STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495155	A. BUILDING _____ B. WING _____	08/23/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SLEEPY HOLLOW HEALTHCARE CENTER	6700 COLUMBIA PK ANNANDALE, VA 22003

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
F 000	Initial Comments An unannounced biennial State Licensure Inspection was conducted 8/20/18 through 8/23/18. The facility was not in compliance with the Virginia Rules and Regulations for the Licensure of Nursing Facilities. Six complaints were investigated during the survey. The census in this 222 licensed bed facility was 193 at the time of the survey. The survey sample consisted of 38 current Resident reviews and 4 closed record reviews.	F 000	F 000 - The statements made in the following plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies nor the reported conversations and other information cited in support of the alleged deficiencies. The facility sets forth the following plan of correction to remain in compliance with all federal and state regulations. The facility has taken or will take the actions set forth in the plan of correction. The following plan of correction constitutes the facilities allegation of compliance. All alleged deficiencies cited have been or will be corrected by the date or dates indicated.	
F 001	Non Compliance The facility was out of compliance with the following state licensure requirements: This RULE: is not met as evidenced by: 12VAC5-371-220 (A) Nursing Services, Cross reference to F-550 and F-689. 12VAC5-371-220 (A) Nursing Services, Cross Reference to F-656. 12VAC5-371-360 (E) Clinical Records, Cross reference to F-842. 12VAC5-371-140 (E.1.b.) Policies and Procedures, Cross Reference to F-606: 12VAC5-371-140 (A) Policies and Procedures. Cross Reference to F-607. COV 32.1-126.01 (A) Cross-Reference to F-606 and F-607. 12 VAC 5-371-210 (B) Nurse Staffing, Cross Reference to F-726.	F 001		

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F 001	Continued From Page 1 12VAC5-371-370 (E) Maintenance and Housekeeping, Cross Refence to F-925.	F 001	F 550 1. Certified Nursing Assistant that sat on resident #49's couch to complete activity of daily living was educated not to infringe on resident privacy by completing her ADL's sitting on resident couch on 8/23/18. 2. All residents have the potential to be affected. On 8/23/18 rounds were conducted on all units. Rounds were conducted on all rooms by Director of Nursing to ensure no Certified Nursing Assistants are completing their ADL's 3. All Certified Nursing Assistants will be educated not to infringe on resident privacy by completing the ADL's in resident	09/26/18

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F 001	Continued From Page 1 12VAC5-371-370 (E) Maintenance and Housekeeping, Cross Refence to F-925.	F 001	room by Assistant Director of Nursing or designee on or before 09/26/18. 4. Unit Manager or designee will conduct random rounds weekly on 5 resident's room per unit for compliance. Any deviation will be forwarded to the Director of Nursing and QAPI (Quality Assurance Performance Improvement) committee for recommendations for monthly x 3. 5. Date of compliance 09/26/18 F 606 1. Criminal Background check for Dietary Aide #1 was completed on 8/28/18. No identifiable records were found.	09/26/18

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F 001	Continued From Page 1 12VAC5-371-370 (E) Maintenance and Housekeeping, Cross Refence to F-925.	F 001	2. All dietary employees have the potential to be affected. 100% audit of all current dietary employee's criminal record were reviewed on 9/7/18. No identifiable records were found. Human Resources Manager will review criminal background check for all new dietary employees prior to hire to ensure completion of criminal background check on or before 09/26/18. 3. Human Resources Manager educated dietary manager on 9/7/18 ensuring criminal background checks are completed prior to hiring dietary employee. 4. Human Resources Manager will conduct an audit on 50% of all new dietary hires. Any deviation will be	09/26/18

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F 001	Continued From Page 1 12VAC5-371-370 (E) Maintenance and Housekeeping, Cross Refence to F-925.	F 001	forwarded to the Executive Director or designee and QAPI (Quality Assurance Performance Improvement) committee for recommendations for monthly x 3. 5. Date of compliance 09/26/18. F 607 1. Criminal Background check for Dietary Aide #1 was completed on 8/28/18. No identifiable records were found. 2. All residents have the potential to be affected due to not implementing the abuse policy and procedure to obtain a Criminal Background Check. 100% audit of all current dietary employee's criminal record were reviewed on 9/7/18. No identifiable	09/26/18

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F 001	Continued From Page 1 12VAC5-371-370 (E) Maintenance and Housekeeping, Cross Refence to F-925.	F 001	records were found. Human Resources Manager will review criminal background check for all new dietary employees prior to hire to ensure completion of criminal background check. 3. Human Resources Manager educated dietary manager on ensuring criminal background checks are completed prior to hiring dietary employee on 9/7/18. 4. Human Resources Manager will conduct an audit on 50% of all new dietary hires. Any deviation will be forwarded to the Executive Director or designee and QAPI (Quality Assurance Performance Improvement) committee for recommendations for monthly x 3.	09/26/18

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F 001	Continued From Page 1 12VAC5-371-370 (E) Maintenance and Housekeeping, Cross Refence to F-925.	F 001	5. Date of compliance 09/26/18 F 656 1. Care plan for resident #162 was revised on 8/19/17 to indicate elopement history. 2. All residents have the potential to be affected. Care plans for all current residents on the secured dementia unit will be revised to include at-risk for elopement. For all new admissions that are on the locked dementia unit their care plan will include an at-risk for elopement. 3. All licensed nursing staff will be educated on revising and updating care plan for residents at-risk for elopement on the secured dementia unit by the Assistant Director of Nursing	09/26/18

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F 001	Continued From Page 1 12VAC5-371-370 (E) Maintenance and Housekeeping, Cross Refence to F-925.	F 001	on or before 09/26/18 4. Unit Managers will audit 10% of care plans in locked dementia unit weekly for 3 weeks and then monthly. Any deviation will be forwarded to the Director of Nursing or designee and QAPI (Quality Assurance Performance Improvement) committee for recommendations monthly x3 and ongoing. 5. Compliance date 09/26/18 F 689 1. For resident #241, #47, and #28 smoking materials were secured by Executive Director outside of the designated smoking area on 8/22/18.	09/26/18

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F 001	Continued From Page 1 12VAC5-371-370 (E) Maintenance and Housekeeping, Cross Refence to F-925.	F 001	2. All residents have the potential to be affected. Smoking materials for all current residents were secured by Executive Director on 8/22/18. For all new smokers their smoking materials will be secured per policy. 3. All staff will be educated on the smoking policy by the Assistant Director of Nursing or designee on or before 09/26/18 4. Executive Director or designee will conduct rounds 3 times a week on residents that smoke to ensure that their smoking materials is secured for 3 weeks and then monthly. Any deviation will be	09/26/18

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F 001	Continued From Page 1 12VAC5-371-370 (E) Maintenance and Housekeeping, Cross Refence to F-925.	F 001	forwarded to the Executive Director or designee and QAPI (Quality Assurance Performance Improvement) committee for recommendations for monthly x 3 and ongoing. 5. Compliance date 09/26/18 F 726 1. LPN #1 and Unit Manager RN #1 were educated on how to assess arteriovenous (AV) fistula hemodialysis access site for bruit and thrill on hemodialysis resident #67. 2. All residents receiving dialysis have the potential to be affected. All licensed nursing staff will be educated on how to assess arteriovenous (AV) fistula hemodialysis access	09/26/18

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F 001	Continued From Page 1 12VAC5-371-370 (E) Maintenance and Housekeeping, Cross Refence to F-925.	F 001	site for bruit and thrill on all hemodialysis residents. 3. Assistant Director of Nursing or designee will continue to educate newly hired licensed nursing staff on orientation and annually. 4. Observations will be done by Unit Managers 3 times a week on licensed nursing staff assessing arteriovenous (AV) fistula hemodialysis access site for bruit and thrill weekly x3 and then monthly. Any deviation will be forwarded to the Director of Nursing or designee and QAPI (Quality Assurance Performance Improvement) committee for recommendations for monthly x 3 and	09/26/18

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F 001	Continued From Page 1 12VAC5-371-370 (E) Maintenance and Housekeeping, Cross Refence to F-925.	F 001	ongoing. 5. Date of compliance 09/26/18 F 842 1. Resident #440 was discharged 6/1/17. Resident #240 was discharged 5/30/17. 2. All residents have the potential to be affected. Medical Records department will ensure that medical records are complete, accurate, systematically organized, and readily accessible from date of acquisition – 5/1/17 per policy. 3. Assistant Director of Nursing or designee will educate medical records staff on having complete, accurate, systematically organized, and readily accessible medical records per policy on or before	09/26/18

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F 001	Continued From Page 1 12VAC5-371-370 (E) Maintenance and Housekeeping, Cross Refence to F-925.	F 001	09/26/18. 4. Assistant Executive Director or designee will audit 10% of discharges weekly x3 and then monthly. Any deviation will be forwarded to the Director of Nursing or designee and QAPI (Quality Assurance Performance Improvement) committee for recommendations for monthly x 3 and ongoing. 5. Date of compliance 09/26/18. F 925 1. The following rooms were inspected and treated by Bay city pest management on 9/10/2018 - #308, #309, # 311, # 114 and offices # 324, #328 #329. The following room were inspected and treated by Bay city	09/26/18

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F 001	Continued From Page 1 12VAC5-371-370 (E) Maintenance and Housekeeping, Cross Refence to F-925.	F 001	pest management on 9/12/2018 - # 112, #106, #204, #305, #9, #213, and south dining room. No additional evidence of pest found in the rooms. The Microwave oven was removed from the East Unit on 08/23/18. Holes in walls were sealed on 09/12/18. Trees were trimmed away from the building on or before 09/26/18. South Kitchen sink was cleaned on 08/23/18. 2. All residents have the potential to be affected. For all other resident pest control services will inspect rooms of all resident and treat if needed. 3. Residents and staff	09/26/18

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F 001	Continued From Page 1 12VAC5-371-370 (E) Maintenance and Housekeeping, Cross Refence to F-925.	F 001	will be in-serviced on the process of reporting pest service's needs. A letter was sent to resident on the process of reporting pest sightings. 4. An audit will be done weekly x 3 and then monthly to check pest control book to ensure that all rooms listed in the pest control book has been treated by the pest control company. Audits will be brought to the QAPI monthly x3 months and ongoing. 5. Date of compliance 09/26/18	09/26/18

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E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 8/20/18 through 8/23/18. Corrections are required for compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities. No emergency preparedness complaints were investigated during the survey.	E 000	The statements made in the following plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies nor the reported conversations and other information cited in support of the alleged deficiencies. The facility sets forth the following plan of correction to remain in compliance with all federal and state regulations. The facility has taken or will take the actions set forth in the plan of correction. The following plan of correction constitutes the facilities allegation of compliance. All alleged deficiencies cited have been or will be corrected by the date or dates indicated.	
E 004 SS=C	Develop EP Plan, Review and Update Annually CFR(s): 483.73(a) [The [facility] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility] must develop establish and maintain a comprehensive emergency preparedness program that meets the requirements of this section.] * [For hospitals at §482.15 and CAHs at §485.625(a):] The [hospital or CAH] must comply with all applicable Federal, State, and local emergency preparedness requirements. The [hospital or CAH] must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach. The emergency preparedness program must include, but not be limited to, the following elements:] (a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be [reviewed], and updated at least annually. * [For ESRD Facilities at §494.62(a):] Emergency Plan. The ESRD facility must develop and maintain an emergency preparedness plan that must be [evaluated], and updated at least	E 004		

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SEP 24 2018
VDH/OLC

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

FKEE DIRECTOR — 9/12/18

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

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E 004	Continued From page 1 annually. This REQUIREMENT is not met as evidenced by: Based on record review, and staff interview, the facility staff failed to have documentation of the facilities Emergency Preparedness Plan identified risk assessment. The findings included: During an interview on 08/22/18 at 11:40 A.M. with the Administrator, he was asked for documentation of the facilities community-based risk assessments that will assist the facility in addressing the needs of their patients. The Administrator stated the facility had not conducted a risk assessment of it's emergency preparedness plan. The Administrator presented a summary of a Hurricane Evacuation Plan which he stated was the result of a workshop. The facility staff failed to have documentation of identified risk assessments of the emergency preparedness plan.	E 004	E 004 1. The facility risk assessment will be completed on or before 09/26/18. 2. The facility risk assessment will be completed on or before 09/26/18. 3. Assistant Executive Director or designee will in-service all staff on the facility risk assessment on or before 09/26/18. 4. The risk assessment will be reviewed bi-annually or as necessary and updates will be made to the risk assessment. Any deviation will be forwarded to the Executive Director or designee and QAPI (Quality Assurance Performance Improvement) committee for recommendations for monthly x 3 and ongoing. 5. Compliance date 09/26/18	09/26/18 09/26/18
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	E 006		

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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 006	Continued From page 2 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: Based on record review, and staff interview, the facility staff failed to have documentation of the facilities Emergency Preparedness Plan identified risk assessment and associated strategies. The findings included: During an interview on 08/22/18 at 11:05 A.M. with the Administrator, he was asked for documentation of the facilities community-based risk assessments and strategies that will assist the facility in addressing the needs of their patients. The administrator stated the facility had not conducted a risk assessment of it's emergency preparedness plan. The facility staff failed to have documentation of identified risk assessments and strategies of the emergency preparedness plan.	E 006	E 006 1. The hazard risk assessment will be used to develop the strategies in determining the needs of the facility population. 2. The hazard risk assessment will be used to develop the strategies in determining the needs of the facility population. 3. Assistant Executive Director or designee will in-service all staff on the strategies for the risks and strategies identified on or before 09/26/18 4. The hazard risk assessment will be reviewed monthly x3 and updates will be made to the risk assessment. Any deviation will be forwarded to the Executive Director or designee and QAPI (Quality Assurance Performance Improvement) committee for recommendations for monthly x 3 and ongoing. 5. Compliance date 09/26/18	09/26/18 09/26/18

