.html. 2. A condition in which not enough oxygen passes from your lungs into your blood. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/respiratoryfailure.html.	F 625		

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F 625	Continued From page 103 3. A problem with the speed or rhythm of the heartbeat. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/atrialfibrillation.html. 5. The facility staff failed to evidence documentation that a copy of the bed hold policy was provided to the resident and/or resident representative upon a facility initiated transfer to the hospital on 7/17/18 for Resident #87. Resident #87 was admitted to the facility on 8/31/16 with a recent readmission on 7/30/18, with diagnoses that included but were not limited to: cancer of the colon, retention of urine, high blood pressure, dementia, and depression. The most recent MDS (minimum data set) assessment, a Medicare 30 day assessment, with an assessment reference date of 8/25/18, coded the resident as scoring a "4" on the BIMS (brief interview for mental status) score, indicating the resident was severely impaired to make cognitive daily decisions. The nurse's note dated, 7/17/18 at 9:21 a.m. documented, "It was reported to this nurse by night shift that resident had vomited several times on the night shift. Resident awake and alert, however stating that he 'feels bad.' Resident's stomach distended. Staff attempted ordered lab [laboratory] work, unable to obtain. NP (nurse practitioner) informed unit supervisor and administrator and it was agreed that resident be sent out to ER (emergency room) for eval (evaluation)." The physician order dated, 7/17/18, documented, "Send to ER to eval and treat."	F 625		

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F 625	Continued From page 104 On 9/27/18 at 10:25 a.m., an interview was conducted with OSM (other staff remember) #10, the admissions director. When asked the process for written bed hold notification for a transfer to the hospital, OSM #10 stated that when a resident is transferred to the hospital, an outside marketer would visit the resident in the hospital. OSM #10 stated that the outside marketer is the liaison for the nursing home. OSM #10 stated that outside marketer would ask the resident at the hospital about holding their bed. OSM #10 stated that if the resident is not their own RP (responsible party), she (OSM #10), will call the RP and ask about holding the bed over the phone. OSM #10 stated that if the resident or family member want to hold the bed, they would fill out the appropriate paperwork. OSM #10 stated that she also documents in a nursing note if the resident or RP wanted a bed hold. OSM #10 stated that the bed hold policy is not sent with the resident or RP at the time of transfer. Review of the clinical record failed to evidence documentation of a written bed hold or a note by OSM #10 regarding the bed hold. Administrative staff member (ASM) #1, the administrator, and ASM #2, the director of nursing, were made aware of the above concern on 9/27/18 at 10:43 a.m. No further information was provided prior to exit.	F 625		
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	F 645	Resident #83 came from the Veteran's hospital in West VA. A Level 1 PASARR was not Received by them, no correction Can be made for resident #83 at this time.	

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F 645	Continued From page 105 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 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	F 645	PASARR Level 1 screening is To be obtained with every Admission. All admissions have the potential to be affected. An audit was conducted on 09/28/18 by the admission director on admits over the past 30 days to ensure compliance with a PASARR completion. Administrator educated Admission and marketing Director on 09/28 of the Regulation of having a PASARR with each admit. Admissions coordinator will Ensure that a PASARR is obtained prior to each admission. Administrator will review each admission for the PASARR monthly. The results will be presented to the QAPI committee for review and recommendations. Date of Compliance: 10/30/2018.	

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F 645	Continued From page 106 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 and clinical record review, it was determined the facility staff failed to complete a Level I Preadmission Screening and Resident Review (PASARR) for one of 43 residents in the survey sample, Resident #83. The facility staff failed to ensure a Level I PASARR was completed for Resident #83 to ensure the resident was evaluated and receiving care and services in the most integrated setting appropriate for the resident's needs.	F 645		

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F 645	Continued From page 107 The findings include: Resident #83 was admitted to the facility on 7/26/18, with diagnoses that included but were not limited to: chronic obstructive pulmonary disease (COPD), gastric esophageal reflux disease (GERD), benign prostatic hyperplasia (BPH), major depressive disorder and schizoaffective disorder (A mental condition that causes both a loss of contact with reality [psychosis] and mood problems [depression or mania].) (1) The most recent MDS (minimum data set) assessment, a thirty day assessment, with an assessment reference date (ARD) of 8/23/18, coded the resident as scoring a 13 of 15 on the BIMS (brief interview for mental status) score, indicating the resident was cognitively intact to make daily decisions. Review of the clinical record failed to evidence that a Level I PASARR was completed prior to admission. On 9/26/18 at approximately 11:00 a.m., surveyor requested a copy of Resident #83's PASARR. On 09/26/18 at approximately 4:23 p.m. administrative staff member (ASM) #1 the Administrator, informed surveyor that the facility could not evidence Resident #83 had a Level 1 PASARR completed. ASM #1 was asked if Resident #83 had a level #1 PASARR at admission, ASM #1 responded "No". On 09/26/18 at approximately 5:14 p.m., a joint interview was conducted with ASM #1 and OSM (other staff member) #9, Admission Director.	F 645		

