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

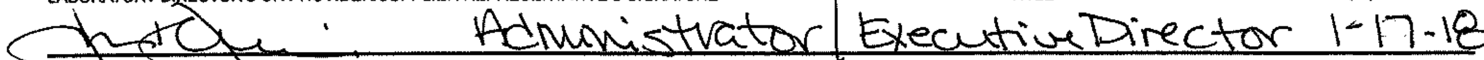
PRINTED: 12/20/2017
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495246	A. BUILDING ______ B. WING ______	C 12/08/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODMONT CENTER	11 DAIRY LANE FREDERICKSBURG, VA 22405

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 12/04/17 through 12/08/17. Corrections are required for compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities. One complaint was investigated during the survey.	E 000		
E 015 SS=C	Subsistence Needs for Staff and Patients CFR(s): 483.73(b)(1) [(b) Policies and procedures. [Facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually.] At a minimum, the policies and procedures must address the following: (1) The provision of subsistence needs for staff and patients whether they evacuate or shelter in place, include, but are not limited to the following: (i) Food, water, medical and pharmaceutical supplies (ii) Alternate sources of energy to maintain the following: (A) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions. (B) Emergency lighting. (C) Fire detection, extinguishing, and alarm systems. (D) Sewage and waste disposal. *[For Inpatient Hospice at §418.113(b)(6)(iii):] Policies and procedures.	E 015	1. No residents were affected. 2. All residents have the potential to be affected. 3. A provision of subsistence needs for staff and residents will be incorporated into the facility's Emergency Preparedness Plan (EPP) by the Center Executive Director/designee to include food, water, medical/pharmaceutical supplies, alternate sources of energy, fire detection, extinguishing, alarm systems, and sewage and waste disposal. Center Executive Director/designee will then communicate this information to all facility staff as part of the emergency-preparedness training. 4. Center Executive Director will share this information from the EPP at the monthly QAPI Committee meeting for education	1/17/18

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



Administrator | Executive Director 1-17-18

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 015	Continued From page 1 (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 staff interview and facility document review it was determined that the facility staff failed to have a complete emergency preparedness plan. The facility staff failed to develop policies and procedures for the provision of substance needs including but not limited to, food, water, and pharmaceutical supplies for patients and staff and to provide for sewage and waste disposal. The findings include: On 12/01/17 at 10:00 a.m. a review and interview of the facility's emergency preparedness plan was conducted with OSM (other staff member) # 1, director of maintenance. Review of the facility's emergency preparedness plan failed to evidence	E 015	and review purposes, and will review twice annually to determine continued completeness and accuracy, sharing results with the QAPI committee.	1/17/18

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E 015	Continued From page 2 policies and procedures for the provision of substance needs including but not limited to, food, water, and pharmaceutical supplies for residents and staff and to provide for sewage and waste disposal. OSM # 1 stated that the facility did not have it. On 12/06/17 at approximately 5:00 p.m. ASM (administrative staff member) # 1, the executive director (administrator), ASM # 2, interim director of nursing and ASM # 3, clinical quality specialist, were made aware of the findings. No further information was obtained prior to exit.	E 015		
E 018 SS=C	Procedures for Tracking of Staff and Patients CFR(s): 483.73(b)(2) [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually.] At a minimum, the policies and procedures must address the following:] (2) A system to track the location of on-duty staff and sheltered patients in the [facility's] care during an emergency. If on-duty staff and sheltered patients are relocated during the emergency, the [facility] must document the specific name and location of the receiving facility or other location. *[For PRTFs at §441.184(b), LTC at §483.73(b), ICF/IIDs at §483.475(b), PACE at §460.84(b):] Policies and procedures. (2) A system to track the	E 018	1. No residents were affected. 2. All residents have the potential to be affected. 3. A system to track the specific location of on-duty staff and sheltered residents during an emergency situation will be incorporated into the facility's Emergency Preparedness Plan (EPP) by the Center Executive Director/designee. Center Executive Director/designee will then communicate this information to all facility staff as part of the emergency-preparedness training. 4. Center Executive Director will share this information from the EPP at the monthly QAPI Committee meeting for education	

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E 018	Continued From page 3 location of on-duty staff and sheltered residents in the [PRTF's, LTC, ICF/IID or PACE] care during and after an emergency. If on-duty staff and sheltered residents are relocated during the emergency, the [PRTF's, LTC, ICF/IID or PACE] must document the specific name and location of the receiving facility or other location. *[For Inpatient Hospice at §418.113(b)(6):] Policies and procedures. (ii) Safe evacuation from the hospice, which includes consideration of care and treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s) and primary and alternate means of communication with external sources of assistance. (v) A system to track the location of hospice employees' on-duty and sheltered patients in the hospice's care during an emergency. If the on-duty employees or sheltered patients are relocated during the emergency, the hospice must document the specific name and location of the receiving facility or other location. *[For CMHCs at §485.920(b):] Policies and procedures. (2) Safe evacuation from the CMHC, which includes consideration of care and treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s); and primary and alternate means of communication with external sources of assistance. *[For OPOs at § 486.360(b):] Policies and procedures. (2) A system of medical documentation that preserves potential and actual donor information, protects confidentiality of	E 018	and review purposes, and will review twice annually to determine continued completeness and accuracy, sharing results with the QAPI committee.	1/17/18

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E 018	Continued From page 4 potential and actual donor information, and secures and maintains the availability of records. *[For ESRD at § 494.62(b):] Policies and procedures. (2) Safe evacuation from the dialysis facility, which includes staff responsibilities, and needs of the patients. This REQUIREMENT is not met as evidenced by: Based on staff interview and facility document review it was determined that the facility staff failed to have a complete emergency preparedness plan. The facility staff failed to develop a tracking system to document locations of patients and staff. The findings include: On 12/01/17 at 10:00 a.m. a review and interview of the facility's emergency preparedness plan was conducted with OSM (other staff member) # 1, director of maintenance. Review of the facility's emergency preparedness plan failed to evidence a tracking system to document locations of patients and staff. OSM # 1 stated that the facility did not have it. On 12/06/17 at approximately 5:00 p.m. ASM (administrative staff member) # 1, the executive director (administrator), ASM # 2, interim director of nursing and ASM # 3, clinical quality specialist, were made aware of the findings. No further information was obtained prior to exit.	E 018		
E 022 SS=C	Policies/Procedures for Sheltering in Place CFR(s): 483.73(b)(4)	E 022		

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E 022	Continued From page 5 [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. At a minimum, the policies and procedures must address the following:] (4) A means to shelter in place for patients, staff, and volunteers who remain in the [facility]. [(4) or (2),(3),(5),(6)] A means to shelter in place for patients, staff, and volunteers who remain in the [facility]. *[For Inpatient Hospices at §418.113(b):] Policies and procedures. (6) The following are additional requirements for hospice-operated inpatient care facilities only. The policies and procedures must address the following: (i) A means to shelter in place for patients, hospice employees who remain in the hospice. This REQUIREMENT is not met as evidenced by: Based on staff interview and facility document review it was determined that the facility staff failed to have a complete emergency preparedness plan. The facility staff failed to develop policies and procedures of how the facility will provide a means to shelter in place for patients, staff and volunteers who remain in the facility and how those policies and procedures are aligned with the facility's emergency plan and risk	E 022	1. No residents were affected. 2. All residents have the potential to be affected. 3. Policy and procedure will be incorporated into the facility's Emergency Preparedness Plan (EPP) by the Center Executive Director/designee, specific to how the facility will provide a means to shelter in place for residents, staff and volunteers who remain in the facility during an emergency. Center Executive Director/designee will then communicate this information to all facility staff as part of the required emergency-preparedness inservice/training. 4. Center Executive Director will share this information from the EPP at the monthly QAPI Committee meeting for education and review purposes, and will review twice annually to determine continued completeness and accuracy, sharing results with the QAPI committee.	1/17/18

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E 022	Continued From page 6 management. The findings include: On 12/01/17 at 10:00 a.m. a review and interview of the facility's emergency preparedness plan was conducted with OSM (other staff member) # 1, director of maintenance. Review of the facility's emergency preparedness plan failed to evidence policies and procedures for how the facility will provide a means to shelter in place for patients, staff and volunteers who remain in the facility and how those policies and procedures are aligned with the facility's emergency plan and risk management. OSM # 1 stated that the facility did not have it. On 12/06/17 at approximately 5:00 p.m. ASM (administrative staff member) # 1, the executive director (administrator), ASM # 2, interim director of nursing and ASM # 3, clinical quality specialist, were made aware of the findings. No further information was obtained prior to exit.	E 022		
E 023 SS=C	Policies/Procedures for Medical Documentation CFR(s): 483.73(b)(5) [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. At a minimum, the policies and procedures must address the following:]	E 023	1. No residents were affected. 2. All residents have the potential to be affected. 3. A system of medical documentation will be incorporated into the facility's Emergency Preparedness Plan (EPP) by the Center Executive Director/designee, a system that preserves and protects confidentiality of resident information, and secures and	

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E 023	Continued From page 7 (5) A system of medical documentation that preserves patient information, protects confidentiality of patient information, and secures and maintains availability of records. [(5) or (3),(4),(6)] A system of medical documentation that preserves patient information, protects confidentiality of patient information, and secures and maintains availability of records. This is what's in SOM. *[For RNHCIs at §403.748(b):] Policies and procedures. (5) A system of care documentation that does the following: (i) Preserves patient information. (ii) Protects confidentiality of patient information. (iii) Secures and maintains the availability of records. *[For OPOs at §486.360(b):] Policies and procedures. (2) A system of medical documentation that preserves potential and actual donor information, protects confidentiality of potential and actual donor information, and secures and maintains the availability of records. This REQUIREMENT is not met as evidenced by: Based on staff interview and facility document review it was determined that the facility staff failed to have a complete emergency preparedness plan. The facility staff failed to develop policies and procedures of how the facility preserves patient information, protects confidentiality of patient information, and secures and maintains availability of records. The findings include:	E 023	maintains availability of records. The Center Executive Director/designee will include this information in the emergency-preparedness inservice/training for all facility staff. 4. Center Executive Director will share this information from the EPP at the monthly QAPI Committee meeting for education and review purposes, and will review twice annually to determine continued completeness and accuracy, sharing results with the QAPI committee.	1/17/18