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	495155	A. BUILDING _____ B. WING _____	C 08/23/2018

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E 007 SS=C	EP Program Patient Population CFR(s): 483.73(a)(3) [(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do the following:] (3) Address patient/client population, including, but not limited to, persons at-risk; the type of services the [facility] has the ability to provide in an emergency; and continuity of operations, including delegations of authority and succession plans.** *Note: ["Persons at risk" does not apply to: ASC, hospice, PACE, HHA, CORF, CMCH, RHC, FQHC, or ESRD facilities.] This REQUIREMENT is not met as evidenced by: Based on record review, and staff interview, the facility staff failed to have documentation of the facilities identified population at risk during an emergency and delegation of authority during an emergency. The findings included: During an interview on 08/22/18 at 11: 20 A.M. with the Administrator, he was asked for documentation of the facilities identified population at risk during an emergency and delegation of authority during an emergency. The administrator stated the facility had not conducted a risk assessment of it's resident population at risk during an emergency. He stated, he would be the Authority during an emergency. The Administrator stated, all Supervisors had delegated authority during an emergency. Unit Managers on various units and during the	E 007	E007 1. Facility will conduct a meeting to determine delegation of authority on or before 09/26/18 2. Facility will conduct a meeting to determine delegation of authority on or before 09/26/18 3. Assistant Executive Director or designee will in-service all staff on the strategies for the risks identified. 4. The delegation of authority will be reviewed monthly x3 and updates will be made to the Emergency Preparedness Manual. Any deviation will be forwarded to the Executive Director or designee and QAPI (Quality Assurance Performance Improvement) committee for recommendations for monthly x 3 and ongoing. 5. Compliance date 09/26/18	09/26/18 09/26/18

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E 007	Continued From page 4 morning and evening shifts were asked if they had the authority to act during an emergency and received training for acting during an emergency and they all stated "No." The facility did not have documentation of delegation of authority during an emergency. The facility staff failed to have documentation of the facilities identified population at risk and documentation of delegation of authority during an emergency.	E 007	E015 1. Facility will have documentation and a contracted agreement for the provision of water, food, fuel, and sewage disposal on or before 09/26/18. 2. Facility will have documentation and a contracted agreement for the provision of water, food, fuel, and sewage disposal on or before 09/26/18. 3. Assistant Executive Director or designee will in-service all staff on contracted emergency providers. 4. The contracts will be reviewed monthly x3. Any deviation will be forwarded to the	09/26/18
E 015 SS=C	Subsistence Needs for Staff and Patients CFR(s): 483.73(b)(1) [(b) Policies and procedures. [Facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually.] At a minimum, the policies and procedures must address the following: (1) The provision of subsistence needs for staff and patients whether they evacuate or shelter in place, include, but are not limited to the following: (i) Food, water, medical and pharmaceutical supplies (ii) Alternate sources of energy to maintain the following: (A) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions. (B) Emergency lighting. (C) Fire detection, extinguishing, and alarm systems.	E 015		

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E 015	Continued From page 5 (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 and safety and for the safe and sanitary storage of provisions. (2) Emergency lighting. (3) Fire detection, extinguishing, and alarm systems. (C) Sewage and waste disposal. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility staff failed to provide documentation that the emergency preparedness plan addressed provisions of subsistence including food and water and sewage disposal services. The findings included: The facility emergency preparedness plan failed to have documentation for the provision of food, water, and fuel during an emergency. The facility also failed to have a plan for sewage disposal services.	E 015	Executive Director or designee and QAPI (Quality Assurance Performance Improvement) committee for recommendations for monthly x 3 and ongoing. 5. Compliance date 09/26/18	09/26/18

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E 015	Continued From page 6 During a review of the emergency preparedness plan with the administrator on 08/22/18 at 11:30 A.M. he was asked for documentation for vendor contracts for food, water, fuel, and sewage disposal services. The administrator and the Division Director of Facility Maintenance stated, they would provided contracts for the food, water, and fuel. No contracts were provided during the survey. The Regional Director of Operations's provided this surveyor on 8/23/18 at 2:15 P.M. during the exit conference with a Proposal dated 10/5/17 to pump and clean (3) internal grease traps.	E 015	E026 1. Facility will have documentation describing the facility's role in providing care off-site on or before 09/26/18. 2. Facility will have documentation describing the facility's role in providing care off-site on or before 09/26/18. 3. Assistant Executive Director or designee will in-service all staff on describing the facilities role in providing care off-site on or before 09/26/18. 4. The document describing the facility's role in providing care will be reviewed monthly x3. Any deviation will be forwarded to the Executive Director or designee and QAPI (Quality Assurance Performance Improvement) committee for recommendations for monthly x 3 and ongoing. 5. Compliance date 09/26/18	09/26/18 09/26/18
E 026 SS=C	Roles Under a Waiver Declared by Secretary CFR(s): 483.73(b)(8) [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. At a minimum, the policies and procedures must address the following:] (8) [(6), (6)(C)(iv), (7), or (9)] The role of the [facility] under a waiver declared by the Secretary, in accordance with section 1135 of the Act, in the provision of care and treatment at an alternate care site identified by emergency management officials. *[For RNHCIs at §403.748(b):] Policies and procedures. (8) The role of the RNHCI under a waiver declared by the Secretary, in accordance with section 1135 of Act, in the provision of care	E 026		

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E 026	Continued From page 7 at an alternative care site identified by emergency management officials. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility staff failed to have documentation describing the facilities role in providing care in an alternate care site. The findings included: During an interview with the administrator on 08/22/18 at 11:57 a.m. the administrator was asked for documentation describing the facilities role in providing care in an alternate care site. The administrator stated, he did not have any documentation describing the facilities role or the care that would be provided at an alternate care site. During interviews with various nursing staff on several units, they were asked if they had training on providing care at alternate care sites during an emergency. The staff responded they had not had training nor had they been provided with what roles they would carry out during an emergency. The facility staff failed to have documentation describing the facilities role in providing care in an alternate care site.	E 026		
E 033 SS=C	Methods for Sharing Information CFR(s): 483.73(c)(4)-(6) [(c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least annually.] The communication plan must include	E 033		

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E 033	Continued From page 8 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 facility's care as permitted under 45 CFR 164.510(b)(4). This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility staff failed to have documentation that the communication plan included a method for sharing information and medical documentation to maintain continuity of care.	E 033	E033 1. The facility will add facility communication plan to the Emergency Preparedness Manual on or before 09/26/18 2. Facility will add facility communication plan to the Emergency Preparedness Manual on or before 09/26/18 3. Assistant Executive Director or designee will in-service all staff on facility communication plan on or before 09/26/18 4. The facility communication plan will be reviewed monthly x3. Any deviation will be forwarded to the Executive Director or designee and QAPI (Quality Assurance Performance Improvement) committee for recommendations for monthly x 3 and ongoing.	09/26/18

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E 033	Continued From page 9 The findings included: During an interview on 08/22/18 at 12:08 p.m. with the administrator, he was asked for evidence that the facility had a method for sharing information and medical care for residents with other health care providers to maintain continuity of care. The administrator stated, he did not have documentation for sharing information and medical care needs for residents in an alternate care site. The facility staff failed to have documentation that the communication plan included methods for sharing information and medical care with other health care providers.	E 033	5. Compliance date 09/26/18	09/26/18
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.	E 034	E034 1. The facility will provide documentation and have means of providing information about facilities needs and our ability to provide assistance on or before 09/26/18The facility will utilize Virginia Hospital Alert and Status System and walkie-talkie's to provide information about facilities needs and our ability to provide assistance on or before 09/26/18 2. The facility will provide documentation and have means of providing information about facilities needs and our ability to provide assistance on or before 10/2/18. The facility will utilize Virginia Hospital Alert and Status System and walkie-talkie's to provide information about facilities needs and our ability to provide assistance on or before 09/26/18	

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E 034	Continued From page 10 *[For Inpatient Hospice at §418.113:] (7) A means of providing information about the hospice's inpatient occupancy, needs, and its ability to provide assistance, to the authority having jurisdiction, the Incident Command Center, or designee. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility staff failed to have documentation about the facility's occupancy needs and its ability to provide assistance. The findings included: During an interview on 08/22/18 at 12:16 P.M. with the administrator, he was asked for documentation for identifying the needs of the facility, including the residents as well as the facility's ability to provide assistance to the Incident Command Center. The administrator stated, the facility had not identified the needs of the residents nor had the facility identified how the facility could provide assistance. The process for communicating the information was not included in the facility's plan. The facility staff failed to provide documentation and have means of providing information about the facility's needs and its ability to provide assistance.	E 034	3. Facility will participate in regular system testing of the emergency alert system through Virginia Hospital Alert and Status System. Assistant Executive Director or designee will in-service all staff on documentation and means of providing information about facilities needs and our ability to provide assistance plan on or before 09/26/18 4. The facility will check the effectiveness of the emergency alert system monthly x3. Any deviation will be forwarded to the Executive Director or designee and QAPI (Quality Assurance Performance Improvement) committee for recommendations for monthly x 3 and ongoing.	
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	E 036	5. Date of compliance 09/26/18	09/26/18

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E 036	Continued From page 11 based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least annually. *[For ICF/IIDs at §483.475(d):] Training and testing. The ICF/IID must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least annually. The ICF/IID must meet the requirements for evacuation drills and training at §483.470(h). *[For ESRD Facilities at §494.62(d):] Training, testing, and orientation. The dialysis facility must develop and maintain an emergency preparedness training, testing and patient orientation program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training, testing and orientation program must be reviewed and updated at least annually. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility staff failed to have an emergency preparedness training and testing program.	E 036	E036 1. The facility will develop an emergency preparedness training and testing program on or before 09/26/18 2. The facility will develop an emergency preparedness training and testing program on or before 09/26/18 3. Assistant Executive Director or designee will in-service all staff on emergency preparedness training and testing program on or before 09/26/18 4. Assistant Executive Director or designee will monitor compliance with the emergency preparedness training and testing program monthly x3. Any deviation will be forwarded to the	09/26/18

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E 036	Continued From page 12 The findings included: During an interview on 08/22/18 at 12: 27 p.m. with the administrator, he was asked for documentation of the facility's training and testing program. The administrator stated the facility had a training and testing program however, no evidence was presented during the survey of a Emergency Preparedness Test or Staff Training. The facility staff failed to have a training and testing program.	E 036	Executive Director or designee and QAPI (Quality Assurance Performance Improvement) committee for recommendations for monthly x 3 and ongoing. 5. Date of compliance 09/26/18.	09/26/18
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.	E 037		

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E 037	Continued From page 13 (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. *[For Hospices at §418.113(d):] (1) Training. The hospice must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing hospice employees, and individuals providing services under arrangement, consistent with their expected roles. (ii) Demonstrate staff knowledge of emergency procedures. (iii) Provide emergency preparedness training at least annually. (iv) Periodically review and rehearse its emergency preparedness plan with hospice employees (including nonemployee staff), with special emphasis placed on carrying out the procedures necessary to protect patients and 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.	E 037	E 037 1. The facility staff did not have initial emergency preparedness training. 2. Assistant Executive Director or designee will in-service all current staff on emergency preparedness training on or before 09/26/18 3. Assistant Executive Director or designee will in-service all new hires during orientation and all staff will be in-serviced annually. 4. Assistant Executive Director or designee will monitor compliance with the emergency preparedness training monthly x3. Any deviation will be forwarded to the Executive Director or designee and QAPI (Quality Assurance Performance Improvement) committee for recommendations for monthly x 3 and ongoing. 5. Date of compliance 09/26/18	09/26/18 09/26/18

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SLEEPY HOLLOW HEALTHCARE CENTER	6700 COLUMBIA PIKE ANNANDALE, VA 22003

(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 037	Continued From page 14 *[For PACE at §460.84(d):] (1) The PACE organization must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing on-site services under arrangement, contractors, participants, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least annually. (iii) Demonstrate staff knowledge of emergency procedures, including informing participants of what to do, where to go, and whom to contact in case of an emergency. (iv) Maintain documentation of all training. *[For CORFs at §485.68(d):](1) Training. The CORF must do all of the following: (i) Provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (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	E 037		

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E 037	Continued From page 15 reporting and extinguishing of fires, protection, and where necessary, evacuation of patients, personnel, and guests, fire prevention, and cooperation with firefighting and disaster authorities, to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. *[For CMHCs at §485.920(d):] (1) Training. The CMHC must provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles, and maintain documentation of the training. The CMHC must demonstrate staff knowledge of emergency procedures. Thereafter, the CMHC must provide emergency preparedness training at least annually. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility staff failed to have an initial emergency preparedness training program. The findings included: During an interview on 08/22/18 at 12: 32 P.M. with the administrator, he was asked for documentation for an initial training program in emergency preparedness policies and procedures for all new new and existing staff. The	E 037		