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F 645	Continued From page 108 When asked if Resident #83 should have, had a Level 1 PASARR completed prior to admission, ASM #1 and OSM #9 answered "Yes." On 9/26/18 at approximately 6:00 p.m., ASM #1 and ASM #2, Director of Nursing were made aware of the above findings. The director of nursing informed this surveyor on 9/27/18 at approximately 1:00 p.m., the facility did not have a policy for PASARR completion. No further information was provided prior to exit. 1. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/ency/article/000930.htm.	F 645		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required	F 656	Resident #92 care plan was revised to include pain management. Resident #106 care plan was revised to include follow-up pain assessment after administration of as needed pain medication and to provide non-pharmacological intervention prior to offering an as needed pain medication. Resident #100 care plan was revised to include changing of water bottle and H2O bottle changed on 9/25/18 at 7:30p.m	

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F 656	Continued From page 109 under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, facility document review and clinical record review, it was determined that the facility staff failed to implement the comprehensive care plan for three of 43 residents in the survey sample, Residents #92, #106 and #100. 1. The facility staff failed to implement Resident #92's care plan for pain management. 2. The facility staff failed to implement the plan of care and complete a follow up pain assessment after the administration of prn (as needed) pain	F 656	An audit of residents receiving as needed pain medications and pain management will have non- pharmacological interventions applied and care plans revised by 10/18/2018. An audit of residents receiving Oxygen to be completed. By 10/18/2018 to ensure that all water bottles are per policy. Staff education on the use of non – pharmacological interventions prior to offering as needed pain medications provided by the ADON on 10/17/18, Interventions will be placed on MARs for easy access to the nurses. Residents who receive greater than 2Liters of oxygen will be given 1,000ml H2O humidifier bottle. Education Provided by the ADON on 10/17/18 on checking H2O humidifier bottles to ensure H2O in humidifier bottle. Random audits will be conducted for non-pharmacological interventions by DON/Designee weekly x4 weeks then monthly x2 months and audits on oxygen administration for water in humidifier bottles weekly x 4weeks with results taken to QAPI for Date of Compliance: 10/30/2018	

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	495255	A. BUILDING _____ B. WING _____	C 09/27/2018

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F 656	Continued From page 110	F 656		

medications to Resident #106 on 9/13/18 and 9/25/18.

3. The facility staff failed to implement Resident #100's comprehensive care plan to check the water bottle on an oxygen concentrator every shift.

The findings include:

1. The facility staff failed to implement Resident #92's care plan for pain management.

Resident #92 was admitted to the facility on 2/13/17. Resident #92's diagnoses included but were not limited to chronic pain syndrome, diabetes and major depressive disorder. Resident #92's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 8/29/18, coded the resident as being cognitively intact. Section J coded Resident #92 as reporting frequent pain over the last five days that limited day-to-day activities.

Resident #92's comprehensive care plan with an effective date of 2/13/17 documented, "Musculoskeletal pain r/t (related to) diagnosis of Osteoarthritis of knees and shoulder, low back pain...Use non-pharmacological interventions to manage pain such as relaxation, heat/cold therapy, repositioning, etc..."

Review of Resident #92's clinical record revealed a physician's order dated 6/20/18, for Percocet [oxycodone/acetaminophen (1)] 5/325 mg (milligrams)- one tablet by mouth every four hours as needed and a physician's order dated 9/8/18 for Percocet 5/325 mg- two tablets by mouth

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F 656	Continued From page 111 every four hours as needed. Resident #92's September 2018 MAR (medication administration record) documented both Percocet orders and documented, "Protocol: PAIN INTERVENTIONS: PLEASE INDICATE THE NUMERIC VALUE(S) IN THE COMMENT FIELD: 1=Re positioning Diversions: 2=Reading 3=Watching TV 4=Music 5=Eating 6=Getting OOB (out of bed) 7=Laying Down 8=Activities 9=ROM (range of motion) 10=Refused any alternatives." Further review of Resident #92's September 2018 MAR revealed Percocet 5/325 mg was administered on the following dates: -One tablet on 9/1/18 and 9/7/18. -Two tablets on 9/8/18, 9/11/18, 9/14/18 and 9/22/18. Review of the September 2018 MAR comments and the September 2018 pain clinical monitoring detail report revealed non-pharmacological interventions were not offered to Resident #92 on 9/1/18, 9/8/18, 9/11/18, 9/14/18 and 9/22/18. On 9/26/18 at 1:33 p.m., an interview was conducted with Resident #92. The resident was lying in bed and stated he has pain in his knees and needs surgery. When asked if the nurses offer non-medication, interventions prior to or along with administering his as needed pain medication, Resident #92 stated, "No."	F 656		