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E 023	Continued From page 8 On 12/01/17 at 10:00 a.m. a review and interview of the facility's emergency preparedness plan was conducted with OSM (other staff member) # 1, director of maintenance. Review of the facility's emergency preparedness plan failed to evidence policies and procedures for how the facility preserves patient information, protects confidentiality of patient information, and secures and maintains availability of records. OSM # 1 stated that the facility did not have it. On 12/06/17 at approximately 5:00 p.m. ASM (administrative staff member) # 1, the executive director (administrator), ASM # 2, interim director of nursing and ASM # 3, clinical quality specialist, were made aware of the findings. No further information was obtained prior to exit.	E 023		
E 024 SS=C	Policies/Procedures-Volunteers and Staffing CFR(s): 483.73(b)(6) [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. At a minimum, the policies and procedures must address the following:] (6) [or (4), (5), or (7) as noted above] The use of volunteers in an emergency or other emergency staffing strategies, including the process and role for integration of State and Federally designated health care professionals to address surge needs during an emergency.	E 024	1. No residents were affected. 2. All residents have the potential to be affected. 3. Policy and procedure will be incorporated into the facility's Emergency Preparedness Plan (EPP) by the Center Executive Director/designeie, specific to the use of volunteers or other emergency-staffing strategies, including the process and role for integration of State and Federally-designated health care professionals during an emergency situation. The Center Executive Director/designee will include this	

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E 024	Continued From page 9 *[For RNHCIs at §403.748(b):] Policies and procedures. (6) The use of volunteers in an emergency and other emergency staffing strategies to address surge needs during an emergency. This REQUIREMENT is not met as evidenced by: Based on staff interview and facility document review it was determined that the facility staff failed to have a complete emergency preparedness plan. Facility staff failed to develop policies and procedures for the use of volunteers and other staffing strategies are in the emergency plan. The findings include: On 12/01/17 at 10:00 a.m. a review and interview of the facility's emergency preparedness plan was conducted with OSM (other staff member) # 1, director of maintenance. Review of the facility's emergency preparedness plan failed to evidence policies and procedures for the use of volunteers and other staffing strategies are in the emergency plan. OSM # 1 stated that the facility did not have it. On 12/06/17 at approximately 5:00 p.m. ASM (administrative staff member) # 1, the executive director (administrator), ASM # 2, interim director of nursing and ASM # 3, clinical quality specialist, were made aware of the findings. No further information was obtained prior to exit.	E 024	information in the emergency-preparedness training for all facility staff. 4. Center Executive Director will share this information from the EPP at the monthly QAPI Committee meeting for education and review purposes, and will review twice annually to determine continued completeness and accuracy, sharing results with the QAPI committee.	1/17/18
E 025 SS=C	Arrangement with Other Facilities CFR(s): 483.73(b)(7)	E 025		

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E 025	Continued From page 11 This REQUIREMENT is not met as evidenced by: Based on staff interview and facility document review it was determined that the facility staff failed to have a complete emergency preparedness plan. The facility staff failed to provide documentation of the arrangements and/or any agreements the facility has with other facilities to receive patients in the event the facility is not able to care for them during an emergency. The findings include: On 12/01/17 at 10:00 a.m. a review and interview of the facility's emergency preparedness plan was conducted with OSM (other staff member) # 1, director of maintenance. Review of the facility's emergency preparedness plan failed to evidence documentation of the arrangements and/or any agreements the facility has with other facilities to receive patients in the event the facility is not able to care for them during an emergency. OSM # 1 stated that the facility did not have it. On 12/06/17 at approximately 5:00 p.m. ASM (administrative staff member) # 1, the executive director (administrator), ASM # 2, interim director of nursing and ASM # 3, clinical quality specialist, were made aware of the findings. No further information was obtained prior to exit.	E 025		
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	E 026		

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E 026	Continued From page 12 policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually..At a minimum, the policies and procedures must address the following:] (8) [(6), (6)(C)(iv), (7), or (9)] The role of the [facility] under a waiver declared by the Secretary, in accordance with section 1135 of the Act, in the provision of care and treatment at an alternate care site identified by emergency management officials. *[For RNHCIs at §403.748(b):] Policies and procedures. (8) The role of the RNHCI under a waiver declared by the Secretary, in accordance with section 1135 of Act, in the provision of care at an alternative care site identified by emergency management officials. This REQUIREMENT is not met as evidenced by: Based on staff interview and facility document review it was determined that the facility staff failed to have a complete emergency preparedness plan. The facility staff failed to develop policies and procedures in the emergency plan that describe the facility's role in providing care and treatment at altered care sites under an 1135 waiver. The findings include: On 12/01/17 at 10:00 a.m. a review and interview of the facility's emergency preparedness plan was conducted with OSM (other staff member) # 1,	E 026	1. No residents were affected. 2. All residents have the potential to be affected. 3. Policy and procedures will be incorporated into the facility's Emergency Preparedness Plan (EPP) by the Center Executive Director/designee, specific to the facility's role in providing care and treatment at altered care sites under an 1135 waiver. The Center Executive Director/designee will include this information in the emergency-preparedness training for all facility staff. 4. Center Executive Director will share this information from the EPP at the monthly QAPI Committee meeting for education and review purposes, and will review twice annually to determine continued completeness and accuracy, sharing results with the QAPI committee.	1/17/18

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E 026	Continued From page 13 director of maintenance. Review of the facility's emergency preparedness plan failed to evidence policies and procedures in the emergency plan that describe the facility's role in providing care and treatment at altered care sites under an 1135 waiver. OSM # 1 stated that the facility did not have it. On 12/06/17 at approximately 5:00 p.m. ASM (administrative staff member) # 1, the executive director (administrator), ASM # 2, interim director of nursing and ASM # 3, clinical quality specialist, were made aware of the findings. No further information was obtained prior to exit.	E 026		
E 032 SS=C	Primary/Alternate Means for Communication CFR(s): 483.73(c)(3) [(c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least annually.] The communication plan must include all of the following: (3) Primary and alternate means for communicating with the following: (i) [Facility] staff. (ii) Federal, State, tribal, regional, and local emergency management agencies. *[For ICF/IIDs at §483.475(c):] (3) Primary and alternate means for communicating with the ICF/IID's staff, Federal, State, tribal, regional, and local emergency management agencies. This REQUIREMENT is not met as evidenced by: Based on staff interview and facility document	E 032	1. No residents were affected. 2. All residents have the potential to be affected . 3. Documentation will be incorporated into the facility's Emergency Preparedness Plan (EPP) by the Center Executive Director/designee, specific to primary and alternate means for communicating with facility staff, Federal, State, tribal and local emergency management agencies during an emergency situation. The Center Executive Director/designee will include this information in the emergency-preparedness training for all facility staff.	

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E 032	Continued From page 14 review it was determined that the facility staff failed to have a complete emergency preparedness plan. The facility staff failed to provide evidence of documentation that the communication plan includes primary and alternate means for communicating with facility staff, Federal, State, tribal, and local emergency management agencies by reviewing the communication plan. The findings include: On 12/01/17 at 10:00 a.m. a review and interview of the facility's emergency preparedness plan was conducted with OSM (other staff member) # 1, director of maintenance. Review of the facility's emergency preparedness plan failed to evidence of documentation that the communication plan includes primary and alternate means for communicating with facility staff, Federal, State, tribal, and local emergency management agencies by reviewing the communication plan. OSM # 1 stated that the facility did not have it. On 12/06/17 at approximately 5:00 p.m. ASM (administrative staff member) # 1, the executive director (administrator), ASM # 2, interim director of nursing and ASM # 3, clinical quality specialist, were made aware of the findings. No further information was obtained prior to exit.	E 032	4. Center Executive Director will share this information from the EPP at the monthly QAPI Committee meeting for education and review purposes, and will review twice annually to determine continued completeness and accuracy, sharing results with the QAPI committee.	1/17/18
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	E 033		

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E 033	Continued From page 15 and must be reviewed and updated at least annually.] The communication plan must include all of the following: (4) A method for sharing information and medical documentation for patients under the [facility's] care, as necessary, with other health providers to maintain the continuity of care. (5) A means, in the event of an evacuation, to release patient information as permitted under 45 CFR 164.510(b)(1)(ii). [This provision is not required for HHAs under §484.22(c), CORFs under §485.68(c), and RHCs/FQHCs under §491.12(c).] (6) [(4) or (5)]A means of providing information about the general condition and location of patients under the [facility's] care as permitted under 45 CFR 164.510(b)(4). *[For RNHCIs at §403.748(c):] (4) A method for sharing information and care documentation for patients under the RNHCI's care, as necessary, with care providers to maintain the continuity of care, based on the written election statement made by the patient or his or her legal representative. *[For RHCs/FQHCs at §491.12(c):] (4) A means of providing information about the general condition and location of patients under the facility's care as permitted under 45 CFR 164.510(b)(4). This REQUIREMENT is not met as evidenced by: Based on staff interview and facility document review it was determined that the facility staff failed to have a complete emergency	E 033		

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E 033	Continued From page 16	E 033		

preparedness plan.

The facility staff failed to provide evidence of documentation that the communication plan includes a method for sharing information and medical documentation for patients under the facility's care, as necessary, with other health providers to maintain the continuity of care by reviewing the communication plan and documentation that the facility has developed policies and procedures that address the means the facility will use to release patient information to include the general condition and location of patients by reviewing the communication plan.

The findings include:

On 12/01/17 at 10:00 a.m. a review and interview of the facility's emergency preparedness plan was conducted with OSM (other staff member) # 1, director of maintenance. Review of the facility's emergency preparedness plan failed to provide evidence of documentation that the communication plan includes a method for sharing information and medical documentation for patients under the facility's care, as necessary, with other health providers to maintain the continuity of care by reviewing the communication plan and documentation that the facility has developed policies and procedures that address the means the facility will use to release patient information to include the general condition and location of patients by reviewing the communication plan. OSM # 1 stated that the facility did not have it.