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E 037	Continued From page 16 administrator stated, the facility staff had been trained and tested on the Initial Training Program for Emergency Preparedness. However, no evidence of an Initial Training Program was presented during the survey. The facility staff failed to have an Initial Emergency Preparedness Training Program.	E 037	E 039 1. The facility will conduct a table-top exercise on or before 09/26/18. 2. Assistant Executive Director or designee will analyze and respond to the table-top on or before 09/26/18 3. Assistant Executive Director or designee will review the analysis and response to the table-top on or before 09/26/18 4. Assistant Executive Director or designee will forward recommendations to the Executive Director or designee and QAPI (Quality Assurance Performance Improvement)	09/26/18
E 039 SS=C	EP Testing Requirements CFR(s): 483.73(d)(2) (2) Testing. The [facility, except for LTC facilities, RNHCIs and OPOs] must conduct exercises to test the emergency plan at least annually. The [facility, except for RNHCIs and OPOs] must do all of the following: *[For LTC Facilities at §483.73(d):] (2) Testing. The LTC facility must conduct exercises to test the emergency plan at least annually, including unannounced staff drills using the emergency procedures. The LTC facility must do all of the following:] (i) Participate in a full-scale exercise that is community-based or when a community-based exercise is not accessible, an individual, facility-based. If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in a community-based or individual, facility-based full-scale exercise for 1 year following the onset of the actual event. (ii) Conduct an additional exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, facility-based.	E 039		

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E 039	Continued From page 17 (B) A tabletop exercise that includes a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed. *[For RNHCIs at §403.748 and OPOs at §486.360] (d)(2) Testing. The [RNHCI and OPO] must conduct exercises to test the emergency plan. The [RNHCI and OPO] must do the following: (i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group discussion led by a facilitator, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (ii) Analyze the [RNHCI's and OPO's] response to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCI's and OPO's] emergency plan, as needed. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility staff failed to have documentation of the facility's Emergency Preparedness exercise analysis and response. The findings include: During an interview on 08/22/18 at 12:35 P.M. with the administrator, he was asked for	E 039	committee for review monthly x 3 and ongoing. 5. Date of compliance 09/26/18	09/26/18

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E 039	Continued From page 18 documentation of the facility's table top exercise analysis. The administrator stated, the facility staff did not conduct an analysis of the table top exercise nor did the facility staff revise the Emergency Preparedness Plan as a result. The facility staff failed to have documentation of the facilities exercise analysis and response.	E 039		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 8/20/18 through 8/23/18. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. 6 complaints were investigated during the survey. The census in this 222 certified bed facility was 193 at the time of the survey. The survey sample consisted of 38 current Resident reviews and 4 closed record reviews.	F 000	F000 The statements made in the following plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies nor the reported conversations and other information cited in support of the alleged deficiencies. The facility sets forth the following plan of correction to remain in compliance with all federal and state regulations. The facility has taken or will take the actions set forth in the plan of correction. The following plan of correction constitutes the facilities allegation of compliance. All alleged deficiencies cited have been or will be corrected by the date or dates indicated.	
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and	F 550		09/26/18

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F 550	Continued From page 19 promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observations, clinical record review, staff and resident interview, and facility documentation, the facility staff failed to respect the dignity and privacy for 1 of 42 (Resident #49) residents in the survey sample. 1. The facility staff routinely sat on Resident #49's couch in her room to complete Activities of Daily Living (ADL) documentation which infringed upon her privacy.	F 550	F 550 1. Certified Nursing Assistant that sat on resident #49's couch to complete activity of daily living was educated not to infringe on resident privacy by completing her ADL's sitting on resident couch on 8/23/18. 2. All residents have the potential to be affected. On 8/23/18 rounds were conducted on all units. Rounds were conducted on all rooms by Director of Nursing to ensure no Certified Nursing Assistants are completing their ADL's	

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F 550	Continued From page 20 Resident #49 was admitted to the nursing facility on 4/8/14 with diagnoses that included stroke and Parkinson's disease. The most recent Minimum Data Set (MDS) assessment was a quarterly dated 6/1/18 and coded Resident #49 on the Brief Interview for Mental Status (BIMS) with a score of 15 out of a possible score of 15 which indicated the resident was cognitively intact in the skills needed for daily decision making. On 8/21/18 at approximately 2:00 p.m., a surveyor observed CNA #1 sitting on Resident #49's couch using an electronic device that was similar to a cell phone. On 8/22/18 at 10:00 a.m., during a group interview with 6 facility residents, they stated the Certified Nursing Assistants use their cell phones in their rooms on a regular basis. Resident #49 indicated the CNAs sit in her room and use their cell phones. On 8/22/18 at 4:15 p.m., Resident #49 stated when the CNAs came into her room to talk on the phone, they sat on her love seat, thus she would pull her curtain for personal privacy. On 8/23/18 at 10:30 p.m., a telephone interview was conducted with CNA #1. She stated she routinely used the couch in the resident's room to enter resident ADL information on her assigned 8 residents, as well do other CNAs in other resident rooms. She stated the residents may think the electronic device used may appear to residents to be a cell phone, but is a 6 inch electronic pad designed to enter ADL documentation on each resident. When asked if she or other CNAs	F 550	3. All Certified Nursing Assistants will be educated not to infringe on resident privacy by completing the ADL's in resident room by Assistant Director of Nursing or designee on or before 09/26/18. 4. Unit Manager or designee will conduct random rounds weekly on 5 resident's room per unit for compliance. Any deviation will be forwarded to the Director of Nursing and QAPI (Quality Assurance Performance Improvement) committee for recommendations for monthly x 3. 5. Date of compliance 09/26/18	09/26/18

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F 550	Continued From page 21 asked the residents to sit in their rooms to document on their electronic pads, or that this daily practice infringed on resident privacy, she stated, "I have those residents in that area and it was a good place for me to chart on my residents with my 'I-Pad'." On 8/23/18 at 1:35 p.m., a debriefing was held with the Administrator and the Director of Nursing (DON). The DON verified the devices that residents thought were cell phone were the electronic tablets used by the CNAs to enter ADL information. The DON stated she was not aware the CNAs were using the resident's rooms to sit and document via their electronic tablets. The Administrator stated there should be a better place to document other than in the resident's rooms and it was an invasion on their privacy. The facility's policy and procedure titled Resident Rights dated 8/11/17 indicated that dignity was a state worthy of honor and respect and privacy, which was a resident right with regard to personal belongings, space and privacy.	F 550		
F 606 SS=D	Not Employ/Engage Staff w/ Adverse Actions CFR(s): 483.12(a)(3)(4) §483.12(a) The facility must- §483.12(a)(3) Not employ or otherwise engage individuals who- (i) Have been found guilty of abuse, neglect, exploitation, misappropriation of property, or mistreatment by a court of law; (ii) Have had a finding entered into the State nurse aide registry concerning abuse, neglect, exploitation, mistreatment of residents or misappropriation of their property; or	F 606		

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F 606	Continued From page 22 (iii) Have a disciplinary action in effect against his or her professional license by a state licensure body as a result of a finding of abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property. §483.12(a)(4) Report to the State nurse aide registry or licensing authorities any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff. This REQUIREMENT is not met as evidenced by: Based on an Employee Record Review, staff interviews, and facility document review, the facility staff failed to obtain a Criminal Background Check for 1 staff member, Dietary Aide #1. The facility staff failed to obtain a Criminal Background Check for Dietary Aide #1, with a hire date of 9/15/17. The findings included: On 8/22/18 an Employee Record Review was conducted on 25 current employees from 8/20/16 to 8/20/18. The employee record for Dietary Aide #1, with hire date of 9/15/17 did not contain Virginia State Police criminal background check. On 8/23/18 at 10:24 AM an interview was conducted with the Human Resources Manager and she was asked to present documentation of the criminal background check for Dietary Aide #1, hired on the date of 9/15/18. The Human Resources Manager stated, "We do not have it, I even checked with dietary department and corporate and we don't have it."	F 606	F 606 1. Criminal Background check for Dietary Aide #1 was completed on 8/28/18. No identifiable records were found. 2. All dietary employees have the potential to be affected. 100% audit of all current dietary employee's criminal record were reviewed on 9/7/18. No identifiable records were found. Human Resources Manager will review criminal background check for all new dietary employees prior to hire to ensure completion of criminal background check on or before 09/26/18.	09/26/18

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F 606	Continued From page 23 On 8/23/18 at 12:11 PM an interview was conducted with the facilities Executive Director and he stated, "I have spoken with the Human Resources Manager and understand we do not have this employee's criminal background check. Our policy is that a state background check is to be done on all employees working in this facility." The facility policy titled "Abuse, Neglect and Exploitation" with effective date 10/07/2014 was reviewed and is documented in part, as follows: Procedure: I. Screening 1. Employees seeking hire will complete an application including three (3) personal references as well as a work history of the last three (3) positions held, if applicable. a. Following the personal interview and upon recommendation of the interviewer, a background check will be performed. 2. A criminal background check will be completed, per the requirements of SB 160. The facility policy titled "Hiring" last modified 1/20/10 was reviewed and is documented in part, as follows: POLICY STATEMENT It is the policy of CommuniCare Health Services (CHS) to be an equal opportunity employer and to hire individuals solely upon the basis of their qualifications and ability to do the job to be filled. Unless otherwise provided in writing, employment with CHS is considered to be at-will, so that either party may terminate the relationship at any time and for any lawful reason.	F 606	3. Human Resources Manager educated dietary manager on 9/7/18 ensuring criminal background checks are completed prior to hiring dietary employee. 4. Human Resources Manager will conduct an audit on 50% of all new dietary hires. Any deviation will be forwarded to the Executive Director or designee and QAPI (Quality Assurance Performance Improvement) committee for recommendations for monthly x 3. 5. Date of compliance 09/26/18.	09/26/18

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F 606	Continued From page 24 Procedure: (e) Following a decision to hire the applicant, the local Human Resources Representative is responsible for conducting the following steps: 2) Complete a criminal background check in accordance with federal and state requirements. (g) If the background, medical, or any other subsequent investigation discloses any misrepresentation on the application form, or information indicating that the individual is not suited for employment with CHS, the applicant will be refused employment or, if already employed, may be terminated. On 8/23/18 at 1:31 PM a pre-exit conference was conducted with the Administrator, Director of Nursing, Cooperate Clinical Nurse, Chief Executive Officer, and Assistant Administrator where the above information was shared. Prior to exit no further information was shared.	F 606	F 607 1. Criminal Background check for Dietary Aide #1 was completed on 8/28/18. No identifiable records were found. 2. All residents have the potential to be affected due to not implementing the abuse policy and procedure to obtain a Criminal Background Check. 100% audit of all current dietary employee's criminal record were reviewed on 9/7/18. No identifiable records were found. Human Resources Manager will review criminal background check for all new dietary employees prior to hire to ensure completion of criminal background check.	09/26/18
F 607 SS=D	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(3) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, This REQUIREMENT is not met as evidenced	F 607		

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F 607	Continued From page 25 by: Based on the Employee Record Review, staff interviews, and facility document review, the facility staff failed to implement their abuse policy and procedure to obtain a Criminal Background Check for all newly hired employees. The facility staff failed to obtain a criminal background check for 1 current staff member (Dietary Aide #1) with a hire date of 9/15/17. The findings included: On 8/22/18 an Employee Record Review was conducted on 25 current employees hired from 8/20/16 to 8/20/18. The employee record for 1 current employee (Dietary Aide #1) with a hire date of 9/15/17 did not contain a Virginia State Police criminal background check. On 8/23/18 at 10:24 AM an interview was conducted with the Human Resources Manager and she was asked to present documentation of criminal background check for Dietary Aide #1's record with hire date of 9/15/18. Human Resources Manager stated, "We do not have it, I even checked with dietary department and corporate and we don't have it." On 8/23/18 at 12:11 PM an interview was conducted with the facility's Executive Director and he stated, "I have spoken with the Human Resources Manager and understand we do not have this employee's criminal background check. Our policy is a state background check is to be done on all employees working in this facility." The facility policy titled "Abuse, Neglect and Exploitation" with effective date 10/07/2014 was	F 607	3. Human Resources Manager educated dietary manager on ensuring criminal background checks are completed prior to hiring dietary employee on 9/7/18. 4. Human Resources Manager will conduct an audit on 50% of all new dietary hires. Any deviation will be forwarded to the Executive Director or designee and QAPI (Quality Assurance Performance Improvement) committee for recommendations for monthly x 3. 5. Date of compliance 09/26/18	09/26/18

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F 607	Continued From page 26 reviewed and is documented in part, as follows: Procedure: I. Screening 1. Employees seeking hire will complete an application including three (3) personal references as well as a work history of the last three (3) positions held, if applicable. a. Following the personal interview and upon recommendation of the interviewer, a background check will be performed. 2. A criminal background check will be completed, per the requirements of SB 160. The facility policy titled "Hiring" last modified 1/20/10 was reviewed and is documented in part, as follows: The facility policy titled "Hiring" last modified 1/20/10 was reviewed and is documented in part, as follows: POLICY STATEMENT It is the policy of CommuniCare Health Services (CHS) to be an equal opportunity employer and to hire individuals solely upon the basis of their qualifications and ability to do the job to be filled. Unless otherwise provided in writing, employment with CHS is considered to be at-will, so that either party may terminate the relationship at any time and for any lawful reason. Procedure: (e) Following a decision to hire the applicant, the local Human Resources Representative is responsible for conducting the following steps: 2) Complete a criminal background check in accordance with federal and state requirements. (g) If the background, medical, or any other	F 607		