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F 656	Continued From page 112 On 9/26/18 at 4:15 p.m., an interview was conducted with LPN (licensed practical nurse) #2. LPN #2 was asked to explain the purpose of a care plan. LPN #2 stated, "It's a guideline of what the patient's problems are and the interventions we are going to do to help assist with those problems." When asked how the nursing staff ensures they follow each resident's care plan, LPN #2 stated, "Everyone has access to the care plans in their computers. If they had questions or concerns, you can log into each patient's care plans and review each care plan and what their interventions and goals are." On 9/27/18 at 6:45 a.m., an interview was conducted with LPN #5 (a nurse responsible for administering as needed Percocet to Resident #92 in September 2018). When asked what should be done prior to administering as needed pain medication to a resident, LPN #5 stated, "I would think Tylenol would be an intervention. Try first but a lot of residents know what they want but some you try to talk to or reposition or see if you can them give something to eat or put the television on. That maybe distracts them." When asked if she documents the non-pharmacological interventions that she offers, LPN #5 stated, "On our pain med (medication), it has a place for you to put a one, a ten, as to what you tried. You put a number in the comment box." When asked if she offers non-pharmacological interventions to Resident #92 prior to administering as needed pain medication, LPN #5 stated, "I ask him what he's rating his pain. A lot of times, he rates a ten. I have asked before if there is anything I can do for him." When asked if she offers non-pharmacological interventions prior to each time she administers Resident #92's as needed pain medication, LPN #5 stated, "Not each time."	F 656		

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F 656	Continued From page 113 On 9/27/18 at 9:35 a.m., ASM (administrative staff member) #1 (the administrator) was made aware of the above concern. The facility policy titled, "Comprehensive Person-Centered Care Planning" documented, "2) The facility will develop and implement a comprehensive person-centered care plan for each resident, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs as identified throughout the comprehensive Resident Assessment Instrument (RAI)..." No further information was presented prior to exit. (1) Percocet is used to treat pain. This information was obtained from the website: https://medlineplus.gov/ency/article/000949.htm 2. The facility staff failed to implement the plan of care and complete a follow up pain assessment after the administration of prn (as needed) pain medications on 9/13/18 and 9/25/18. Resident #106 was admitted to the facility on 7/10/18 with diagnoses that included but were not limited to diabetes mellitus (type two), high blood pressure, atrial fibrillation, chronic kidney disease, and heart disease. Resident #106's most recent MDS (minimum data set) assessment was an admission assessment with an ARD (assessment reference date) of 7/18/18. Resident #106 was coded as being cognitively intact in the ability to make daily decisions scoring 13 out of 15 on the BIMS (Brief Interview for Mental Status exam). Review of Resident #106's September 2018	F 656		

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F 656	Continued From page 114 physician order sheet revealed the following order: "Oxycodone 5 mg (milligrams) by oral route 2 times a day as needed (PRN)." Review of Resident #106's September 2018 MAR (Medication Administration Record) revealed that she received oxycodone on the following dates and times: "9/8/18 at 7:00 p.m., 9/13/18 at 2:30 a.m., and 9/25/18 at 7:43 p.m." Review of Resident #106's clinical record failed to evidence that non-pharmacological interventions were attempted prior to the administration of oxycodone on all three dates above. There was no evidence that a follow up pain evaluation was conducted on 9/13/18 and 9/25/18 on the MAR or in the nursing notes. Review of the "Clinical Monitoring Detail Report" for September 2018, failed to evidence that non-pharmacological interventions were attempted prior to the administration of oxycodone on all three dates above. There was no evidence that a follow up pain evaluation was conducted on 9/13/18 and 9/25/18. Resident #106's comprehensive care plan documented the following intervention under care area "Pain": "Evaluate the effectiveness of pain interventions 1 hour after giving. Review for compliance, alleviating symptoms, dosing schedules, and resident satisfaction with results, impact on functional ability and impact on cognition." On 9/27/18 at 8:20 a.m., an interview was conducted with LPN (licensed practical nurse) #7, Resident #106's nurse. When asked about the process staff follows after a pain medication is	F 656		

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F 656	Continued From page 115 administered, LPN #7 stated that nursing should be following up with the resident in an hour, assessing, and then documenting their level of pain. When asked where follow up pain evaluations are documented, LPN #7 stated that follow up pain evaluations should also be documented on the MAR. When asked what it meant if documentation could not be found for follow up pain evaluations, LPN #7 stated, "Probably assume it wasn't done. They should be doing it. It does pop up on the MAR to be done." When asked the purpose of the care plan, LPN #7 stated that the purpose of the care plan was to serve as a guide to meet the resident's needs. LPN #7 stated that all nurses had access to the care plan. When asked if it was important for the care plan to be followed, LPN #7 stated, "Yes." On 9/27/18 at 12:12 p.m., an interview was conducted with Resident #106. When asked if staff come back and evaluate if the pain medication is working, Resident #106 stated that the staff did not come back but that her pain medication works when she needs it. On 9/27/18 at approximately 12:30 p.m., ASM (administrative staff member) #1, the administrator was made aware of the above concerns. No further information was provided prior to exit. (1) Oxycodone is a narcotic analgesic used to relieve moderate to severe pain. This information was obtained from The National Institutes of Health. https://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0001326/. 3. The facility staff failed to implement Resident #100's comprehensive care plan to check the	F 656		