On 12/06/17 at approximately 5:00 p.m. ASM (administrative staff member) # 1, the executive director (administrator), ASM # 2, interim director

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E 033	Continued From page 17 of nursing and ASM # 3, clinical quality specialist, were made aware of the findings. No further information was obtained prior to exit.	E 033		
E 034 SS=C	Information on Occupancy/Needs CFR(s): 483.73(c)(7) [(c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least annually.] The communication plan must include all of the following: (7) [(5) or (6)] A means of providing information about the [facility's] occupancy, needs, and its ability to provide assistance, to the authority having jurisdiction, the Incident Command Center, or designee. *[For ASCs at 416.54(c)]: (7) A means of providing information about the ASC's needs, and its ability to provide assistance, to the authority having jurisdiction, the Incident Command Center, or designee. *[For Inpatient Hospice at §418.113:] (7) A means of providing information about the hospice's inpatient occupancy, needs, and its ability to provide assistance, to the authority having jurisdiction, the Incident Command Center, or designee. This REQUIREMENT is not met as evidenced by: Based on staff interview and facility document review it was determined that the facility staff failed to have a complete emergency preparedness plan.	E 034	1. No residents were affected. 2. All residents have the potential to be affected 3. Documentation will be incorporated into the facility's Emergency Preparedness Plan (EPP) by the Center Executive Director/designee, specific to a means of providing information to the authority having jurisdiction, the incident Command Center/designee about the facility's needs, their occupancy and its ability to provide assistance. The Center Executive Director/designee will include this information in the emergency-preparedness training for all facility staff. 4. Center Executive Director will share this information from the EPP at the monthly QAPI Committee meeting for education and review purposes, and will review twice annually to determine continued completeness and accuracy, sharing results with the QAPI committee.	1/17/18

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E 034	Continued From page 18 The facility staff failed to provide evidence of documentation that the communication plan includes a a means of providing information about the facility's needs, and its ability to provide assistance, to the authority having jurisdiction, the incident Command Center, or designee by reviewing the communication plan and documentation that the communication plan includes a means of providing information about their occupancy. The findings include: On 12/01/17 at 10:00 a.m. a review and interview of the facility's emergency preparedness plan was conducted with OSM (other staff member) # 1, director of maintenance. Review of the facility's emergency preparedness plan failed to provide evidence of documentation that the communication plan includes a a means of providing information about the facility's needs, and its ability to provide assistance, to the authority having jurisdiction, the incident Command Center, or designee by reviewing the communication plan and documentation that the communication plan includes a means of providing information about their occupancy. OSM # 1 stated that the facility did not have it. On 12/06/17 at approximately 5:00 p.m. ASM (administrative staff member) # 1, the executive director (administrator), ASM # 2, interim director of nursing and ASM # 3, clinical quality specialist, were made aware of the findings. No further information was obtained prior to exit.	E 034		
E 035	LTC and ICF/IID Sharing Plan with Patients	E 035		

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E 035 SS=C	Continued From page 19 CFR(s): 483.73(c)(8) [(c) The [LTC facility and ICF/IID] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least annually.] The communication plan must include all of the following: (8) A method for sharing information from the emergency plan, that the facility has determined is appropriate, with residents [or clients] and their families or representatives. This REQUIREMENT is not met as evidenced by: Based on staff interview and facility document review it was determined that the facility staff failed to have a complete emergency preparedness plan. The facility staff failed to provide evidence of documentation that the communication plan includes a method for sharing information from the emergency plan, and that the facility has determined it is appropriate with residents or clients and their families or representatives by reviewing the plan. The findings include: On 12/01/17 at 10:00 a.m. a review and interview of the facility's emergency preparedness plan was conducted with OSM (other staff member) # 1, director of maintenance. Review of the facility's emergency preparedness plan failed to provide evidence of documentation that the communication plan includes a method for sharing information from the emergency plan, and that the facility has determined it is	E 035	1. No residents were affected. 2. All residents have the potential to be affected. 3. Documentation will be incorporated into the facility's Emergency Preparedness Plan (EPP) by the Center Executive Director/designee, specific to a method for sharing information from the EPP with residents and their families or representatives. Center Executive Director/designee will communicate this information to residents, families and their representatives as part of the EPP education. The Center Executive Director/designee will include this information in the emergency-preparedness training for all facility staff. 4. Center Executive Director will share this information from the EPP at the monthly QAPI Committee meeting for education and review purposes, and will review twice annually to determine continued completeness and accuracy, sharing results with the QAPI committee.	1/17/18

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E 035	Continued From page 20 appropriate with residents or clients and their families or representatives by reviewing the plan. OSM # 1 stated that the facility did not have it. On 12/06/17 at approximately 5:00 p.m. ASM (administrative staff member) # 1, the executive director (administrator), ASM # 2, interim director of nursing and ASM # 3, clinical quality specialist, were made aware of the findings. No further information was obtained prior to exit.	E 035		
E 036 SS=C	EP Training and Testing CFR(s): 483.73(d) (d) Training and testing. The [facility] must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least annually. *[For ICF/IIDs at §483.475(d):] Training and testing. The ICF/IID must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least annually. The ICF/IID must meet the requirements for evacuation drills and training at §483.470(h).	E 036	1. No residents were affected. 2. All residents have the potential to be affected. 3. Documentation will be incorporated into the facility's Emergency Preparedness Plan (EPP) by the Center Executive Director/designee, specific to a written training and testing program that meets the requirements of the regulation 4. Center Executive Director will ensure that the emergency-preparedness training and testing program has been documented, reviewed, completed for all facility staff, and updated at least annually per regulation, and will share these findings at the monthly QAPI Committee meeting for its review to determine continued compliance.	1/17/18

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E 036	Continued From page 21	E 036		

*[For ESRD Facilities at §494.62(d):] Training, testing, and orientation. The dialysis facility must develop and maintain an emergency preparedness training, testing and patient orientation program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training, testing and orientation program must be reviewed and updated at least annually.
This REQUIREMENT is not met as evidenced by:
Based on staff interview and facility document review it was determined that the facility staff failed to have a complete emergency preparedness plan.

The facility staff failed to provide evidence of documentation that the facility has a written training and testing program that meets the requirements of the regulation and documentation that the training and testing program has been reviewed and updated on, at least an annual basis by asking for documentation of the annual review as well as any updates made.

The findings include:

On 12/01/17 at 10:00 a.m. a review and interview of the facility's emergency preparedness plan was conducted with OSM (other staff member) # 1, director of maintenance. Review of the facility's emergency preparedness plan failed to provide evidence of that the facility has a written training and testing program that meets the requirements

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E 036	Continued From page 22 of the regulation and documentation that the training and testing program has been reviewed and updated on, at least an annual basis by asking for documentation of the annual review as well as any updates made. OSM # 1 stated that the facility did not have it. On 12/06/17 at approximately 5:00 p.m. ASM (administrative staff member) # 1, the executive director (administrator), ASM # 2, interim director of nursing and ASM # 3, clinical quality specialist, were made aware of the findings. No further information was obtained prior to exit.	E 036		
E 037 SS=C	EP Training Program CFR(s): 483.73(d)(1) (1) Training program. The [facility, except CAHs, ASCs, PACE organizations, PRTFs, Hospices, and dialysis facilities] must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected role. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. *[For Hospitals at §482.15(d) and RHCs/FQHCs at §491.12:] (1) Training program. The [Hospital or RHC/FQHC] must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing on-site services under arrangement, and volunteers, consistent with their	E 037	1. No residents were affected. 2. All residents have the potential to be affected. 3. Documentation will be incorporated into the facility's Emergency Preparedness Plan (EPP) by the Center Executive Director specific to facility staff receiving initial and annual emergency-preparedness training. Center Executive Director will oversee all aspects of this training. 4. Center Executive Director will ensure that the initial and annual emergency-preparedness training has been implemented and completed for all facility staff consistent with regulation, and will share these findings at the monthly QAPI Committee meeting for its review to determine continued compliance.	1/17/18

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E 037	Continued From page 23 expected roles. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. This is what's in SOM but is missing here. *[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	E 037		

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E 037	Continued From page 24 preparedness training. *[For PACE at §460.84(d):] (1) The PACE organization must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing on-site services under arrangement, contractors, participants, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least annually. (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:	E 037		

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E 037	Continued From page 25 (i) Initial training in emergency preparedness policies and procedures, including prompt reporting and extinguishing of fires, protection, and where necessary, evacuation of patients, personnel, and guests, fire prevention, and cooperation with firefighting and disaster authorities, to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. *[For CMHCs at §485.920(d):] (1) Training. The CMHC must provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles, and maintain documentation of the training. The CMHC must demonstrate staff knowledge of emergency procedures. Thereafter, the CMHC must provide emergency preparedness training at least annually. This REQUIREMENT is not met as evidenced by: Based on staff interview and facility document review it was determined that the facility staff failed to have a complete emergency preparedness plan. The facility staff failed to provide evidence of documentation of the facility's initial emergency preparedness training and annual emergency preparedness training offerings and documentation that facility staff have received	E 037		

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E 037	Continued From page 26 initial & annual emergency preparedness training. The findings include: On 12/01/17 at 10:00 a.m. a review and interview of the facility's emergency preparedness plan was conducted with OSM (other staff member) # 1, director of maintenance. Review of the facility's emergency preparedness plan failed to provide evidence of documentation of the facility's initial emergency preparedness training and annual emergency preparedness training offerings and documentation that facility staff have received initial & annual emergency preparedness training. OSM # 1 stated that the facility did not have it and that not all staff had been trained. On 12/06/17 at approximately 5:00 p.m. ASM (administrative staff member) # 1, the executive director (administrator), ASM # 2, interim director of nursing and ASM # 3, clinical quality specialist, were made aware of the findings. No further information was obtained prior to exit.	E 037		
E 039 SS=C	EP Testing Requirements CFR(s): 483.73(d)(2) (2) Testing. The [facility, except for LTC facilities, RNHCIs and OPOs] must conduct exercises to test the emergency plan at least annually. The [facility, except for RNHCIs and OPOs] must do all of the following: *[For LTC Facilities at §483.73(d):] (2) Testing. The LTC facility must conduct exercises to test the emergency plan at least annually, including unannounced staff drills using the emergency procedures. The LTC facility must do all of the	E 039	1. No residents were affected. 2. All residents have the potential to be affected. 3. Documentation will be incorporated into the facility's Emergency Preparedness Plan (EPP) by the Center Executive Director/designee, specific to the facility's related exercises, exercise analyses and responses, and how the facility updated it	

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E 039	Continued From page 27 following:] (i) Participate in a full-scale exercise that is community-based or when a community-based exercise is not accessible, an individual, facility-based. If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in a community-based or individual, facility-based full-scale exercise for 1 year following the onset of the actual event. (ii) Conduct an additional exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, facility-based. (B) A tabletop exercise that includes a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or 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	E 039	EPP based on the exercise analyses and responses. Center Executive Director will oversee all aspects of this training toward timely completion and compliance per regulation. 4. Center Executive Director will ensure that the EPP exercises, exercise analyses and responses and related plan updates are conducted, completed and documented consistent with regulations, and will share these findings at the monthly QAPI Committee meeting for its review to determine continued compliance.	1/17/18

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E 039	Continued From page 28 emergency plan. (ii) Analyze the [RNHCI's and OPO's] response to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCI's and OPO's] emergency plan, as needed. This REQUIREMENT is not met as evidenced by: Based on staff interview and facility document review it was determined that the facility staff failed to have a complete emergency preparedness plan. The facility staff failed to provide evidence of documentation of the facility's exercise analysis and response and how the facility updated its emergency program based on the exercise analysis. The findings include: On 12/01/17 at 10:00 a.m. a review and interview of the facility's emergency preparedness plan was conducted with OSM (other staff member) # 1, director of maintenance. Review of the facility's emergency preparedness plan failed to provide evidence of documentation of the facility's exercise analysis and response and how the facility updated its emergency program based on the exercise analysis. OSM # 1 stated that the facility did not have it. On 12/06/17 at approximately 5:00 p.m. ASM (administrative staff member) # 1, the executive director (administrator), ASM # 2, interim director of nursing and ASM # 3, clinical quality specialist, were made aware of the findings. No further information was obtained prior to exit.	E 039		

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F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted from 12/4/17 through 12/8/17. One complaint was investigated during the survey. Significant corrections are required for compliance with the following 42 CFR Part 483 of the Federal Long Term Care requirements. An Immediate Jeopardy situation was identified in the area of Quality of Care at a Scope and Severity Level 4, isolated, (F689) which constituted the substandard quality of care. After accepting the plan for removal of Immediate Jeopardy from the Administrator, and determining the Immediate Jeopardy was removed, the deficiency was assigned a scope and severity of Level 2, isolated. The survey sample was not expanded because, during a tour of the facility, all other residents with oxygen were identified and observed, revealing that their oxygen tanks were properly secured. The Life Safety Code survey/report will follow. The census at this 118 certified bed facility was 94 at the time of the survey. The survey sample consisted of 26 current residents Residents #43, 70, 52, 39, 184, 40, 51, 29, 74, 286, 36, 284, 83, 47, 63, 12, 56, 23, 62, 72, 64, 9, 19, 185, 234 and 66 and three closed records, Residents #84, 85 and 86.	F 000		
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	F 550	1. Residents # 47 and # 284 had privacy bags put on their Foley Catheter drainage bags upon discovery and continue to have the privacy bags in place.	