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	495155	A. BUILDING _____ B. WING _____	C 08/23/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 607	Continued From page 27 subsequent investigation discloses any misrepresentation on the application form, or information indicating that the individual is not suited for employment with CHS, the applicant will be refused employment or, if already employed, may be terminated. On 8/23/18 at 1:31 PM a pre-exit conference was conducted with the Administrator, Director of Nursing, Cooperate Clinical Nurse, Chief Executive Officer, and Assistant Administrator where the above information was shared. Prior to exit no further information was shared.	F 607	F 623 1. Resident #45, #142, and #91 were discharged to the hospital without notifying the Ombudsman prior to 8/20/2018. 2. All residents have the potential to be affected. Ombudsman was notified of all discharged from 1/1/2018 to 8/31/2018 on 9/12/2018 by Admissions Director. Ombudsman will be notified monthly by fax of all discharges and transfers to the hospital monthly by Admissions Director or designee. 3. Admissions Director was educated by Executive Director on 8/23/18. recommendations for monthly x 3.	09/26/18
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	F 623		

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F 623	Continued From page 28 resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section 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	F 623	4. Executive Director or designee will conduct an audit monthly on the fax receipt of all discharges and transfer to ensure the discharge log was sent to Ombudsman office. Any deviation will be forwarded to the Executive Director or designee and QAPI (Quality Assurance Performance Improvement) committee for recommendations for monthly x 3 5. Date of compliance 09/26/18.	09/26/18

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F 623	Continued From page 29 telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on clinical record review, staff interviews, and facility document review the facility staff failed to notify the office of the State Long-Term Care Ombudsman in writing of applicable discharges for 3 of 42 residents in the survey sample (Resident #45, #142 and #91).	F 623		

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F 623	Continued From page 30 1. The facility staff failed to notify the office of the State Long-Term Care Ombudsman of Resident #45's discharge to the hospital on 4/6/18. 2. The facility staff failed to notify the office of the State Long-Term Care Ombudsman of Resident #142's discharge to the hospital on 6/20/18. 3. The facility staff failed to notify the office of the State Long-Term Care Ombudsman of Resident #91's discharged to the hospital on 6/13/18. The finding include: 1. Resident #45 was admitted to the nursing facility on 5/16/17 with a diagnoses that included osteomyelitis of left foot and ankle and diabetes mellitus. The most recent Minimum Data Set (MDS) assessment was an Annual dated 5/18/18 and coded the resident on the Brief Interview for Mental Status (BIMS) with a score of 15 out of a possible score of 15 which indicated the resident was intact in the cognitive skills for daily decision making. The discharge tracking MDS assessment was dated 4/6/18. The nurse's notes dated 4/6/18 at 6:48 a.m., indicated Emergency Medical Services (EMS) was called due to complaints of left shoulder pain with numbness and tingling. The Transfer Discharge Report indicated Resident #45 was transferred to the local hospital on 4/6/18.	F 623		

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F 623	Continued From page 31 The Re-entry MDS was dated 4/9/18. The nurse's notes dated 4/9/18 at 6:59 p.m., indicated Resident #45 was re-admitted to the nursing facility from the local hospital. On 8/21/18 at 12:30 p.m., during an interview with the Social Worker, she stated, "I do not notify the Ombudsman of transfers to local hospital or discharges from the nursing facility." On 8/21/18 at 12:35 p.m., the Business Office Manager (BOM) was not aware of a process to notify the local Ombudsman of discharges from the nursing facility. The BOM stated, "I'm not sure who does that." On 8/21/18 at 12:43 p.m., the Director of Admissions stated, "Here, never. We are not doing that." On 8/23/18 at 1:35 p.m., a pre-exit debriefing was held with the Administrator and Director of Nursing (DON). They validated there was no system in place to report discharges to the local Ombudsman's office. No further information was shared prior to survey exit. 2. Resident #142 was admitted to the nursing facility on 1/3/18 with a diagnoses that included age related osteoporosis, swallowing problems, dementia and chronic obstructive pulmonary disease (COPD). The most recent Minimum Data Set (MDS) assessment was an Significant Change in Status assessment dated 7/5/18 and coded the resident	F 623		

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F 623	Continued From page 32 on the Brief Interview for Mental Status (BIMS) with a score of 13 out of a possible score of 15 which indicated the resident was intact in the cognitive skills for daily decision making. The discharge tracking MDS assessment was dated 6/20/18. The nurse's notes dated 6/20/18 at 3:15 p.m., indicated Emergency Medical Services (EMS) was called due to a fall and the resident's complaints of right hip pain. The Transfer Discharge Report indicated Resident #142 was transferred to the local hospital on 6/20/18. The Re-entry MDS was dated 6/28/18. The nurse's notes dated 6/28/18 at 12:37 p.m., indicated Resident #142 was re-admitted to the nursing facility from the local hospital. On 8/21/18 at 12:30 p.m., during an interview with the Social Worker, she stated, "I do not notify the Ombudsman of transfers to local hospital or discharges from the nursing facility." On 8/21/18 at 12:35 p.m., the Business Office Manager (BOM) was not aware of a process to notify the local Ombudsman of discharges from the nursing facility. The BOM stated, "I'm not sure who does that." On 8/21/18 at 12:43 p.m., the Director of Admissions stated, "Here, never. We are not doing that." On 8/23/18 at 1:35 p.m., a pre-exit debriefing was	F 623		

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F 623	Continued From page 33 held with the Administrator and Director of Nursing (DON). They validated there was no system in place to report discharges to the local Ombudsman's office. No further information was shared prior to survey exit. 3. Resident #91 was originally admitted to the facility on 01/08/16. Diagnosis for Resident #91 included but not limited to *Generalized Anxiety Disorder. *Anxiety disorder is a mental condition in which you are frequently worried or anxious about many things. Even when there is no clear cause, you are still not able to control your anxiety (https://medlineplus.gov/ency/patientinstructions/000685.htm). The current Minimum Data Set (MDS), a significant change assessment with an Assessment Reference Date (ARD) of 6/28/18 coded the resident with a 15 out of a possible score of 15 on the Brief Interview for Mental Status (BIMS) indicating no cognitive impairment. The Discharge MDS assessment was dated for 6/13/18-discharge return anticipated; resident re-admitted to the facility on 6/19/18. On 6/13/18, according to the facility's documentation, Resident #91 was picked up by transportation to be transported to local hospital on 6/13/18 at 5:50 a.m. An interview was conducted with the Social Worker (SW) on 8/21/18 at approximately 12:30 p.m., who stated, "I do not notify the Ombudsman when a resident has been discharged out the hospital; you can check with the Business of	F 623		

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F 623	Continued From page 34 Manager (BOM)." On 8/21/18 at approximately 12:35 p.m., an interview was conducted with the BOM, who stated, "I'm not sure who notifies the Ombudsman when a resident is discharged out to the hospital but we do not do that her in the business office." An interview was conducted with Director of Admissions on 08/21/18 at approximately 12:43 p.m., who replied, "Here, never, we are not doing that" (here). The Director of Admissions stated "We are not notifying the Ombudsman when a resident has been discharged out to the hospital." The facility administration was informed of the findings during a briefing on 08/23/18 at approximately 2:00 p.m. The facility did not present any further information about the findings.	F 623	F625 1. Resident #45 was not issued a bed hold notice and policy prior to discharge to the hospital on 4/6/18. Resident #142 was not issued a bed notice and policy prior to discharge to the hospital on 6/20/18. Resident #91 was not issued a bed notice and policy prior to discharge to the hospital on 6/13/18. Resident #68 was not issued a bed notice and policy prior to leave of absence from 8/20/18 – 8/23/18. Resident #99 was not issued a bed notice and policy prior to leave of absence on 8/16/18. Resident #175 was not issued facility's bed	09/26/18
F 625 SS=E	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that 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	F 625		

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F 625	Continued From page 35 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 clinical record review, staff interviews, and facility document review the facility staff failed to issue bed-hold notices and policy for 7 of 42 residents in the survey sample (Resident #45, #142, #91, 68, #99, #175 and #162). 1. The facility staff failed to issue a bed-hold notice and policy to Resident #45 prior to discharge to the hospital on 4/6/18. 2. The facility staff failed to issue a bed-hold notice and policy to Resident #142 prior to discharge to the hospital on 6/20/18. 3. The facility staff failed to issue a bed-hold notice and policy to Resident #91 prior to discharge to the hospital on 6/13/18. 4. The facility staff failed to issue a bed-hold notice for Resident #68 prior to a Leave of Absence (LOA), 8/20/18 through 8/23/18. 5. The facility staff failed to issue a bed-hold notice for Resident #99 prior to LOA on 8/16/18.	F 625	hold policy and reserve bed payment policy upon discharge/transfer to the hospital on 8/17/18. Resident #162 was not issued facility's bed hold policy and reserve bed payment policy upon discharge/transfer to the hospital on 7/10/18. 2. All residents have the potential to be affected. For current residents that will discharge to the hospital a bed hold notice and policy will be issued prior to discharge. For current residents that will go on leave of absence a bed hold notice and policy will be issued prior to leave of absence. For residents who are discharged/transferred to the hospital a bed hold policy and reserve bed payment policy will be issued prior to discharge/transfer to the hospital.	

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F 625	Continued From page 36 6. The facility staff failed to ensure that Resident #175 was issued the facility's bed hold policy and reserve bed payment policy upon transfer/discharge to the hospital on 08/17/18. 7. The facility staff failed to ensure that Resident #162 was issued a facility bed-hold and a reserve bed payment policy upon transfer/discharge to the hospital on 7/10/18. The finding include: 1. The facility staff failed to issue a bedhold notice to Resident #45 prior to discharge to the hospital on 4/6/18. Resident #45 was admitted to the nursing facility on 5/16/17 with a diagnoses that included osteomyelitis of left foot and ankle and diabetes mellitus. The most recent Minimum Data Set (MDS) assessment was an Annual dated 5/18/18 and coded the resident on the Brief Interview for Mental Status (BIMS) with a score of 15 out of a possible score of 15 which indicated the resident was intact in the cognitive skills for daily decision making. The discharge tracking MDS assessment was dated 4/6/18. The nurse's notes dated 4/6/18 at 6:48 a.m., indicated Emergency Medical Services (EMS) was called due to complaints of left shoulder pain with numbness and tingling. The Transfer Discharge Report indicated	F 625	3. All Nursing staff, all Business Office staff, all Social Services staff, and all Admissions staff will be educated on the facility bed hold policy on or before 09/26/18. 4. Social Services department will audit monthly 10% of all residents that were issued a bed hold notice and policy prior to discharge/transfer to the hospital and leave of absence. Any deviation will be forwarded to the Executive Director or designee and QAPI	

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F 625	Continued From page 37 Resident #45 was transferred to the local hospital on 4/6/18. The Re-entry MDS was dated 4/9/18. The nurse's notes dated 4/9/18 at 6:59 p.m., indicated Resident #45 was re-admitted to the nursing facility from the local hospital. On 8/21/18 at 12:30 p.m., during an interview with the Social Worker, she stated, "I do not issue bedhold notices to residents or their representatives at the time of discharge to the hospital." On 8/21/18 at 12:35 p.m., the Business Office Manager (BOM) was not aware of a process to issue bedhold notices to the residents or their representatives at the time of discharge to the hospital. The BOM stated, "I'm not sure who does that." On 8/21/18 at 12:43 p.m., the Director of Admissions stated, "Here, never. We are not doing that." On 8/23/18 at 1:35 p.m., a pre-exit debriefing was held with the Administrator and Director of Nursing (DON). They validated there was no system in place to issue bedhold notices to either the resident or the resident's representative at the time of transfer or discharge to the hospital. No further information was shared prior to survey exit. 2. The facility staff failed to issue a bedhold notice to Resident #142 prior to discharge to the hospital on 6/20/18.	F 625	(Quality Assurance Performance Improvement) committee for recommendations for monthly x 3. 5. Date of compliance 09/26/18	09/26/18

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F 625	Continued From page 38 Resident #142 was admitted to the nursing facility on 1/3/18 with a diagnoses that included age related osteoporosis, swallowing problems, dementia and chronic obstructive pulmonary disease (COPD). The most recent Minimum Data Set (MDS) assessment was an Significant Change in Status assessment dated 7/5/18 and coded the resident on the Brief Interview for Mental Status (BIMS) with a score of 13 out of a possible score of 15 which indicated the resident was intact in the cognitive skills for daily decision making. The discharge tracking MDS assessment was dated 6/20/18. The nurse's notes dated 6/20/18 at 3:15 p.m., indicated Emergency Medical Services (EMS) was called due to a fall and the resident's complaints of right hip pain. The Transfer Discharge Report indicated Resident #142 was transferred to the local hospital on 6/20/18. The Re-entry MDS was dated 6/28/18. The nurse's notes dated 6/28/18 at 12:37 p.m., indicated Resident #142 was re-admitted to the nursing facility from the local hospital. On 8/21/18 at 12:30 p.m., during an interview with the Social Worker, she stated, "I do not issue bedhold notices to residents or their representatives at the time of discharge to the hospital." On 8/21/18 at 12:35 p.m., the Business Office	F 625		