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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 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 observation, staff interview, facility document review and clinical record review, it was determined the facility staff failed to maintain

F 550

2. All residents with Indwelling Catheters have the potential to be affected. 100% audit was completed by the Unit Managers for all current residents with indwelling catheters to ensure that they all have privacy bags in place, any deviations were corrected immediately.

3. Education was provided to nursing staff by the Nurse Practice Educator or the Nursing Supervisor related to providing dignity for residents with indwelling catheters.

4. Unit Managers will audit all residents with indwelling catheters 3 times a week for 6 weeks and then randomly thereafter to ensure privacy is provided for these residents. Results of audits will be brought to the Quality Assurance and Performance Improvement Committee for follow up monthly. 1/17/18

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dignity for two of 29 residents in the survey sample, Residents #47 and #284.

1. The facility staff failed to provide privacy for Resident #47's urinary catheter collection bag.

2. The facility staff failed to provide privacy for Resident # 284's catheter collection bag.

The findings include:

1. The facility staff failed to provide privacy for Resident #47's urinary catheter collection bag.

Resident #47 was admitted to the facility on 10/26/17 and readmitted on 11/22/17. Resident #47's diagnoses included but were not limited to: diabetes, chronic kidney disease and adult failure to thrive. Resident #47's most recent MDS (minimum data set), a five day Medicare assessment with an ARD (assessment reference date) of 11/29/17, coded the resident's cognition as moderately impaired. Section G coded Resident #47 as being totally dependent of two or more staff with transfers, and as requiring extensive assistance of two or more staff with bed mobility, dressing and personal hygiene. Section H coded Resident #27 as having an indwelling catheter (1).

Review of Resident #47's clinical record revealed a physician's order dated 11/5/17 for a catheter and to check the placement of the privacy bag every shift.

Resident #47's comprehensive care plan initiated on 10/30/17 failed to document information regarding privacy of the catheter collection bag.

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F 550	Continued From page 32 On 12/4/17 at 12:12 p.m. and 1:09 p.m. Resident #47 was observed lying in bed. The resident's catheter collection bag was attached to the bed frame and was uncovered. Yellow urine was observed in the collection bag. A blue privacy cover was observed attached to the bed frame next to the collection bag. On 12/6/17 at 12:05 p.m. an interview was conducted with CNA (certified nursing assistant) #6. CNA #6 was asked how staff maintains dignity for a resident with a catheter. CNA #6 stated, "We have a privacy bag." CNA #6 stated the privacy bag should be used at all times including when the resident is in and out of the room. On 12/6/17 at 12:08 p.m. an interview was conducted with RN (registered nurse) #1. RN #1 was asked how staff maintains dignity for a resident with a catheter. RN #1 stated a privacy cover is placed over the drainage bag. When asked if the privacy bag should be used in the room, RN #1 stated, "Yes." RN #1 stated the privacy bag can be attached to the wheelchair or the bed. On 12/6/17 at 5:45 p.m. ASM (administrative staff member) #1 (the executive director), ASM #2 (the interim director of nursing) and ASM #3 (the clinical quality specialist) were made aware of the above concerns. The facility policy titled, "Resident Rights Under Federal Law" documented, "PURPOSE: To treat each patient with respect and dignity and care for each patient in a manner and in an environment that promotes maintenance or enhancement of his/her quality of life..."	F 550		

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No further information was presented prior to exit.

(1) "A urinary catheter is a tube placed in the body to drain and collect urine from the bladder." This information was obtained from the website: https://medlineplus.gov/ency/article/003981.htm

2. The facility staff failed to provide privacy for Resident # 284's catheter collection bag.

Resident # 284 was admitted to the facility on 11/30/17 with diagnoses that included but were not limited to: atrial fibrillation (1), dysphagia, (2), osteoporosis (3), attention of ileostomy (4) and attention to gastrostomy.

Resident # 284's most recent MDS (minimum data set), an admission assessment was not due at the time of survey.

The facility's "Nursing Assessment-Initial" for Resident # 284 dated 11/30/17 documented, "Orientation to person, place and time; Judgement/Insight-intact and clear speech." Further review of the "Nursing Assessment-Initial" for Resident # 284 documented, "Indwelling catheter."

On 12/05/17 at approximately 10:27 a.m. Resident #284's catheter collection bag was observed hanging on the side of the bed and not in a privacy bag. The catheter collection bag could be observed from the hallway.

On 12/05/17 at approximately 11:25 a.m. Resident #284 was observed dressed, in her wheelchair being pushed down the hall by her

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F 550	Continued From page 34 husband. Observation of the wheelchair revealed the catheter collection bag, uncovered and hanging on the side of the wheelchair. When Resident # 284 was asked how she felt about the catheter bag being exposed, she stated, "I would like it covered." On 12/05/17 at approximately 11:30 a.m. a facility staff member took Resident # 284 from the hallway, back to her room and placed the catheter collection bag into a privacy cover. Review of Resident # 284's care plan dated 11/04/17 failed to evidence a care plan for an indwelling catheter. On 12/06/17 at approximately 2:10 p.m. an interview was conducted with LPN (licensed practical nurse) # 4 regarding the privacy of Resident # 284's catheter collection bag. LPN # 4 stated, "The collection bag should be place in a privacy bag at all times." On 12/06/17 at approximately 5:00 p.m. ASM (administrative staff member) # 1, executive director, ASM # 2, the interim director of nursing and ASM # 3, clinical quality specialist, were made aware of the findings. No further information was obtained prior to exit.	F 550		
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by:	F 558	1. Resident # 12 had call bell placed within reach and continues to have it in place when in her room. Resident # 184 no longer resides in the center. 2. All residents have potential to be affected, as it relates to Call Bells being within reach. House wide audit of current residents	

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 558	Continued From page 35 Based on observation, resident interview, staff interview, facility document review and clinical record review, it was determined, the facility staff failed to provide accommodation to meet the residents' physical needs for two of 29 residents in the survey sample, Resident #12 and #184. 1. The facility staff failed to ensure that Resident #12's call bell was positioned within her reach. 2. The facility staff failed to provide accommodations to meet the physical needs of Resident #184. The findings include: 1. Resident #12 was admitted to the facility on 11/15/10 with a readmission on 5/5/16 with diagnoses that included, but were not limited to: dementia, osteoporosis (weakening of the bones), anemia (low red blood cells), acid reflux disease, depression, difficulty swallowing, and cognitive deficit. Resident #12's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 11/17/17, revealed, in part, that Resident #12 was unable to answer the questions on the BIMS (brief interview of mental status) and was coded on the staff assessment as being severely impaired to make decisions regarding tasks of daily life. Resident #12 was further coded as being dependent on staff for activities of daily living. Resident #12 was observed on the following dates and times; 12/04/17 12:51 p.m Resident #12 lying in bed, head up against the bed rail. Call bell hanging,out of Resident #12's reach,	F 558	completed by Unit Managers to ensure that room is set up to accommodate individual resident needs. 3. Education provided to facility staff related to ensuring residents have call bells within reach when in their rooms, provided by Nurse Practice Educator or supervisor. Education provided to nursing staff by the Nurse Practice Educator or Supervisor on ensuring residents room is set up to best meet their needs. 4. Department Heads will audit Call Bell Placement on daily rounds, and Manager on Duty will audit call bell placement on the weekends. Unit Managers and Supervisors will audit Call Bell Placement randomly 3 times a week for 6 weeks and randomly thereafter. Social Services will audit resident rooms set up to accommodate needs weekly times 6 weeks and then randomly thereafter and with new admissions. Results of audits will be brought to the Quality Assurance and Performance Improvement Committee for follow up monthly.	1/17/18

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from the bed frame. Debris observed on call bell.
12/04/17 01:10 p.m. Call bell hanging off of bed frame, out of Resident # 12's reach.
12/4/17 2:05 p.m. Call bell hanging off of bed frame, out of Resident # 12's reach.

On 12/07/17 11:51 a.m. an interview was conducted with CNA (certified nursing assistant) #14, an aide working on the floor with Resident #12. CNA #14 was asked where a call bell should be placed. CNA #14 stated, "In the area of the resident, in case they have to push for help or need assistance, me personally I place it in their lap." CNA #14 was asked where Resident #12's call bell was placed. CNA #14 stated "She has a "pushy" one, I make her aware, most of the time I put it under her arm so she can push." At this time Resident #12's call bell was observed hanging off the bed. CNA #14 stated "Most of the time she throws it off of the bed when she gets mad." CNA #14 was asked how Resident #12 lets staff know she needs assistance or help when she throws the call bell on the floor. CNA #14 stated "She will scream."

A review of Resident #12's comprehensive care plan dated 5/6/2016 did not reveal any documentation related to Resident #12 throwing her call bell on the floor or screaming for assistance.

Further review of Resident #12's clinical record did not reveal any documentation related to Resident #12 throwing her call bell on the floor or screaming for assistance.

An interview was conducted with ASM (administrative staff member) #2, the interim director of nursing (DON) on 12/7/17 at 12:30

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p.m. ASM #2 was asked if she was aware Resident #12 threw her call bell on the floor. ASM #2 stated she was unaware. ASM #2 further stated the call bell should be placed in her hand whenever she was in the bed. When asked what her expectation was in regards to placement of call bells, the DON stated that the staff should be placing the call bell in the resident's hands or at least within reach.

An end of day meeting occurred on 12/7/17 at 4:45 p.m. with ASM #1, the executive director, ASM #2, the interim director of nursing, and ASM #3, the clinical quality specialist. ASM #1, ASM #2 and ASM #3 were made aware of the above concerns. A facility policy was requested at this time.

A review of the facility policy titled "Call Lights" revealed, in part, the following documentation: "POLICY: All (name of facility company name) patients will have a call light or alternative communication device within their reach at all times when unattended. Staff will respond to call lights and communication devices promptly. PURPOSE: To ensure safety and communication between staff and patients."

No further information was provided prior to the end of the survey process.
2. The facility staff failed to provide accommodations to meet the physical needs of Resident #184.