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F 625	Continued From page 39 Manager (BOM) was not aware of a process to issue bedhold notices to the residents or their representatives at the time of discharge to the hospital. The BOM stated, "I'm not sure who does that." On 8/21/18 at 12:43 p.m., the Director of Admissions stated, "Here, never. We are not doing that." On 8/23/18 at 1:35 p.m., a pre-exit debriefing was held with the Administrator and Director of Nursing (DON). They validated there was no system in place to issue bedhold notices to either the resident or the resident's representative at the time of transfer or discharge to the hospital. No further information was shared prior to survey exit. 3. Resident #91 was originally admitted to the facility on 01/08/16. Diagnosis for Resident #91 included but not limited to *Generalized Anxiety Disorder. *Anxiety disorder is a mental condition in which you are frequently worried or anxious about many things. Even when there is no clear cause, you are still not able to control your anxiety (https://medlineplus.gov/ency/patientinstructions/000685.htm). The current Minimum Data Set (MDS), a significant change assessment with an Assessment Reference Date (ARD) of 6/28/18 coded the resident with a 15 out of a possible score of 15 on the Brief Interview for Mental Status (BIMS) indicating no cognitive impairment.	F 625		

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F 625	Continued From page 40 The Discharge MDS assessments was dated for 6/13/18-discharge return anticipated; resident re-admitted to the facility on 6/19/18. On 6/13/18, according to the facility's documentation, Resident #91 was Nothing by mouth after midnight. Norvasc 2.5 mg administered as ordered, scheduled Percocet 5-325 mg administered with sip of water. Resident picked up by transportation to be transported to local hospital on 6/13/18 at 5:50 a.m. An interview was conducted with the Social Worker (SW) on 8/21/18 at approximately 12:30 p.m., who stated, "I do not issue the bed hold policy to the residents when they are discharged out the hospital; you can check with the Business of Manager (BOM)." On 8/21/18 at approximately 12:35 p.m., an interview was conducted with the BOM, who stated, "I'm not sure who issues the Bed Hold Policy but we do not do that here in the business office." An interview was conducted with Director of Admissions on 08/21/18 at approximately 12:43 p.m., who replied, "Here, never, we are not doing that here; giving the resident or their representative a copy of the bed hold policy." The facility administration was informed of the findings during a briefing on 08/23/18 at approximately 2:00 p.m. The facility did not present any further information about the findings. The facility's policy titled: Bed Hold Policy (Reviewed: 4/20/17)	F 625		

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F 625	Continued From page 41 -It is the intent of this facility to obtain the proper authorization to hold a resident bed when the resident returns to the hospital or goes on a leave. -The bed hold authorization form may be signed prior to the patient leaving the building, or within 24 hours of the resident leaving the facility or the following business day if the resident leaves on the weekend or a holding. Procedure: -The nurse of designee will obtain the residents or responsible party's signature on the bed hold authorization form each time the resident leaves on a bed hold. If the bed hold authorization form cannot be signed prior to the resident leaving and needs to be mailed, it must be mailed certified return receipt requested by the BOM or designee. 4. For Resident #68, the facility staff failed to offer a bed hold prior to a three-day leave of absence from 8/20/18-8/23/18. Resident #68 was a 48 year old who was admitted to the facility on 6/5/15. Resident #68's diagnoses included Schizoaffective disorder, and Dementia. The Minimum Data Set, which was an Annual Assessment with an assessment reference date of 6/13/18, coded Resident #68 as having a Brief Interview of Mental Status Score of 11. A score of 11 is indicative of modified independence in daily decision making. On 8/20/18, an interview was conducted with Resident #68 in his room. His son and daughter	F 625		

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F 625	Continued From page 42 were present. Resident #68 stated that he was very happy to be going to visit his children for three days (8/20/18 - 8/23/18). On 8/20/18 a review was conducted of Resident #68's clinical record, revealing a Request for Pass Medication /Leave of Absence, dated 8/16/18. The facility had made arrangements with the pharmacy to obtain the medications for Resident #68 to take with him during his leave of absence. On 8/21/18, at approximately 9:00 A.M. an interview was conducted with the Director of Nursing (DON-Administration B). The DON stated that Resident #68 had not been offered a bed hold. She further stated that the facility was currently developing a bed hold procedure that would be implemented as of 8/22/18. No further information was received. 5. Facility staff failed to provide Resident # 99 with bed hold information prior to a leave of absence and hospitalization. Resident # 99's clinical record was reviewed on 8/23/18. The resident was admitted to the facility on 2/9/17. His diagnoses included diabetes, dementia, and depression. The latest MDS (minimum data set) assessment, dated 7/3/18, coded the resident with severely impaired cognitive function. He required facility staff for completion of all the ADLS (activities of daily living). On 8/20/18 at 3:15 PM the surveyor observed Resident #99's room to be empty and asked where the resident was. Licensed Practical	F 625		

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F 625	Continued From page 43 Nurse-LPN I said the resident was on leave of absence with family members since 8/16/18 and she didn't know when she would be returning. On 8/21/18 at 10:30 AM LPN I and Social Worker-SW I were interviewed regarding the resident's absence from the facility. Neither employee knew when the resident was due to return to the facility. LPN I made several phone calls to unidentified staff members and finally established the resident had actually been discharged from the facility on Saturday, 8/18/18, after his family admitted him to a hospital. SW I and LPN I were asked if the resident was on a bed hold or if he was actually discharged. They did not know what a bed hold was. On 8/21/18 at 4:18 PM the DON was asked if the resident or his family members had been issued bedhold information prior to his leave of absence and discharge to the hospital. The DON said they didn't provide any bedhold information prior to the resident leaving the facility. No other information was forthcoming prior to the survey team exit. 6. The facility staff failed to ensure that Resident #175 was made aware of the facility's bed hod and reserve bed payment policy upon transfer/discharge to the hospital on 8/17/18. Resident #175 was a 98 year old that was admitted to the facility originally on 7/23/18 and readmitted on 8/20/18, with a diagnosis of (1) - cerebrovascular accident. The most recent Minimum Data Set (MDS)	F 625		

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F 625	Continued From page 44 assessment was an Admission 5 Day with an Assessment Reference Date (ARD) of 7/30/18. The Brief Interview for Mental Status (BIMS) for Resident #175 was a 10 out of possible 15 which indicated the resident was mildly cognitively impaired. Resident #175 Progress Notes dated 8/17/18 were reviewed and are documented in part, as follows: Date: 8/17/18 Resident was observed with weakness of the left arm and right leg. Resident was unable to move the left side of her body. Resident was alert and responsive, V/s B/P 120/70 P86/R 18. Md called. Order to send resident to ER for evaluation. Sister was at the bedside. On 8/22/18 at 1:30 PM an interview was conducted with the Unit Manager Registered Nurse-RN #5 and she was asked if Resident #175's Responsible Party was notified of the facility's bed hold policy upon transfer/discharge to the hospital on 8/17/18. RN #5 stated, "I don't see anything like that in the chart, I don't know if we do that and I don't know who is responsible for giving family that." On 8/23/18 at 1:31 PM a pre-exit conference was conducted with the Administrator, Director of Nursing, Corporate Clinical Nurse, Chief Executive Officer, and Assistant Administrator where the above information was shared. Prior to the exit no further information was shared. (1). Cerebrovascular Accident: an abnormal condition of the brain characterized by occlusion by an embolus, thrombus, or cerebrovascular	F 625		

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F 625	Continued From page 45	F 625		

hemorrhage or vasospasm, resulting in ischemia of the brain tissues normally perfused by the damaged vessels.

The above definition was derived from Mosby's Dictionary of Medicine, Nursing, and Health Professions 8th Edition.

7. The facility staff failed to ensure that Resident #162 was issued a facility bed-hold and a reserve bed payment policy upon transfer/discharge to the hospital on 7/10/18

Resident #162 was a 70 year old admitted to the facility originally on 6/29/17 and then re-admitted on 7/18/18 with diagnoses of (1). Dementia, (2). Liver Carcinoma, and (3). Communication Deficit.

A Minimum Data Set (MDS) Discharge Return anticipated assessment with an Assessment Reference Date of 7/10/18 was completed and submitted for Resident #162.

A Minimum Data Set (MDS) Entry assessment with an Assessment Reference Date of 7/18/18 was completed and submitted for Resident #162.

Resident #162's Progress Notes were reviewed and are documented in part, as follows:

7/10/18 20:34 (8:34 P.M.) Nurses Note: Lab result seen by MD (medical doctor) order to transfer patient via non emergency transportation, patient picked up at 5:30 pm report given to charge nurse at (Hospital Name) ER (emergency room). family aware.

7/11/18 7:13 A.M. Nurses Note: Follow up call

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F 625	Continued From page 46 made to (Hospital) nurse on duty said patient is admitted for observation. Resident #162's Physician Orders were reviewed and are documented in part, as follows: 7/10/18 Transfer patient to ER via non emergency transportation. Resident #162's Hospital After Visit Summary was reviewed and indicated a hospital stay from 7/10/18 through 7/18/18. The facility Census Report for Resident #162 was reviewed and is documented in part, as follows: Effective Date: 7/10/18 Status: STOP BILLING Action Code: Discharge Date Effective Date: 7/18/18 Status: Active Action Code: ReAdmission On 8/21/18 at 2:00 P.M. the Administrator provided a typed statement regarding Bed Hold Policy Requirements which was reviewed and is documented in part as follows: 8/21/18 It was identified that the facility failed to follow the bed hold policy per requirements. For all past and current residents this practice was not initiated. From 8/22/18 forward, facility will initiate this policy. On 8/22/18, at approximately 10:15 A.M. an interview was conducted with the Director of Nursing. The DON stated, "Name (Resident #162) had not been offered a bed hold. She	F 625		

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F 625	Continued From page 47 further stated that the facility was currently developing a bed hold procedure that would be implemented as of 8/22/18. The facility policy titled "Bed Hold Policy" effective 2/17/17 was reviewed and is documented in part, as follows: POLICY STATEMENT It is the policy of this facility to provide resident centered care that meets the psychosocial, physical and emotional needs and concerns of the residents. It is the intent of this facility to obtain the proper authorization to hold a resident bed when the resident returns to the hospital or goes on a leave. The bed hold authorization form may be signed prior to the patient leaving the building or within 24 hours of the resident leaving the facility or the following business day if the resident leaves on the weekend or a holiday. Procedure: 1. In the event a resident returns to the hospital or goes on a leave, the following process will be followed by the facility: a. The Admissions Director or designee will notify the resident and/or responsible party of the days available under their Medicaid benefits or the private pay cost associated with holding the bed will be explained, within 24 hours of the patient leaving the facility, or the following business day if the patient leaves on the weekend or a holiday. b. The nurse or designee will obtain the residents or responsibly party's signature on the bed hold authorization form each time the resident leaves on a bed hold. If the bed hold authorization form cannot be signed prior to the resident leaving and	F 625		

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F 625	Continued From page 48 needs to be mailed, it must be mailed certified return receipt requested by the Business Office Manager or designee. On 8/23/18 at 1:31 PM a pre-exit conference was conducted with the Administrator, Director of Nursing, Cooperate Clinical Nurse, Chief Executive Officer, and Assistant Administrator where the above information was shared. The Administrator validated there was no system in place to issue bedhold notices to either the resident or the resident's representative at the time of transfer or discharge to the hospital. Prior to exit no further information was shared.	F 625	F 656 1. Care plan for resident #162 was revised on 8/19/17 to indicate elopement history. 2. All residents have the potential to be affected. Care plans for all current residents on the secured dementia unit will be revised to include at-risk for elopement. For all new admissions that are on the locked dementia unit their care plan will include an at-risk for elopement. 3. All licensed nursing staff will be educated on revising and updating care plan for residents at-risk for elopement on the secured dementia unit by the Assistant Director of Nursing on or before 09/26/18.	09/26/18
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized	F 656		

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F 656	Continued From page 49 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 observations, clinical record review, staff interviews, and facility document review the facility staff failed to develop and implement a comprehensive person-centered care plan to include the risk of unsafe wandering for 1 of 42 resident in the survey sample, Resident #162. The facility staff failed to develop and implement a comprehensive person-centered care plan to include the risk of unsafe wandering after the resident was identified as a "significant risk of getting to a potentially dangerous place" on the admission Minimum Data Set (MDS) for Resident #162 who eloped from the facility on 8/19/17. The findings included: 1. Resident #162 was a 70 year old admitted to	F 656	4. Unit Managers will audit 10% of care plans in locked dementia unit weekly for 3 weeks and then monthly. Any deviation will be forwarded to the Director of Nursing or designee and QAPI (Quality Assurance Performance Improvement) committee for recommendations monthly x3 and ongoing. 5. Compliance date 09/26/18	09/26/18