Resident #184 was admitted to the facility on 11/30/17 with diagnoses that included, but were not limited to: fracture of the left humerus, chronic obstructive pulmonary disease (general term for chronic nonreversible lung disease that is usually

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a combination of emphysema and chronic bronchitis (1)), atrial fibrillation (a condition characterized by rapid and random contraction of the atria of the heart causing irregular beats of the ventricles and resulting in decreased heart output and frequently clot formation in the atria (2)), pulmonary fibrosis (pulmonary fibrosis is a condition in which the tissue deep in your lungs becomes scarred over time. This tissue gets thick and stiff. That makes it hard for you to catch your breath, and your blood may not get enough oxygen (3)), diabetes and high blood pressure.

There was no completed MDS (minimum data set) assessment as of the dates of the survey.

The Initial Nursing Assessment, dated 11/30/17, documented Resident #184 was alert and oriented to person, place and time. The form documented the resident had functional limitation in range of motion in his left arm and had a "device/cast/splint" in place.

Resident #184 was observed on 12/4/17 at 12:00 p.m. in bed, his left arm was in an immobilizer keeping his left arm secured across his chest. He was able to move his fingers but not the rest of his arm.

A resident interview was conducted on 12/04/17 at 2:25 p.m. Resident #184 stated he would like things on his useable side (right side) and to move the bedside table to the other side of the bed. Both his bedside table and night stand were observed located on his left side. Resident #184 stated he had the staff put his "goodie bag" of food treats on the right side of the bed, on the floor, so he could reach them.

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Observation was made of Resident #184's room on 12/5/17, the night stand and the bedside table were observed on the resident's left side.

On 12/6/17 at 10:55 a.m. Resident #184's room was observed. The room had been rearranged so that the bed was observed against the wall, with the night stand to the right of the head of the bed.

An interview was conducted with other staff member (OSM) #9, the occupational therapist on 12/6/17 at 11:08 a.m. OSM #9 was asked when Resident #184 was placed on case load since admission. OSM #9 stated the resident was admitted on Thursday (11/30/17) and occupational therapy worked with him on Friday, Saturday, Monday, Tuesday and this morning. When asked why the room was changed today, OSM #9 stated the social worker had left a message with her boss that the resident would like his room rearranged. He doesn't like the current way the room is arranged (the new way) but we will keep modifying it until we reach a mutually acceptable arrangement." When asked if this should have been done sooner to better accommodate his needs, since Resident #184 has an immobilizer on his left side and has no use of that side, OSM #9 stated, "Yes, it should have been looked at upon his initial assessment and further therapy observations."

The facility policy, "Accommodation of Needs" documented in part, "Residents have the right to reside and receive services in the Center with reasonable accommodation of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. "Reasonable accommodation of

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individual needs and preferences" means the Center's efforts to individualize the patient's physical environment. This includes the physical environment of the resident's bedroom and bathroom, as well as individualized as much as feasible the Center's common living areas. The Center's physical environment and staff behaviors should be directed toward assisting the resident in maintaining and/or achieving independent functioning, dignity and well-being to the extent possible in accordance with the resident's own needs and preferences......1. The center must provide a safe, clean comfortable and homelike environment, allowing the resident to use/his/her personal belongings to the extent possible. This includes ensuring that the resident can receive care and services safely and that the physical layout of the Center maximizes resident independence and does not pose a safety risk."

Administrative staff member (ASM) #1, the executive director, ASM #2, the interim director of nursing, and ASM #3, were made aware of the above concern on 12/7/17 at 4:45 p.m.

No further information was obtained prior to exit.

(1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman; page 124.
(2) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman; page 55.
(3) This information was obtained from the following website:
https://medlineplus.gov/pulmonaryfibrosis.html

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F 580 SS=E	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15)	F 580		

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F 580	Continued From page 41 §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s).	F 580	1. Physician has been notified that resident # 83 medication was not given. Physician was notified of resident # 234 missing 4 doses of antibiotic. Responsible Party was notified of old bruise noted on resident #12's chin. Resident # 56 has been discharged from facility. Resident # 286 is currently in the hospital. These corrections were made by the Unit Managers. 2. All residents with changes of condition have potential to be affected. Audit was completed by Unit Managers, by reviewing 24 hour report and eInteract Changes of condition for the past 30 days to ensure that appropriate notification to physician's and Responsible Parties has been completed and documented. 3. Education provided to licensed nursing staff by the Nurse Practice Educator regarding notifying Physician's and Responsible Parties of changes in resident condition and documentation of this notification. 4. Clinical Management Team including Director of Nursing Services, Unit Managers will audit 24 hour report and changes of condition in the Clinical Morning Meeting 5 days	

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F 580	Continued From page 42 §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview, facility document review and clinical record review, it was determined the facility staff failed to notify the physician of a change in condition or need to alter treatment for five of 29 residents in the survey sample, Residents #83, #234, #12, #56 and #286. 1. The facility staff failed to notify Resident #83's physician when 9:00 p.m. medications were not administered to the resident on 11/3/17. 2. The facility staff failed to notify the physician Resident #234 did not receive four doses of an antibiotic after admission to the facility on 12/4/17. 3. The facility staff failed to notify the RP (responsible party) when a bruise was discovered on Resident #12's chin. 4. The facility staff failed to notify Resident #56's responsible party (RP) when a wound was discovered on her left lower extremity requiring physician intervention. 5. The facility staff failed to notify the physician of	F 580	per week, to ensure that appropriate notifications have been completed and documented. Results of audits will be brought to the QAPI Committee for follow up monthly.	1/17/18

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Resident 286's blood sugar of 454 as ordered by the physician.

The findings include:

1. The facility staff failed to notify Resident #83's physician when 9:00 p.m. medications were not administered to the resident on 11/3/17.

Resident #83 was admitted to the facility on 9/24/17 and readmitted on 11/2/17. Resident #83's diagnoses included but were not limited to: pain in the right knee, muscle weakness and high blood pressure. Resident #83's most recent MDS (minimum data set), a 30 day Medicare assessment with an ARD (assessment reference date) of 11/28/17, coded the resident as cognitively intact.

Review of Resident #83's clinical record revealed the following readmission orders dated 11/2/17:
- carisoprodol (1) 350 mg (milligrams) every night
- Advair diskus (2) 250 micrograms/50 micrograms- one puff twice daily

Review of Resident #83's November 2017 MAR (medication administration record) revealed the resident was not administered the 9:00 p.m. dose of the above medications as evidenced by the nurse circling her initials on the MAR. There was no documentation on the back of the MAR or in the nurses' notes that Resident #83 was out of the facility or that the resident's physician (or nurse practitioner) was notified that the medications were not administered.

Resident #83's comprehensive care plan revised on 11/6/17 documented, "Focus: Resident exhibits or is at risk for alterations in

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comfort...Interventions: Medicate resident as ordered for pain...Focus: Resident exhibits or is at risk for respiratory complications related to Asthma...Interventions: Administer aerosol as ordered/indicated..."

On 12/4/17 at approximately 2:14 p.m. an interview was conducted with Resident #83. The resident stated she did not get her medications for 24 hours after coming back from hospital.

On 12/7/17 at 10:23 a.m. a telephone interview was conducted with LPN (licensed practical nurse) #6 (the nurse responsible for administering the 9:00 p.m. medications to Resident #83 on 11/3/17). LPN #6 was asked who should be notified if medications are not administered to a resident. LPN #6 stated she notifies the supervisor. When asked if she contacts the physician, LPN #6 stated, "I get him involved if need be. If I need another prescription or if I can't find the original one. I don't always notify the physician. It's not always needed and I have got a lot of other things to call him on."

On 12/7/17 at 11:24 a.m. an interview was conducted with LPN #4. LPN #4 stated once a resident is readmitted to the facility, she writes out the medication orders and faxes the orders to the pharmacy. LPN #4 stated the pharmacy usually delivers the medications by the night of admission but this depends on what time the medication list is faxed to the pharmacy. LPN #4 stated she also uses the Omni cell (a machine in the facility that contains various medications) but the Omni cell does not contain all medications. LPN #4 stated if scheduled medications aren't in the Omni cell and haven't been delivered by the pharmacy then she calls the physician.

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On 12/7/17 at 2:23 p.m. ASM (administrative staff member) #1 (the executive director), ASM #2 (the interim director of nursing) and ASM #3 (the clinical quality specialist) were made aware of the above concern.

The facility policy titled, "Medication Shortages/Drugs Not Available" documented, "When medication orders are not received or unavailable, the licensed nurse will immediately initiate action in cooperation with the attending physician and the pharmacy provider. All medication orders unavailable to the patient will be managed with urgency..."

No further information was presented prior to exit.

(1) carisoprodol is used to relax muscles and relieve pain. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a682578.html

(2) Advair diskus is used to treat asthma. This information was obtained from the website: https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=4eeb5f6a-593f-4a9e-9692-adefa2caf8fc

2. The facility staff failed to notify the physician Resident #234 did not receive four doses of an antibiotic after admission to the facility on 12/4/17.

Resident #234 was admitted to the facility on 12/4/17 with the diagnoses of but not limited to: MRSA (methicillin-resistant Staphylococcus aureus) [1] in a wound, Chronic Obstructive Pulmonary Disease, chronic back pain, scoliosis,

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opiate addiction, chronic pain syndrome, and aortic valve endocarditis. An MDS (minimum data set) assessment had not yet been completed. A review of the admission nursing assessment dated 12/4/17 documented the resident as being cognitively intact. The resident was documented as being able to participate in activities of daily living. The resident was also documented as having a PICC (peripherally inserted central catheter) [2] line and requiring oxygen therapy.

A review of the clinical record revealed the "Discharge Medication List" from the hospital, undated, which documented the resident was on Minocycline (an antibiotic) [3] 100 mg (milligrams) twice daily by mouth. A review of the admission orders revealed this medication was written on the facility admission orders as well.

A review of Resident #234's December 2017 MAR (Medication Administration Record) on 12/7/17 at 04:00 p.m., revealed that the Minocycline was not administered until 9:00 p.m. on 12/6/17. The resident had missed 4 doses of the medication since admission.

A review of the pharmacy delivery manifest revealed the Minocycline was filled on 12/4/17 but was not delivered to the facility until 12/5/17 at 5:48 p.m. (See F 755). The resident went over 24 hours without the medication after it was delivered and 2 of the 4 missed doses should have been administered as the medication was available (See F684).

Further review of the clinical record failed to reveal evidence the physician was notified of Resident #234 not receiving this medication for

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several doses as ordered.

On 12/08/17 at 10:32 a.m., RN (Registered Nurse) #2 stated she was contacting the nurse (LPN #7 - Licensed Practical Nurse) from 12/7/17 (who had realized the medication had not been administered and started the medication) about if the doctor was notified of missed doses of Minocycline.

On 12/08/17 at 11:00 a.m. RN #2 stated LPN #7 and LPN #9 (another nurse that had worked with Resident #234) both stated they did not notify the doctor of Resident #234 not getting his Minocycline.

A review of the facility policy, "Changes in Condition: Notification of" did not address notifying the physician of missed doses of medication.

On 12/8/17 at 10:14 a.m., ASM #2 (Administrative Staff Member - the interim director of nursing) and ASM #3 (the corporate Clinical Quality Specialist) were made aware of the findings; and on 12/8/17 at 10:50 a.m., ASM #1 (the Executive Director, Administrator), was made aware of the findings.

No further information was provided by the end of the survey.

[1] MRSA stands for methicillin-resistant Staphylococcus aureus. It causes a staph infection that is resistant to several common antibiotics. There are two types of infection. Hospital-associated MRSA happens to people in health care settings. Community-associated MRSA happens to people who have close

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skin-to-skin contact with others, such as athletes involved in football and wrestling.
Infection control is key to stopping MRSA in hospitals. To prevent community-associated MRSA
*Practice good hygiene
*Keep cuts and scrapes clean and covered with a bandage until healed
*Avoid contact with other people's wounds or bandages
*Avoid sharing personal items, such as towels, washcloths, razors, or clothes
*Wash soiled sheets, towels, and clothes in hot water with bleach and dry in a hot dryer
If a wound appears to be infected, see a health care provider. Treatments may include draining the infection and antibiotics.
Information obtained from
https://medlineplus.gov/mrsa.html

[2] PICK stands for peripherally inserted central catheter. A long catheter that extends from an arm or leg vein into the largest vein (superior vena cava or inferior vena cava) near the heart and typically provides central IV access for several weeks. Unlike a standard intravenous catheter (IV) which is for short term use, a PICC is more durable and does not easily become blocked or infected. It may remain in place for several months so that blood can be repeatedly drawn or medication and nutrients can be routinely injected into the patient's bloodstream.
Information obtained from
https://www.radiologyinfo.org/en/info.cfm?pg=vasc_access

[3] Minocycline is used to treat infections caused by bacteria including pneumonia and other respiratory tract infections; certain infections of

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the skin, eye, lymphatic, intestinal, genital, and urinary systems; and certain other infections that are spread by ticks, lice, mites, and infected animals. Information obtained from https://medlineplus.gov/druginfo/meds/a682101.html

3. The facility staff failed to notify the RP (responsible party) when a bruise was discovered on Resident #12's chin.

Resident #12 was admitted to the facility on 11/15/10 with a readmission on 5/5/16 with diagnoses that included, but were not limited to: dementia, osteoporosis (weakening of the bones), anemia (low red blood cells), acid reflux disease, depression, difficulty swallowing, and cognitive deficit.

Resident #12's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 11/17/17, revealed, in part, that Resident #12 was unable to answer the questions on the BIMS (brief interview of mental status) and was coded on the staff assessment as being severely impaired to make decisions regarding tasks of daily life. Resident #12 was further coded as being dependent on staff for activities of daily living.

A review of Resident #12's clinical record revealed, in part, the following progress note; "Effective Date: 11/8/17 23:20 (11:20 p.m.) Type: Change in Condition. Note: A change in condition has been noted. The symptoms include: Skin wound or ulcer 11/8/2017. Change reported to Primary Care Clinician: (name of clinician notified) 11/8/2017 4:00 p.m. Name of Family / Healthcare agen (agent) notified: SELF

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11/8/2017 4:00 p.m."

Further review of Resident #12's clinical record revealed, in part, a change in condition document dated 11/8/17 that documented, in part, the following; "Old bruise, fadded (sic) bluish color to right chin."

On 12/7/17 at 3:10 p.m. an interview was conducted with LPN (licensed practical nurse) #3, a floor nurse. LPN #3 was asked when he would notify the RP. LPN #3 stated, "I would notify the RP with any change in condition." LPN #3 was asked who he would notify regarding an injury of unknown origin. LPN #3 stated that he would notify the director of nursing, the administrator, the MD (medical doctor) and the RP.

On 12/7/17 3:20 p.m. an interview was conducted with RN (registered nurse) #7, the MDS Coordinator. RN #7 was asked when it was appropriate to notify the RP of a significant change assessment, RN #7 stated whenever a change in condition was found. RN #7 was asked to review Resident #12's progress note dated 11/8/17 regarding a change in condition. RN #7 was asked who was notified regarding the injury. RN #7 stated that it looked like the nurse practitioner was notified. RN #7 was asked who was "Self" that was notified. RN #7 stated that it should have been Resident #12's daughter, "but it looks like they just told her (the resident). They (the nursing staff) should have told the daughter." RN # 7 further stated that she (Resident #12's RP) should have been notified because of the resident's cognitive status and she (Resident #12's RP) was not.

An end of day meeting occurred on 12/7/17 at

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F 580	Continued From page 51 4:45 p.m. with ASM #1, the executive director, ASM #2, the interim director of nursing, and ASM #3, the clinical quality specialist. ASM #1, ASM #2 and ASM #3 were made aware of the above concerns. A facility policy was requested at this time. A review of the facility policy titled "Change in Condition: Notification of (sic)" revealed, in part, the following documentation: "POLICY: A center must immediately inform the patient, consult with the patient's physician, and notify, consistent with his/her authority, the patient's Health Care Decision Maker, where there is: An accident involving the patient which results in injury and has the potential for requiring physician intervention." No further information was provided prior to the end of the survey process. 4. The facility staff failed to notify Resident #56's responsible party (RP) when a wound was discovered on her left lower extremity requiring physician intervention. Resident #56 was admitted to the facility 12/21/12 with diagnoses that included, but were not limited to: dementia, a gastrostomy tube (a tube to deliver feeding directly into the stomach), peripheral vascular disease (poor circulation to the legs), high blood pressure, depression, difficulty swallowing, anemia (low red blood cell count), an irregular heartbeat, and difficulty speaking. Resident #56's most recent MDS (minimum data set), a quarterly assessment with an ARD	F 580		

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F 580	Continued From page 52 (assessment reference date) of 10/13/2017 coded Resident #56 as being unable to answer the questions on the BIMS (brief interview for mental status) and the staff assessment coded Resident #56 as being severely impaired to make decisions regarding task of daily life. Resident #56 was coded as being dependent with activities of daily living. A review of Resident #56's progress notes revealed, in part, the following nurse practitioner note dated 12/1/2017; "Effective Date: 12/1/2017. Visit Type: Wound History of Present Illness: The patient seen on routine/30-day/NF (nursing facility) visit and follow-up of chronic AFib (atrial fibrillation, an irregular heart beat), CVA (cerebral vascular attack - stroke), dementia. SEEN FOR: Wounds. PLAN: L. (left) outer calfe (sic) stage 2 (two) ulcer - Ordered NS (normal saline) wound flush, dry, apply Medihoney [1] (a medically certified honey used to treat wounds) gel & (and) silicone dressing qd (every day)." There was no documentation in the progress evidencing the RP was notified of the wounds. Further review of Resident #56's clinical record did not reveal any documentation the RP was notified of the wound discovered on 12/1/17. The nurse who documented the change in condition in regards to a new wound on Resident #56's left leg on 12/1/17 was not available for interview. On 12/7/17 at 3:10 p.m. an interview was conducted with LPN #3, a floor nurse. LPN #3 was asked when an RP should be contacted. LPN #3 stated, "With any change in condition or change in treatments the RP should be notified."	F 580		

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On 12/7/17 at 3:20 p.m. an interview was conducted with ASM (administrative staff member) #2, the interim director of nursing. ASM #2 was asked when an RP should be notified, ASM #2 stated any time there was a change of condition or change of therapy.

An end of day meeting occurred on 12/7/17 at 4:45 p.m. with ASM #1, the executive director, ASM #2, the interim director of nursing, and ASM #3, the clinical quality specialist. ASM #1, ASM #2 and ASM #3 were made aware of the above concerns. A facility policy was requested at this time.

A review of the facility policy titled "Change in Condition: Notification of" revealed, in part, the following documentation; "A Center must immediately inform the patient, consult with the patient's physician, and notify, consistent with his / her authority, the patient's Health Care Decision Maker, where there is; A significant change in the patient's physical mental, or psychosocial status."

5. The facility staff failed to notify the physician of Resident 286's blood sugar of 454 as ordered by the physician.

Resident #286 was admitted to the facility on 2/15/17 and readmitted on 11/18/17 with diagnoses that included but were not limited to diabetes, stroke, high blood pressure, heart disease, prostate cancer and arthritis.

Resident # 286's most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 11/25/17, coded Resident # 286 as scoring a 15 on the brief

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F 580	Continued From page 54 interview for mental status (BIMS) exam, of a score of 0 - 15, 15 being cognitively for making daily decisions. Resident # 286 was coded as requiring extensive assistance to being totally dependent of one staff member for activities of daily living and supervision of one staff member for eating. Review of the physician's orders dated 11/18/17 documented, "Fingerstick blood sugar AC (before meals) & HS (hour of sleep). Call MD (medical doctor) (if blood sugar is) < (less than) 70 or > (greater than) 400. Review of the December 2017 MAR (medication administration record) documented, "Accuchecks (fingerstick blood sugar) AC + HS. Call MD/NP (nurse practitioner) if BS (blood sugar) <70 >400. Review of LPN (licensed practical nurse) #2's 12/4/17 worksheet documented, "(Name of Resident #286) BS 454." Review of the nurse's notes did not evidence documentation the physician had been notified of Resident #286's elevated blood sugar. 12/07/17 11:18 a.m. An interview was conducted on 12/7/17 with ASM (administrative staff member) #2, the interim director of nursing. When asked when a physician is notified, ASM #2 stated, "Any changes in condition." When asked about Resident #286, ASM #2 stated, "There was an order to call the MD (medical doctor)." 12/07/17 12:48 p.m. An interview was conducted on 12/7/17 at 12:48 p.m. with LPN (licensed practical nurse) #2, the resident's nurse. When	F 580		

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F 580	Continued From page 55 asked when she would notify the physician, LPN #2 stated, "If I find a new wound. If the patient burnt themselves and because he wrote an order to be notified." When asked why the physician was not notified as ordered when Resident #286's blood sugar was 454, LPN #2 stated, "I didn't know there was an order for that." On 12/5/17/ at 5:10 p.m. ASM (administrative staff member) #1, the executive director and ASM #2, the interim director of nursing were made aware of the findings. Review of the facility's policy titled, "Physician/Advanced Practice Provider (APP) Notification" documented, "POLICY. Upon identification of a patient who has a change in condition or abnormal lab (laboratory) values, a licensed nurse will perform appropriate clinical observations and data collection and report to physician/advanced practice provider (APP)." No further information was provided prior to exit.	F 580		
F 583 SS=D	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident.	F 583	1. Resident # 12 and # 9 are having their care provided with privacy, as evidenced by audits. 2. All residents have the potential to be affected. Privacy will be provided for all residents with care. 3. Education was provided to facility staff by the Nurse Practice Educator on ensuring privacy is provided during care, including	

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F 583	Continued From page 56 §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review and clinical record review, it was determined the facility staff failed to provide personal privacy for two of 29 residents in the survey sample, Resident #12 and #9. 1. The facility staff failed to close the window blinds while bathing Resident #12, providing an unrestricted view from the outside into Resident #12's room. 2. The facility staff failed to provide Resident #9 privacy during wound care, by failing to pull the privacy curtain between Resident #9 and her roommate, who was in present in the room during Resident #9's wound care treatment.	F 583	pulling the privacy curtains and the blinds to the outside. Regional Nurse provided education to the Nurse Practioner on providing privacy during wound care. 4. Unit Managers to observe personal care of 5 residents per week to ensure that privacy is provided during care. Director of Nursing will observe Wound Care provided by the Nurse Practitioner once per week for 6 weeks and then randomly thereafter to ensure that privacy is provided. Results of these audits will be brought before the Quality Assurance and Performance Improvement Committee monthly for review.	1/17/18

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The findings include:

1. Resident #12 was admitted to the facility on 11/15/10 with a readmission on 5/5/16 with diagnoses that included, but were not limited to; dementia, osteoporosis (weakening of the bones), anemia (low red blood cells), acid reflux disease, depression, difficulty swallowing, and cognitive deficit.