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F 656	Continued From page 50 the facility originally on 6/29/17 and then re-admitted on 7/18/18 with diagnoses of (1). Dementia, (2). Liver Carcinoma, and (3). Communication Deficit. The Resident #162's Admission 5 day Minimum Data Set (MDS) assessment with an Assessment Reference Date (ARD) of 7/6/17 was reviewed. The Brief Interview for Mental Status (BIMS) was a 4 out of a possible 15 which indicated that Resident #162 was severely cognitively impaired. Under Section E-Behavior E0900 Wandering-Presence and frequency Resident #162 was coded as a 1-Behavior of this type occurred 1 to 3 days. Under E1000 Wandering -Impact A. (Does the wandering place the resident at significant risk of getting to a potentially dangerous place e.g.. stairs, outside of the facility) Resident #162 was coded as Yes. Resident #162's Comprehensive Care Plan which was initiated on 6/30/17 and revised on 7/7/17 was reviewed. There was no identified Focus, Goal, or Intervention related to wandering addressed on the Comprehensive Care Plan for Resident #162. Resident #162 was also not care planned to be on a locked dementia unit. The current Comprehensive Care Plan for Resident #162 last revised on 6/13/18 was reviewed and was documented in part, as follows: Focus: Name (Resident #162) is at risk for ELOPEMENT due to : diagnosis of Dementia and Hx (history of) elopement. Date Initiated: 8/19/17 Goal:	F 656		

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F 656	Continued From page 51 Name (Resident #162) will remain safely in the facility through next review. Date Initiated: 8/19/17 Interventions/Tasks: *Apply Wanderguard. Check for placement and functioning every shift. Date Initiated: 8/19/17 *Complete elopement risk assessment quarterly and as needed. Date Initiated: 8/19/17 *Notify physician and family of behavior changes. Date Initiated: 8/19/17 *Staff will direct Name (Resident #162) away from exit doors by offering alternative activities and conversation. Name (Resident #162) should be free to ambulate around the unit daily otherwise. Date Initiated: 8/19/17 Provide diversionary activities. Activity staff to take resident outside twice a week. Date Initiated: 8/19/17 Resident #162's Wandering Observation Tool dated 6/29/17 was reviewed and indicated the resident was a Low Risk for wandering. Resident #162's Wandering Observation Tool dated 8/19/17 was reviewed and indicated the resident was a Low Risk for wandering. Resident #162's Wandering Observation Tool dated 8/21/17 was reviewed and indicated the resident was a Moderate Risk for wandering. On 8/21/18 at 11:15 A.M. an interview was conducted with the MDS Director. The MDS Director was asked if the Resident #162 should be care-planned as an elopement/wandering risk. The MDS Director stated, "Yes, because she is	F 656		

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F 656	Continued From page 52 on the locked unit." The MDS Director was unable to provide documentation that Resident #162's comprehensive person-centered care plan initiated on 6/30/17 and revised on 7/7/17 include the risk of elopement. The MDS Director stated, "We did care plan her for an elopement risk after her elopement on 8/18/17." Resident #162's Progress Notes were reviewed and are documented in part, as follows: 8/19/17 17:21 (5:21 P.M.) Incident Note: Resident was last seen by staff at about 10:30 A.M., at 10:45 A.M. was not on unit, facility and grounds check initiated, law enforcement, md/rp (medical doctor/responsible party) notifies. Resident found at 12:11 P.M. by facility staff. 8/19/17 17:49 (5:49 P.M.) Nurses Note: writer first saw resident this morning at 6:30 am in bed sleeping, when giving her room mate medication, staff assist resident with ADL (activities of daily living) at 7:45 am, initially refuses her 9 am meds but she took it close to 10 am, was last seen by staff at about 10:30 am, pacing in the hallway, staff noticed that resident was missing at 10:45 am, facility and grounds search was initiated, law enforcement was notified at 10:59 am. MD was notified at 11:01 am. Resident was found at 12.11 pm by the facility staff on gallows road and masonville road. resident is stable at this time no distress noted. 8/19/17 23:30 (11:30 P.M.) Care Plan Note: resident was placed on 1:1 monitoring from 12:50 pm to 4pm. Window secured at 4pm and 1:1 monitoring was discontinued. During the survey Resident #162 was observed	F 656		

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F 656	Continued From page 53 ambulating all over the locked dementia unit with wanderguard bracelet in place. Resident #162's room was also inspected and the windows were secured shut. On 8/22/18 at 5:00 P.M. an interview was conducted with the Administrator and the Director of Nursing were the above elopement was discussed. The surveyor asked what determines if a resident is placed on the locked dementia unit and if Resident #162 had resided on that unit since admission. The Administrator stated, "The locked unit is for residents who exit seek, need to be secured for their safety and require supervision. Yes, Name (Resident #162) was placed on the locked unit upon admission." The surveyor then asked if the windows on the locked unit should have been secured. The Administrator stated, "Yes, Name (Resident #162's) window had been secured but it had broken and become unsecured." The facility policy titled "Elopement Prevention" last reviewed 4/20/17 is documented in part, as follows: Definition: Elopement is defined as when a resident/patient leaves the premises or a safe area without authorization and/or any necessary supervision and places the resident/patient at harm or injury. Policy: The facility strives to prevent resident/patient elopement, while promoting and supporting resident/patient independence and mobility. The focus is to enable the resident/patient to attain and maintain their highest practicable physical, mental and psychosocial wellbeing while maintaining safety.	F 656		

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F 656	Continued From page 54 Procedures: 1. Identify resident/patients who are at risk for elopement. b. Any resident/patient admitted who is cognitively impaired and can self-ambulate is considered an elopement risk until determined otherwise. 3. Complete the Risk Alert: Elopement 5. Develop the care plan with input from the interdisciplinary team and the resident/patient and family/responsible party. 6. Initiate individualized interventions to address elopement risk factors. 7. Communicate individualized interventions to the caregiving staff, resident/patient and/or family/responsible party. On 8/23/18 at 1:31 PM a pre-exit conference was conducted with the Administrator, Director of Nursing, Cooperate Clinical Nurse, Chief Executive Officer, and Assistant Administrator where the above information was shared. Prior to exit no further information was shared.	F 656	F 689 1. For resident #241, #47, and #28 smoking materials were secured by Executive Director outside of the designated smoking area on 8/22/18. 2. All residents have the potential to be affected. Smoking materials for all current residents were secured by Executive Director on 8/22/18. For all new smokers their smoking materials will be secured per policy. 3. All staff will be educated on the smoking policy by the Assistant Director of Nursing or designee on or before 09/26/18.	09/26/18
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations, clinical record review,	F 689		

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F 689	Continued From page 55 staff interviews, and facility document review the facility staff failed to maintain an environment as free as possible of accident hazards for 3 of 42 Residents in the survey sample (Residents #241, #47, and #28). 1. For Resident #241, who required supervision with smoking, the facility staff failed to ensure that his smoking materials were secured outside of the designated smoking activity. 2. For Resident #47, the facility staff failed to ensure that his smoking materials were secured outside of the designated smoking activity. 3. For Resident #28 the facility staff failed to ensure that his smoking materials were secured outside of the designated smoking activity. The findings included: 1. Resident #241 was observed to have smoking materials which included cigarettes and a lighter. Resident #241 was re-admitted to the facility on 1/11/18 with diagnoses of renal disease, muscle weakness, neurogenic bladder, and hypertension. Resident #241 had a Brief Interview for Mental Status Score of 14. Resident 241 was assessed in area of Activities of Daily Living as 1/1 for transfer and mobility. This resident did not require staff assistant in the area of personal hygiene, bathing or eating. A Care Plan with a revision date of 4/24/18 indicated: Problem- Resident is resistive to care refusing medication. Problem- Resident has a behavior problem due to	F 689	4. Executive Director or designee will conduct rounds 3 times a week on residents that smoke to ensure that their smoking materials is secured for 3 weeks and then monthly. Any deviation will be forwarded to the Executive Director or designee and QAPI (Quality Assurance Performance Improvement) committee for recommendations for monthly x 3 and ongoing. 5. Compliance date 09/26/18	09/26/18

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F 689	Continued From page 56 cognitive impairment. History of combative behavior verbal altercation. Intervention_ Anticipate and meet resident's needs. Intervene as necessary to protect the rights and safety of others. Resident #241 is a smoker- assessed as a supervised smoker. Intervention- complete smoking assessment. Reassess quarterly, annually and with change of condition that affects the ability to smoke. Monitor resident safety during smoking. Educate resident and family regarding center's smoking policy, designated smoking areas, and storage of smoking materials. On 8/20/18 at 4:30 P.M. Resident #241 was observed with a a pack of cigarettes on his person. During the 6:00 P.M. smoking hour this resident was observed to reach into his shirt and pull out a pack of cigarettes. The resident began lighting his own cigarette with a lighter that he had in his front right pocket. Resident was observed smoking in the designated smoking areas. Resident was observed during the 1:P.M. smoking hour on 8/21/18 with cigarettes and a lighter. Resident was observed to light his cigarette and began smoking. Staff was observed to approach Resident #241 and ask where did he get the lighter and cigarettes. This resident responded back to staff, "Mine your own business and leave me alone." A 7/26/18 Smoking Assessment indicated: Resident uses cigarettes. Resident can light his own cigarette. Resident needs supervision for smoking. A Facility Smoking Policy,dated 4/01/2016 indicated: 5. Smokers will be permitted to smoke	F 689		

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F 689	Continued From page 57 only in designated smoking areas. 9. All smoking materials will be maintained by the facility staff and provided to the resident/patient on request. 9-C. Smoking materials will be returned to the facility staff upon completion of smoking. Facility staff failed to ensure safe smoking material management. 2. For Resident #47, the facility staff failed to ensure that his smoking materials were secured outside of designated smoking activity. Resident #47 was a 76 year old who was admitted to the facility on 7/27/16 . Resident #47's diagnoses included Left Eye Cataract. Abnormalities of Gait and Mobility, Wheezing, Type 2 Diabetes Mellitus, Chronic Obstructive kidney Disease with Exacerbation, Muscle Weakness-Generalized, and Hypertension. The Minimum Data Set, which was an Annual Assessment with an assessment reference date of 6/1/18, coded Resident #47 as having a Brief Interview of Mental Status Score of 14. A score of 14 indicated intact cognition. On 8/20/18 at 6:00 P.M., an observation was conducted of Resident #47 entering the designated smoking area. He already had a pack of cigarettes and a lighter in his possession. He lit and smoked a cigarette. Afterwards, he did not give the cigarettes and lighter to the staff member to place in the lock box with the other resident's smoking materials. On 8/20/18 at 6:10 P.M., an interview was conducted with the staff nurse who was supervising the smoking activity (Registered	F 689		

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F 689	Continued From page 58 Nurse 2). She stated that Resident #47 had his smoking materials with him, and that he was not supposed to carry them around on his person. On 8/20/18 at 2:00 P.M., a tour was conducted of the facility. Resident #47's room had a label on the door which indicated that oxygen was in use. The oxygen was ordered for Resident #47's roommate, who was on a leave of absence. On 08/22/18 10:15 A.M. a 2nd interview was conducted with RN 2. When asked about her attempt to get the resident to give her his cigarettes and lighter. "I asked him where did he find the cigarettes and lighter. He said, 'This is my cigarette.' He refused to give me the pack and lighter. He left with it. I told my supervisor." On 8/22/18 a review was conducted of Resident #47's clinical record. His care plan indicated that he had been assessed as having been able to smoke independently, as long as he followed the facility smoking policy. Resident #47's record contained a Smoking Acknowledgement Form dated 6/25/18 that was signed by him on 6/25/18. On 8/22/18 the Director of Nursing was notified of the findings. No further information was received. 3. Resident #28 kept smoking paraphernalia (cigarettes and lighter) in his room to use when out smoking on the facility patio three times a day. Resident #28 was admitted to the nursing facility on 7/26/12 with diagnoses that included stroke and nicotine dependence. The most recent Minimum Data Set (MDS)	F 689		

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F 689	Continued From page 59 assessment was a quarterly dated 5/24/18 and coded the resident on the Brief Interview for Mental Status (BIMS) with a score of 14 out of a possible score of 15 which indicated the resident was cognitively intact in the skills for daily decision making. The resident was coded to required limited assistance from one staff for all activities of daily living (ADL). The resident was assessed to require supervision only for bathing. The resident was not independently steady to walk or transition from a seated to a standing position. The resident was impaired in range of motion on one side in upper and lower extremity. The resident used a cane/crutch or wheelchair for mobility. The care plan dated 12/21/17 and revised 7/25/18 identified Resident #28 was a smoker and was assessed to be safe and an independent smoker. The goal set by the staff for the resident was that they would maintain the resident's independence to safely smoke. Some of the approaches the staff would take to accomplish this goal included to complete smoking assessment per the organization's policy, observe the resident for unsafe smoking behaviors or attempts to obtain smoking materials from outside sources, if so inform facility management, assure smoking material was extinguished prior to resident leaving smoking area, place the resident in position to assure visualization of ashtray and review smoking policy with the resident and or the resident's family. The facility required smoking materials to be locked in a secured area when not in use by the resident for both independent and supervised smokers. Resident #28's most recent smoking assessment was updated on 7/26/18 that indicated the	F 689		

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F 689	Continued From page 60 resident did not have Alzheimer's or dementia, was aware of the risks of Nicotine, had no vision problems, no dexterity problems, smoked 2-5 times a day and requested to smoke morning afternoon and evening, was safe to light a cigarette, had no swallowing problems, no history of choking, had no hand tremors, and can appropriately dispose of a cigarette. On 8/21/18 at 10:00 a.m., the surveyor noticed that Resident #28 was sitting at the table on the patio smoking cigarettes. The surveyor did not notice staff giving resident his cigarette or lighter as she was handing them to other residents on the patio. The surveyor approached the nurse supervisor, Registered Nurse (RN) #2 to find out how the resident received his cigarette and lighter. Nurse supervisor RN # 2 stated that the resident didn't come to her for a cigarette or lighter because he already had it on him. She also stated that he was not supposed to be an independent smoker-meaning that he was not allowed to self carry his lighter or cigarettes. On 8/21/18 at 1:30 p.m., Resident #28 retrieved his smoking materials from a nurse at the nurse's station. He stated he was perfectly fine with asking the nurse for smoking materials at the designated smoking times, 8:30 a.m., 1:30 p.m. and 6:00 p.m. On 8/22/18 at 11:00 a.m., an interview was conducted with the facility's social worker. It was asked of the social worker if Resident #28 was provided the smoking policy. The social worker returned with four smoking acknowledgment forms, signed by the resident that indicated understanding of the smoking safety policy and procedure adopted by the nursing facility. The	F 689		

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F 689	Continued From page 61 social worker stated the significance of the smoking assessment was to determine the needs of the smoker, whether they were independent and their level of supervision, whether they needed a smoking apron, cigarette holder, assistance to light the cigarette, cognition and vision ability. She stated regardless of the assessment, for safety purposes, smoking materials were to be kept locked at the nurse's station and not kept on the resident or in their rooms. On 8/23/18 at 1:35 p.m., a debriefing was held with the Administrator and the Director of Nursing (DON). They stated they expected the staff and residents to abide by the facility's safety policy on smoking that included securing smoking materials at the nurse's station to issue at the designated smoking times.	F 689	F 698 1. LPN #1 and Unit Manager RN #1 were educated on how to assess arteriovenous (AV) fistula hemodialysis access site for bruit and thrill on hemodialysis resident #67.	09/26/18
F 698 SS=D	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observations, medical record review, a Resident Interview, staff interviews, and facility document review the facility staff failed to ensure a dialysis Resident received the necessary care and services to include assessment of an Arteriovenous (AV) fistula hemodialysis access site for bruit and thrill for 1 of 42 Residents in the survey sample, Resident #67.	F 698	2. All residents receiving dialysis have the potential to be affected. All licensed nursing staff will be educated on how to assess arteriovenous (AV) fistula hemodialysis access site for bruit and thrill on all hemodialysis residents.	

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F 698	Continued From page 62 The Facility staff failed to ensure that Resident #67's Arteriovenous fistula hemodialysis access site was adequately assessed for bruit and thrill. Description from https://www.davita.com/treatment-services/dialysis/vascular-access-your-lifeline-to-hemodialysis: Learn the feel of the "thrill" or vibration of blood going through your access and check it several times a day. Call your dialysis care team immediately if the flow stops or changes. This could mean a blood clot. With quick action, many clots can be dissolved or removed. Learn to listen with a stethoscope to the sound (called "bruit") of blood flowing ("whooshing") through your access. If the sound of the bruit changes to a higher pitch, like a whistle, it could be an indication that blood vessels are narrowing (call stenosis), which may slow or stop blood flow through your access. If you do not hear the bruit at all, or only your pulse, you may have a blood clot in your access. Call your dialysis care team if you notice any change in your access. The findings included: Resident #67 was a 61 year old admitted to the facility on 4/24/17 with diagnoses to include (1.) Chronic Kidney Disease, Stage 3, and (2.) Dependence on Renal Dialysis. The most recent comprehensive Minimum Data Set (MDS) assessment was an Annual with an Assessment Reference Date (ARD) of 5/3/18. The Brief Interview for Mental Status (BIMS) was a 15 out of a possible 15 which indicated that Resident #67 cognitively intact and capable of daily decision making. Under Section O Special	F 698	3. Assistant Director of Nursing or designee will continue to educate newly hired licensed nursing staff on orientation and annually. 4. Random observations will be done by Unit Managers on licensed nursing staff assessing arteriovenous (AV) fistula hemodialysis access site for bruit and thrill weekly x3 and then monthly. Any deviation will be forwarded to the Director of Nursing or designee and QAPI (Quality Assurance Performance Improvement) committee for recommendations for monthly x 3 and ongoing.	

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F 698	Continued From page 63 Treatments, Procedures, and Programs, Resident #67 was coded as receiving Dialysis while a resident. Resident #67's Comprehensive Care Plan last revised 5/19/2018 was reviewed and is documented in part, as follows: Focus: (Name) Resident #67 has Alteration in Kidney Function Related to ESRD (end stage renal disease) with Hemodialysis Tuesday, Thursday, and Saturday and at risk from bleeding from dialysis access. Intervention: Monitor thrill and bruit daily in left arm and document findings;report abnormal findings to Physician. Resident #67's current Physician Orders were reviewed and are documented in part, as follows: Order: Monitor A/V (Arteriovenous Fistula) on left arm for bruit and thrill every shift. Status: Active Start Date: 3/25/2018 On 08/22/18 at 09:25 AM an interview was conducted with Resident #67. Resident #67 was asked if the nurse's assess his left arm dialysis fistula when he returns from dialysis on Tuesdays, Thursdays, and Saturdays. Resident # 67 stated, "No, they don't check it here only at dialysis." On 08/22/18 09:35 AM LPN (Licensed Practical Nurse) #1 who was assigned to Resident #67 for the day was asked if she would walk with the	F 698	5. Date of compliance 09/26/18 09/26/18	09/26/18

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SLEEPY HOLLOW HEALTHCARE CENTER	6700 COLUMBIA PIKE ANNANDALE, VA 22003

(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 698	Continued From page 64 surveyor to assess Resident #67's his left arm dialysis fistula for bruit and thrill. LPN #1 entered the resident's room and placed her right hand over the resident's left arm and stated, "It's good, I feel the vibration." Surveyor then asked if that is all you do to check bruit and thrill and was the task completed. LPN #1 stated, "Yes, that is all you do for bruit and thrill." No stethoscope was ever obtained or used to check bruit. On 8/22/18 at 9:45 A.M. the Wing 2 Unit Manager RN (Registered Nurse) #1 was at the nurse's station when LPN #1 and I returned from Resident #67's room she was asked to show the surveyor how to check bruit and thrill on a resident with a Arteriovenous Fistula. RN #1 held LPN #1's right arm and placed her right hand over the lower end and stated, "You feel here and you will feel the vibration." Surveyor then asked if that is all you do to check bruit and thrill and was the task completed. RN #1 stated, "Yes, that's all you so." No stethoscope was ever obtained or used to check bruit. On 8/22/18 at 10:30 A.M. the above information regarding bruit and thrill assessment by LPN #1 and RN #1 was shared with the Director of Nursing and the Regional Nurse Consultant and were asked what would they have expected from their nurses. The Director of Nursing stated, "For them to have used a stethoscope to listen for the bruit and to feel for the thrill." The Regional Nurse Consultant stated, "The RN didn't use a stethoscope either we need to start training now." The surveyor replied, "No." The facility policy titled "Hemodialysis Monitoring" last revised 3/23/18 was reviewed and is documented in part, as follows:	F 698		

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F 698	Continued From page 65 Definitions: Bruit: the "swishing" sound heard over the site of anastomosis using a stethoscope; the sound is due to the large volume and high pressure of blood passing through the site. Thrill: The vibration felt by the flow of blood at the anastomosis; thrills are not audible but must be felt with a light touch and indicate good blood flow. Policy: It is the policy of this facility to provide resident centered care that meets the psychosocial, physical and emotional needs and concerns of the residents. Procedures: III. Signs and Symptoms to monitor: I. Lack of bruit heard or thrill palpated at the site of the anastomosis. VI. General Vascular Access Device care and Precautions: b. Thrill: normal sensation felt at site of anastomosis for grafts and fistulas. c. Bruit: normal sensation heard with stethoscope as swishing sound at site of anastomosis for grafts and fistulas. Thrills and bruits are normal with grafts and fistulas sue to high velocity of blood through the vein at the anastomosis site. VIII. Post-Dialysis b. Nurse to complete the poet-dialysis evaluation upon return from dialysis center to include but not limited to:	F 698		

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F 698	Continued From page 66 i. Thrill absence or presence. ii. Bruit absence or presence On 8/23/18 at 1:31 PM a pre-exit conference was conducted with the Administrator, Director of Nursing, Cooperate Clinical Nurse, Chief Executive Officer, and Assistant Administrator where the above information was shared. Prior to exit no further information was shared.	F 698	F 726 1. LPN #1 and Unit Manager RN #1 were educated on how to assess arteriovenous (AV) fistula hemodialysis access site for bruit and thrill on hemodialysis resident #67. 2. All residents receiving dialysis have the potential to be affected. All licensed nursing staff will be educated on how to assess arteriovenous (AV) fistula hemodialysis access site for bruit and thrill on all hemodialysis residents. 3. Assistant Director of Nursing or designee will continue to educate newly hired licensed nursing staff on orientation and annually.	09/26/18
F 726 SS=D	Competent Nursing Staff CFR(s): 483.35(a)(3)(4)(c) §483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. §483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. §483.35(c) Proficiency of nurse aides. The facility must ensure that nurse aides are able	F 726		

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F 726	Continued From page 67 to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. This REQUIREMENT is not met as evidenced by: Based on observations, medical record review, a Resident Interview, staff interviews, and facility document review, the facility staff failed to ensure competency in assessing an Arteriovenous Fistula hemodialysis access for bruit and thrill for 1 (Resident #67) of 42 residents in the survey sample. The facility staff failed to ensure that Resident #67's Arteriovenous Fistula hemodialysis access was adequately assessed for *bruit and **thrill. The findings included: Resident #67 was a 61 year old admitted to the facility on 4/24/17 with diagnoses to include (1.) Chronic Kidney Disease, Stage 3, and (2.) Dependence on Renal Dialysis. The most recent comprehensive Minimum Data Set (MDS) assessment was an Annual with an Assessment Reference Date (ARD) of 5/3/18. The Brief Interview for Mental Status (BIMS) was a 15 out of a possible 15 which indicated that Resident #67 cognitively intact and capable of daily decision making. Under Section O Special Treatments, Procedures, and Programs, Resident #67 was coded as receiving Dialysis while a resident. Resident #67's Comprehensive Care Plan last revised 5/19/2018 was reviewed and documented in part, as follows:	F 726	4. Observations will be done by Unit Managers 3 times a week on licensed nursing staff assessing arteriovenous (AV) fistula hemodialysis access site for brill and thrill weekly x3 and then monthly. Any deviation will be forwarded to the Director of Nursing or designee and QAPI (Quality Assurance Performance Improvement) committee for recommendations for monthly x 3 and ongoing. 5. Date of compliance 09/26/18	09/26/18

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F 726	Continued From page 68 Focus: (Name) Resident #67 has Alteration in Kidney Function Related to ESRD (end stage renal disease) with Hemodialysis Tuesday, Thursday, and Saturday and at risk from bleeding from dialysis access. Intervention: Monitor thrill and bruit daily in left arm and document findings; report abnormal findings to Physician. Resident #67's current Physician Orders were reviewed and are documented in part, as follows: Order: Monitor A/V (Arteriovenous Fistula) on left arm for bruit and thrill every shift. Status: Active Start Date: 3/25/2018 On 08/22/18 at 09:25 AM an interview was conducted with Resident #67. Resident #67 was asked if the nurse's assess his left arm dialysis fistula when he returns from dialysis on Tuesdays, Thursdays, and Saturdays. Resident # 67 stated, "No, they don't check it here only at dialysis." On 08/22/18 09:35 AM LPN (Licensed Practical Nurse) #1 who was assigned to Resident #67 for the day was asked if she would walk with the surveyor to assess Resident #67's his left arm dialysis fistula for bruit and thrill. LPN #1 entered the resident's room and placed her right hand over the resident's left arm and stated, "It's good, I feel the vibration." Surveyor then asked if that is all you do to check bruit and thrill and was the task completed. LPN #1 stated, "Yes, that is all	F 726		

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F 726	Continued From page 69 you do for bruit and thrill." No stethoscope was ever obtained or used to check bruit. On 8/22/18 at 9:45 A.M. the Wing 2 Unit Manager RN (Registered Nurse) #1 was at the nurse's station when LPN #1 and I returned from Resident #67's room she was asked to show the surveyor how to check bruit and thrill on a resident with a Arteriovenous Fistula. RN #1 held LPN #1's right arm and placed her right hand over the lower end and stated, "You feel here and you will feel the vibration." Surveyor then asked if that is all you do to check bruit and thrill and was the task completed. RN #1 stated, "Yes, that's all you so." No stethoscope was ever obtained or used to check bruit. On 8/22/18 at 10:30 A.M. the above information regarding bruit and thrill assessment by LPN #1 and RN #1 was shared with the Director of Nursing and the Regional Nurse Consultant and were asked what would they have expected from their nurses. The Director of Nursing stated, "For them to have used a stethoscope to listen for the bruit and to feel for the thrill." The Regional Nurse Consultant stated, "The RN didn't use a stethoscope either we need to start training now." The surveyor replied, "No." The facility policy titled "Hemodialysis Monitoring" last revised 3/23/18 was reviewed and is documented in part, as follows: Definitions: *Bruit: the "swishing" sound heard over the site of anastomosis using a stethoscope; the sound is due to the large volume and high pressure of blood passing through the site.	F 726		