Resident #12's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 11/17/17, revealed, in part, that Resident #12 was unable to answer the questions on the BIMS (brief interview of mental status) and was coded on the staff assessment as being severely impaired to make decisions regarding tasks of daily life. Resident #12 was further coded as being dependent on staff for activities of daily living.

On 12/07/17 at 09:44 a.m. an observation was made of OSM (other staff member) #11, a student nurse, providing a bed bath to Resident #12. The curtain was pulled around the resident, shielding Resident #56 from people entering into the room, but the window blind was left open allowing people on the outside of the building to observe Resident #12 while being bathed. At the time of the observation Resident # 12 was naked with only a towel across her breasts and across the lower part of her body. When turned to her side, Resident #12's buttocks were exposed to the window.

On 12/07/17 at 09:48 a.m. an interview was conducted with LPN (licensed practical nurse) #2, a floor nurse. LPN #2 was asked what she did

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when providing a resident bed bath to promote privacy. LPN #2 stated, "I keep them covered at all times. If they are alone in the room I close the door and keep them covered If they have a roommate, I close curtain around them and keep them covered. I cover the parts (of the body) I am not bathing." When LPN #2 was asked about the windows, LPN #2 stated, "If the resident is in the "B" bed which is close to the windows I will pull the blinds and close the curtain." LPN #2 was asked why she would do this. LPN #2 stated, "Because if someone walks by outside you would be exposing the resident to someone seeing them. When asked about a resident with dementia. LPN #2 stated, "You still promote/maintain dignity and treat all patients the same."

On 12/07/17 at 11:29 a.m. an interview was conducted with LPN #3, a floor nurse. LPN #3 was asked to describe his process for protecting the privacy of a resident receiving bed bath. LPN #3 stated, "I close their door, pull the curtain and make sure the blinds are closed, I may ask people to leave the room."

On 12/07/17 at 11:35 a.m. an interview was conducted with OSM #11, a student nurse, and OSM #12 the RN (registered nurse) Instructor. OSM #11 was asked her process to ensure dignity and privacy when providing a bed bath to the resident. OSM #11 stated, "I close the curtain and the door. When asked about the windows in a resident room, OSM #11 stated, "Are you referring to the blinds that were open?" When informed of the above observation of the blinds being open during Resident #56's bed bath, OSM #11 stated, " I guess I wasn't sure about the policy here, but it makes sense." When OSM #11

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asked to if she should have ensured the window blinds beside Resident #12's bed were closed when starting Resident #12's bed bath should, OSM #11 stated, "Yes."

On 12/07/17 at 11:49 a.m. an interview was conducted with CNA (certified nursing assistant) #14. CNA #14 was asked how she preserved a resident's privacy during a bed bath. CNA #14 stated, "I protect their privacy. I pull the curtain, make sure they are covered, escort roommate out and any visitors, so they (the resident) can feel comfortable." CNA #14 was asked about the window blinds. CNA #14 stated, "I pull the blinds down, any old peeping Tom can see."

On 12/7/17 at approximately 1:00 p.m. ASM (administrative staff member) #3, the clinical quality specialist, was asked to supply a facility policy on privacy.

A review of the facility policy titled "Resident Rights Under Federal Law" revealed, in part, the following documentation; "PURPOSE: To treat each patient with respect and dignity and care for each patient in a manner and in an environment that promotes maintenance or enhancement of his/her quality of life."

An end of day meeting occurred on 12/7/17 at 4:45 p.m. with ASM #1, the executive director, ASM #2, the interim director of nursing, and ASM #3, the clinical quality specialist. ASM #1, ASM #2 and ASM #3 were made aware of the above concerns.

No further information provided prior to the end of the survey process.
2. The facility staff failed to provide Resident #9

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F 583	Continued From page 60 privacy during wound care, by failing to pull the privacy curtain between Resident #9 and her roommate, who was in present in the room during Resident #9's wound care treatment. Resident #9 was admitted to the facility on 9/14/16 and readmitted on 8/11/17 with diagnoses that included but were not limited to pancreatic cancer, muscle weakness, pressure ulcer [1] to the right buttock, type two diabetes, and hypothyroidism. Resident #9's most recent MDS (minimum data set) assessment was a quarterly assessment with an ARD (assessment reference date) of 11/09/17. Resident #9 was coded as being moderately impaired in cognitive function scoring 09 out of 15 on the BIMS (brief interview for mental status) exam. Resident #9 was coded as requiring extensive assistance from two or more staff with transfers, bed mobility, and toileting, and extensive assistance from one staff member with dressing and personal hygiene. Review of Resident #9's telephone physician orders revealed the following order dated 11/29/17, "Change Medihoney [2] to Santyl [3] ointment to right sacral ulcer, cleanse with normal saline prior qd (everyday)." On 12/06/17 at 08:52 a.m., wound care observation was conducted with ASM (administrative staff member) #4, the Nurse Practitioner and LPN (licensed practical nurse) # 9, the wound care nurse. LPN #9 gathered her supplies and placed them on a clean field. While LPN #9 was setting up her supplies, ASM #4 donned gloves and turned Resident #9 to the right side. ASM #4 undid Resident #9's brief and took off her old dressing to the right buttock. During the wound care observation, both ASM #4	F 583		

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and LPN #9 forgot to pull the privacy curtain between Resident #9 and her roommate. Resident #9's roommate was lying in the bed next to Resident #9. On 12/06/17 at 9:01 a.m., this writer stood on the side of the room next to Resident #9's roommate. Resident #9 was visible from that side of the room.

On 12/07/17 at approximately 8:00 AM, an interview was conducted with LPN #9. When asked how to maintain privacy during wound care, LPN #9 stated she would close the door, pull the curtain, and try to cover up the resident whenever she can. When asked what she would have done differently when providing wound care to Resident #9, LPN #9 stated, "I don't recall pulling the curtain." When asked why it is important to pull the curtain during wound care, LPN #9 stated the curtain should be pulled to maintain privacy.

On 12/07/17 at 4:45 p.m., ASM #1, the executive director, ASM #2, the interim DON (Director of Nursing) and ASM #3, the clinical quality specialist were made aware of the above concerns.

The facility policy titled, "Wound Dressings" document in part, the following: "...7. Explain the procedure and provide privacy."

[1] A pressure ulcer is an inflammation or sore on the skin over a bony prominence (e.g., shoulder blade, elbow, hip, buttocks, or heel), resulting from prolonged pressure on the area, usually from being confined to bed. Most frequently seen in elderly and immobilized persons, decubitus ulcers may be prevented by frequently change of position, early ambulation, cleanliness, and use of

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F 583	Continued From page 62 skin lubricants and a water or air mattress. Also called bedsores. Pressure sores. Barron's Dictionary of Medical Terms for the Non- Medical Reader 2006; Mikel A. Rothenberg, M.D. and Charles F. Chapman. Page 155. [2] Medihoney- "Honey Impregnated dressing used for the treatment of pressure ulcers." This information was obtained from The National Institutes of Health. https://www.ncbi.nlm.nih.gov/pubmed/15944502. [3] Santyl- enzymatic debriding ointment. Digest collagen and necrotic tissue. This information was obtained from the National Institutes of Health. https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=a7bf0341-49ff-4338-a339-679a3f3f953d .	F 583		
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for	F 584	1. The gouges in the wall next to the bed occupied by resident #9 were repaired by the maintenance supervisor during the survey. 2. All residents have the potential to be affected. An inspection of all resident rooms and common areas was completed, and any needed repairs completed. 3. Education was provided to facility staff by the Maintenance Supervisor or Nurse Practice Educator related to ensuring a safe, comfortable and homelike environment for the	

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F 584	Continued From page 63 the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and facility document review, it was determined, the facility staff failed to maintain a clean, comfortable, and homelike environment for one of 29 residents in the survey sample, Resident #9. The facility staff failed to ensure Resident #9's room was free from gouges in the wall next to her bed. The findings include: Resident #9 was admitted to the facility on 9/14/16 and readmitted on 8/11/17 with diagnoses	F 584	residents, to include making Maintenance aware in a timely manner of any repair needs. 4. Management personnel will conduct assigned, regular rounds/inspections of all resident rooms and common areas, to identify and document, among other items, any issues that detract from a safe, comfortable and homelike environment for the residents. Results of these inspections will be discussed at the monthly QAPI Committee meetings.	1/17/18

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F 584	Continued From page 64	F 584		

that included but were not limited to pancreatic cancer, muscle weakness, pressure ulcer to the right buttock, type two diabetes, and hypothyroidism. Resident #9's most recent MDS (minimum data set) assessment was a quarterly assessment with an ARD (assessment reference date) of 11/09/17. Resident #9 was coded as being moderately impaired in cognitive function scoring 09 out of 15 on the BIMS (brief interview for mental status) exam. Resident #9 was coded as requiring extensive assistance from two or more staff with transfers, bed mobility, and toileting, and extensive assistance from one staff member with dressing and personal hygiene.

On 12/04/17 at 03:21 PM, an observation was made of Resident #9. She was sleeping in bed. A few gouges were observed in the wall on the right side of her bed near the side rail. It appeared the gouges were caused by her right side rail.

On 12/06/17 at 07:58 AM, Resident # 9 was lying in bed. The gouges in the wall were observed on the right side of her bed near the side rails.