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F 726	Continued From page 70 **Thrill: The vibration felt by the flow of blood at the anastomosis; thrills are not audible but must be felt with a light touch and indicate good blood flow. Policy: It is the policy of this facility to provide resident centered care that meets the psychosocial, physical and emotional needs and concerns of the residents. Procedures: III. Signs and Symptoms to monitor: I. Lack of bruit heard or thrill palpated at the site of the anastomosis. VI. General Vascular Access Device care and Precautions: b. Thrill: normal sensation felt at site of anastomosis for grafts and fistulas. c. Bruit: normal sensation heard with stethoscope as swishing sound at site of anastomosis for grafts and fistulas. Thrills and bruits are normal with grafts and fistulas sue to high velocity of blood through the vein at the anastomosis site. VIII. Post-Dialysis b. Nurse to complete the poet-dialysis evaluation upon return from dialysis center to include but not limited to: i. Thrill absence or presence. ii. Bruit absence or presence On 8/23/18 at 1:31 PM a pre-exit conference was conducted with the Administrator, Director of Nursing, Cooperate Clinical Nurse, Chief Executive Officer, and Assistant Administrator	F 726		

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F 726	Continued From page 71 where the above information was shared. Prior to exit no further information was shared.	F 726	F 842 1. Resident #440 was discharged 6/1/17. Resident #240 was discharged 5/30/17. 2. All residents have the potential to be affected. Medical Records department will ensure that medical records are complete, accurate, systematically organized, and readily accessible from date of acquisition – 5/1/17 per policy. 3. Assistant Director of Nursing or designee will educate medical records staff on having complete, accurate, systematically organized, and readily accessible medical records per policy on or before 09/26/18.	
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings,	F 842		

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F 842	Continued From page 72 law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on staff interviews, observation, clinical record review and facility documentation review the facility staff failed to ensure complete and accurate clinical records for 2 of 42 residents (Resident #440 and #240) in the survey sample. 1. The facility staff failed to ensure the clinical	F 842	4. Assistant Executive Director or designee will audit 10% of discharges weekly x3 and then monthly. Any deviation will be forwarded to the Director of Nursing or designee and QAPI (Quality Assurance Performance Improvement) committee for recommendations for monthly x 3 and ongoing. 5. Date of compliance 09/26/18.	09/26/18

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F 842	Continued From page 73 record was accurate for Resident #440; a progress note indicated resident was a status post right hip fracture with staples when in fact was not. 2. The facility staff failed to retain Resident #240's clinical record after new management took over the facility. The findings included: 1. Resident #440 was admitted to the facility on 3/1/17. Diagnosis for Resident #440 included but not limited to *Dementia with behavioral disturbance. *Dementia with behavioral disturbances is frequently the most challenging manifestations of dementia and are exhibited in almost all people with dementia. https://www.ncbi.nlm.nih.gov/pubmed/22644311 The current Minimum Data Set (MDS), a quarterly assessment with an Assessment Reference Date (ARD) of 5/30/17 coded the resident with a 01 out of a possible score of 15 on the Brief Interview for Mental Status (BIMS) indicating severe cognitive impairment. In addition, the MDS coded Resident #440 total dependence of one with bathing, extensive assistance of one with dressing, limited assistance of one with bed mobility, toilet use and personal hygiene for Activities of Daily Living care. The care plan dated as initiated on 03/01/17 did not indicate a recent right hip fracture with surgical interventions. The resident's progress note dated 04/28/17,	F 842		

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F 842	Continued From page 74 include the following under musculoskeletal system: staples to right hip status post fracture (s/p). The assessment and plan: s/p hip fracture of right hip, going today to have staples removed. The review of Resident #440's clinical notes from admission on 3/1/17 through 6/1/18 did not reveal a right hip fracture with surgical interventions. An interview was conducted on 8/22/18 at approximately 1:25 p.m., with the Director of Nursing (DON) who stated, "I was unable to locate where Resident #440 had a recent right hip fracture with surgical interventions." The facility administration was informed of the findings during a briefing on 08/23/18 at approximately 2:00 p.m. The facility did not present any further information about the findings. 2. Resident #240 was admitted to the facility on 8/26/16 with diagnoses which included: Cardiovascular Accident with Aphasia, Renal disease with dialysis, chronic kidney disease, hypothyroidism, hypertension, depression, Type II diabetes mellitus with hyperglycemia, and hyperlipidemia. The facility staff failed to have clinical records available. During the investigation of a complaint that Resident #240 was out of the facility for over 6 hours on a medical appointment without food or any change of her depends. The Administrator was asked for the clinical records of Resident #240. The Administrator stated, "The facility came under new management in May of 2017 and there were no means to obtain the past medical	F 842		

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F 842	Continued From page 75 records of Resident #240. No medical records were made available to confirm that Resident #24 was out of the facility on 3/17/17. Nor were medical records made available to review for the care and treatment of Resident #240.	F 842		
F 925 SS=E	Maintains Effective Pest Control Program CFR(s): 483.90(i)(4) §483.90(i)(4) Maintain an effective pest control program so that the facility is free of pests and rodents. This REQUIREMENT is not met as evidenced by: Based on observations, record review group interview and staff interview, the facility staff failed to maintain an effective Pest Control Program. The findings included: During the Group Interview on 8/22/18 residents complained of mice being in their rooms. The residents stated mice droppings were observed in rooms 106, 204 and 305. A review of the Pest Control Log for the North Unit indicated: On 8/15/18 a mice (sic) was sighted in room 9. A review of the Pest Control Log for the South Unit indicated: On 2/21/18 mice were sighted in the dining room. A review of the Pest Control Log for the West 1 Unit indicated: On 8/21/18 mice were sighted in room 213.	F 925	F 925 1. The following rooms were inspected and treated by Bay city pest management on 9/10/2018 - #308, #309, # 311, # 114 and offices # 324, #328 #329. The following room were inspected and treated by Bay city pest management on 9/12/2018 - # 112, #106, #204, #305, #9, #213, and south dining room. No additional evidence of pest found in the rooms. The Microwave oven was removed from the East Unit on 08/23/18. Holes in walls were sealed on 09/12/18. Trees were trimmed away from the building on or before 09/26/18. South Kitchen sink was cleaned on 08/23/18.	09/26/18

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F 925	Continued From page 76 A review of the Pest Control Log for the 300 Unit indicated: On 2/13/18 mice were sighted in the following rooms, #308, #309, #311, Office, #324, #328, #329. The log indicated: Need to seal holes in walls/trim tree away from building. A review of the Pest Control Log for the East Unit indicated: On 5/30/18 roaches were observed by the microwave oven. On 8/19/18 mice were sighted in room 112. On 8/20/18 mice were sighted in room 114. A Pest Assessment dated 8/14/18 indicated: Kitchen: Serviced mouse traps. West 1 and 2 : Baited all resident rooms for mice. East Unit: Baited for mice. South Unit: Kitchen sink drain is breeding flies. Please clean. Emerald Court Unit: Baited access panels and HVAC Units in hallways for mice. A request for the facilities Pest Policy was requested, the policy was not provided. During an interview with the Administrator and the Regional Director of Operations on 8/23/18 at 11:30 A.M. the Administrator stated the facility was being aggressive in preventing pest in the facility. The Regional Director asked were the pest being cited? The facility staff failed to have an effective Pest Control Program.	F 925	2. All residents have the potential to be affected. For all other resident pest control services will inspect rooms of all resident and treat if needed. 3. Residents and staff will be in-serviced on the process of reporting pest service's needs. A letter was sent to resident on the process of reporting pest sightings. 4. An audit will be done weekly x 3 and then monthly to check pest control book to ensure that all rooms listed in the pest control book has been treated by the pest control company. Audits will be brought to the QAPI monthly x3 months and ongoing. 5. Date of compliance 09/26/18	09/26/18

COMMONWEALTH of VIRGINIA

M. Norman Oliver, MD, MA
State Health Commissioner

Department of Health
Office of Licensure and Certification

TYY 7-1-1 OR
1-800-828-1120
9960 Mayland Drive, Suite 401
Henrico, Virginia 23233-1485
Fax (804) 527-4502

September 4, 2018

Mr. Ezedube Eze, Administrator
Sleepy Hollow Healthcare Center
6700 Columbia Pike
Annandale, VA 22003

RE: Sleepy Hollow Healthcare Center
Provider Number 495155

Dear Mr Eze:

An unannounced licensure, standard and complaint survey, ending August 23, 2018, was conducted at your facility by staff from the Virginia Department of Health's Office of Licensure and Certification (the State Survey Agency) to determine if your facility was in compliance with Federal long term care participation requirements for the Medicare and/or Medicaid programs and, if applicable, State licensure regulations. Six complaints were investigated during the survey. One complaints was substantiated, with deficiencies. Two complaints were substantiated, with no deficiencies. Three complaints were unsubstantiated, with no deficiencies.

All references to regulatory requirements contained in this letter are found in Title 42, Code of Federal Regulations.

Survey Results

The results of this survey are reflected on the enclosed Statement of Isolated Deficiencies, "A" Form and/or the Statement of Deficiencies and Plan of Correction, CMS 2567. All survey findings generated on these forms (including the most recent standard survey and any subsequent revisits or complaint investigations) constitute the facility's current survey report. In accordance with §483.10(g), the current survey report must be made available for examination in a place readily accessible to residents and is disclosable to all interested parties.

This survey found that your facility was not in substantial compliance with the participation requirements. The most serious deficiency in your facility was a pattern deficiency that constitutes no actual harm with potential for more than minimal harm that is not immediate jeopardy (S/S of E), as evidenced by the attached CMS-2567L, whereby corrections are required.

Plan of Correction (PoC): ***Please cross reference the attatched licensure deficiencies to your federal deficiencies.***

A PoC is not required for deficiencies cited on the Statement of Isolated Deficiencies, "A" Form. Nevertheless, the facility is expected to address and correct all areas of concern noted on this form.

Unless specifically otherwise indicated, a PoC for all certification and licensure deficiencies cited on the Statement of Deficiencies and Plan of Correction (CMS-2567) must be submitted within ten (10) calendar days of receipt of these survey findings to Laura Veuhoff, LTC Supervisor, at: Office of Licensure and Certification, Division of Long Term Care Services, 9960 Mayland Drive, Suite 401, Richmond, Virginia 23233. **If you are participating in ePOC, please submit your Plan of Correction through the ePOC website.**

To be considered acceptable, the PoC must:

1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;
2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice;
3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;
4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; and
5. Include dates when the corrective action will be completed. (The "outside" date by which all corrections must be made is the 45th calendar day after the survey ended.)

The PoC will serve as the facility's allegation of compliance. If an acceptable plan is not submitted, the State Survey Agency may propose to the Center for Medicare and Medicaid Services (CMS) Regional Office and/or the State Medicaid agency that remedies be imposed immediately within applicable notice requirements.

Informal Dispute Resolution

Following the receipt and review of your survey report, please contact the assigned supervisor to attempt to resolve any problems or concerns you may have about the citations. If those concerns are not resolved, in accordance with §488.331, you have one opportunity to question cited federal certification deficiencies through the Office's Informal Dispute Resolution Process, which may be accessed at http://www.vdh.virginia.gov/licensure-and-certification/the-division-of-long-term-care/.

To be given such an opportunity, you are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to: Director, Division of Long Term Care, Office of Licensure and Certification, 9960 Mayland Drive, Suite 401, Richmond, Virginia 23233. To be considered, the IDR request must follow the IDR guidelines and be received at the Office within 10 calendar days of your receipt of the enclosed survey findings.

An incomplete informal dispute resolution process will not delay the effective date of the imposition of any enforcement actions.

Recommended Remedies

Based on the deficiencies cited during the survey, under Subpart F of 42 CFR Part 488 the following remedies may be imposed by the Centers for Medicare and Medicaid Services (CMS) Regional Office and/or the State Medicaid Agency (DMAS):

- Pursuant to §488.408(c)
  - Directed Plan of Correction (PoC) (§488.424).
  - State monitoring (§488.422).
  - Directed In-Service Training (§488.425).
- Pursuant to §488.408(d)
  - Denial of payment for new admissions - (§488.417).
  - Denial of payment for all individuals - (§488.418).
  - Civil Money Penalty, $50 - $3,000 per day (§488.430, §488.438), effective on the survey ending date,
- Civil money penalties of $1,000 - $10,000 per instance of noncompliance.

Informal dispute resolution for the cited deficiencies will not delay the imposition of the enforcement actions recommended (or revised, as appropriate). A change in the seriousness of the noncompliance may result in a change in the remedy selected. When this occurs, you will be advised of any change in remedy.

Please note: This survey cover letter does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services or the Virginia Department of Medical Assistance Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination. If you do not achieve substantial compliance within three (3) months after the last day of the survey identifying noncompliance, §488.417(b) requires the denial of payment for new Medicare or Medicaid admissions. If substantial compliance is not attained within six months from the last day of the survey, §488.412(b) provides that "CMS will and the State must terminate the facility's provider agreement."

Please be advised: The facility must maintain compliance with both the Health and the Life Safety Code requirements in order to continue provider certification.

Survey Response Form

The Survey Response Form is offered as a method to share your review of the onsite survey process. Please take a moment to complete this evaluation, which is available at: "http://www.vdh.virginia.gov/OLC/Downloadables/documents/2011/pdf/LTC%20facility%20survey%20response%20form.pdf". We will appreciate your participation.

If you have any questions concerning this letter, please contact me at (804) 367-2100.

Sincerely,

Laura Spruce Veuhoff

Laura S. Veuhoff, LTC Supervisor
Division of Long Term Care

Enclosure

cc: Joani Latimer, State Ombudsman
Bertha Ventura, Dmas (Sent Electronically)