On 12/07/17 at 03:24 PM, an interview was conducted with OSM (other staff member) #1, the maintenance director. When asked how he is made aware that a resident's room needs repair, OSM #1 stated he tells all staff to submit work orders. OSM #1 stated he keeps work orders at the nurses' station, at the receptionist's desk and rehab (rehabilitation). OSM #1 stated work orders help him keep track of what needs to be fixed because it leaves a paper trail. OSM #1 stated he is also always walking through the unit and will make notes if he notices anything that needs to be fixed. OSM #1 stated that for the

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past 6 weeks, he has been by himself in maintenance. OSM #1 stated he has also spent a lot of his time doing emergency preparedness. When asked if he was aware of any issues in Resident #9's room, OSM #1 stated he was not aware of any issues. This writer followed OSM #1 to Resident #9's room. When asked what he had noticed on Resident #9's wall, OSM #1 stated, "I see that (gouges in the wall on the right side of Resident #9's bed). That's a two-minute fix, touch up paint." OSM #1 stated the wall may also need to be patched. When asked if it was homelike for her wall to have gouges in it, OSM #1 stated, "Oh, no. Shouldn't be like that." OSM #1 stated no one had made him aware of the gouges in the wall.

On 12/07/17 at 3:30 p.m. an interview was conducted with CNA (certified nursing assistant) #9. A CNA who was assigned to Resident #9. CNA #9 stated he frequently worked with Resident #9. When asked how long he had noticed the wall with the gouges on the right side of Resident #9's bed, CNA #9 stated the wall had been like that for a few weeks. When asked if he had reported this to anyone, CNA #9 stated, "No." CNA #9 could not explain why he didn't report the wall to maintenance or any other staff.
On 12/07/17 at 4:45 p.m., ASM (administrative staff member) #1, the executive director, ASM #2, the interim DON (Director of Nursing) and ASM #3, the clinical quality specialist was made aware of the above concerns.
The facility policy titled, "Accommodation of Needs" documents in part the following: "The resident has the right to a safe, clean, comfortable, and homelike environment including but not limited to, receiving treatment and supports for daily living safely. The center must

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F 584	Continued From page 66 provide...1.2 Housekeeping and maintenance services necessary to maintain a sanitary orderly, and comfortable interior." No further information was presented prior to exit.	F 584		
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 by: Based on observation, resident interview, staff interview and clinical record review, it was determined that the facility staff failed to implement policies and procedures for the prevention of abuse and neglect for two of 29 residents in the survey sample, Residents # 66 and # 12. 1. The facility staff failed to implement their abuse policies and procedures for an allegation of abuse for Resident # 66; the facility did not follow their abuse policy in regards to the following: "Identification of possible incidents or allegations which need investigation; Investigation of incidents and allegations; Protection of patients during investigations; and Reporting of incidents, investigations, and Center response to the results	F 607	1. Investigations were not completed on these past events for residents # 66 and # 12. Resident #66 still resides in the facility without further incident. Accused CNA received abuse training as part of this Plan of Correction. Resident # 12 was seen by the Nurse Practitioner to examine both identified areas and addressed accordingly (forehead and chin). No further injuries noted for this resident. All future investigations will be completed thoroughly, timely and per policy and regulation. Administrator and Director of Nursing are responsible for investigating and reporting. 2. All residents have potential to be affected. An audit was completed by the Nursing Leadership team with a review of the 24 hour reports, eInteract Change of Condition and Incident Reporting for the past 30 days to ensure all events were investigated appropriately with follow up, conclusion and reported accordingly.	

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F 607	Continued From page 67 of their investigations." 2. The facility staff failed to implement their abuse policies and procedures when Resident #12 had two separate incidents of injuries of unknown origin. The findings include: 1. The facility staff failed to implement their abuse policies and procedures for an allegation of abuse for Resident # 66; the facility did not follow their abuse policy in regards to the following: "Identification of possible incidents or allegations which need investigation; Investigation of incidents and allegations; Protection of patients during investigations; and Reporting of incidents, investigations, and Center response to the results of their investigations." On 12/8/17 at approximately 12:30 p.m., all allegations of abuse since the previous survey were requested from the administrator. At approximately 12:40 p.m. the allegations were provided and one resident was selected for review, Resident #66. Resident # 66 was admitted to the facility on 1/16/17 with diagnoses that included but were not limited to: hypertension, rheumatoid arthritis, gout, and anxiety. Resident # 66's most recent MDS (minimum data set) assessment, a Quarterly Assessment, with an ARD (assessment reference date) of 11/3/17 coded Resident # 66 as usually understood by others and as able to usually understand others. Resident # 66 was coded as being moderately impaired for making daily decisions, scoring 10	F 607	3. Education was provided to the nursing staff by the Nurse Practice Educator related to reporting any identified injury, bruising ect. Abuse Policy and Procedure also reviewed with facility staff. 4. Nurse Management team to audit 24 hour reports, eInteract Change of Conditions, and Incident Reports in Clinical Morning Meeting to ensure all events have appropriate follow up investigations completed and reported according to policy and regulation. Results of these audits will be brought before the Quality Assurance and Performance Improvement Committee monthly for review.	1/17/18

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out of 15 on the BIMS (brief interview for mental status).

A Review of the FRI (facility reported incident) Incident for Resident #66 dated: 3/27/2017, revealed the following was documented on the FRI form: "Incident type: Allegation of abuse/mistreat. Describe incident, including location, and action taken: On 3/27/2017: (name of Resident # 66) alleged that she was slapped by CNA (certified nurse's assistant) about a month ago. She also stated that she slapped the CNA back. The resident's face was assessed for injuries and no injuries were noted. On 3/27/2017: Resident told her daughter that she was slapped by CNA and received a skin tear on her arm, from fingernails while she was being restrained. Initial investigation: The resident was combative in bed and was transferred to a wheelchair using a mechanical lift by two CNAs. The injury sustained during transfer was a skin tear to the RT (right) Forearm measuring 6 cm (centimeter). She is on anticoagulation therapy and has fragile skin. Name of employee(s) involved and their positions: CNA # 12
LPN (licensed practical nurse) # 14 (initial investigator), LPN # 5

Final Report on (Name of Resident # 66) dated 4/2/2017 Notation made that the Office of Licensure and Certification received a copy. Documented in part below:
Initial investigation: "On 3/27/2017: The resident was combative in bed and was transferred to a wheelchair using a mechanical lift by two staff members. The injury sustained during transfer was a skin tear to the right forearm measuring 6 cm. She is on anticoagulation therapy, Lovenox (a blood thinner) 30 s.c. (sic) [subcutaneous] daily

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and has fragile skin. She is also susceptible to bruising. Investigation and Actions Taken: 3/27/2017: Resident's skin was assessed and she had sustained a skin tear on the right forearm and there was purple and yellow bruising around the area. On 3/27/2017: Statements were obtained from all individuals involved. 3/28/2017: An interview of residents who were deemed competent was conducted by the Unit Social Worker. All residents interviewed reported proper care on the evening shift; no reports of any instances of neglect or mishandling by staff." "Conclusion: Allegations of abuse were unsubstantiated. The dates and times reported by the resident were not consistent. No evidentiary data collected from the allegation of being slapped was identified. Investigation of the incident revealed that the resident sustained a skin tear during transfer; no injury to resident's face. She was transferred from bed to chair because of her level of agitation. The transfer was conducted by two individuals per facility policy & procedure."

On 12/8/17 at 12:50 CNA (certified nursing assistant) #12's employee record was requested from ASM (Administrative Staff Member) #1, the Executive Director. The file was reviewed and did not reveal any concerns.

12/8/17 at 1:00 p.m., an interview was conducted with ASM #1, regarding the allegation of abuse for Resident #66. ASM #1 stated, "Have no supporting documents, I can find nothing. I can't give you a confirmation of the fax (indicating this allegation had been reported to the state agency)." When asked about the witness statements, ASM #1 stated, "I can find nothing. I can't find evidence it was thoroughly investigated

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to show it (the allegation of abuse) was unsubstantiated." At this time CNA #12's time card for 3/27/17 forward was requested.

On 12/8/17 at 1:20 p.m., ASM #1 provided the time card for CNA #12 and stated, "It gets even better, she was working."

A review of CNA #12's time card documented in part the following:
"Time period 3/27/2017 -4/2/2017:
Sun (Sunday) 3/26+ In: 11:01 PM 5509/Direct Care/Dove/ Out 7:16 AM
Mon (Monday)3/27+ In: 11:02 PM 5509/Direct Care/Dove/ Out 7:45 AM
Tue (Tuesday) 3/28+ In: 11:06 PM 5509/Direct Care/Dove/ Out 8:18 AM
Wed (Wednesday) 3/29+ In: 10:55 PM 5509/Direct Care/Dove/ Out 7:01 AM
Thur (Thursday) 3/30+ In: 11:06 PM 5509/Direct Care/Dove/ Out 7:20 AM
Fri (Friday) 3/31+ In: 11:05 PM Out: 7:39 AM
Sat (Saturday) 4/01+ In: 11:12 PM 5509/Direct Care/Dove/ Out: 7:24 AM
Sun (Sunday) 4/02 (no time in or out documented)."

On 12/8/17 at approximately 1:35 p.m. the FRI for Resident #66 was reviewed with ASM #1 for the time the allegation was reported on 3/27/17. ASM #1 reviewed the FRI and stated, "I do not see a time." When asked if CNA #12 should have continued working and caring for residents after the allegation of abuse was reported, ASM #1 stated, "Absolutely should have been put on admin (administrative) leave pending investigation. Should have completed our investigation and if substantiated would have terminated the employee and reported her to the

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licensing board. If it was unsubstantiated, then would have abuse identification education. The RP (responsible party), MD (medical doctor), ombudsman, Licensing office (OLC [Office of Licensure and Certification]) would be notified and a fax sent. I have no evidence to support this was completed." When asked if the facility policy and procedures for abuse prevention had been followed, ASM #1 stated, "Based on this evidence, no. There is no evidence of investigation, such as interviews, no supporting documents showing the investigation was done. The FRI documents individual interviews were done, but I am unable to produce them."

On 12//8/17 at approximately 1:45 p.m., a copy of the facility abuse prevention policy and procedures were obtained. ASM #1 was informed of the concern and stated, "It is pretty straight forward."

Review of the facility policy "Abuse Prohibition" documented the following: Under "POLICY:" Genesis HealthCare Centers will prohibit abuse, mistreatment, neglect, misappropriation of resident property, and exploitation for all residents. This include, but is not limited to, freedom from corporal punishment, involuntary seclusion, and any physical or chemical restraint not required to treat the patient's medical symptoms. The Center will implement an abuse prohibition program through the following:
Screening of potential hires;
Training of employees (both new employees and ongoing training for all employees);
Prevention of occurrences;
Identification of possible incidents or allegations which need investigation; Investigation of incidents and allegations;

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F 607	Continued From page 72 Protection of patients during investigations; and Reporting of incidents, investigations, and Center response to the results of their investigations. Under "PURPOSE" The following was documented in part: "To ensure Center staff are doing all that is within their control to prevent occurrences of abuse, mistreatment, neglect, exploitation, involuntary seclusion, injuries of unknown source, and misappropriation of property for all patients." Under "PROCESS: 1. The Center Executive Director, or designee is responsible for operationalizing policies and procedures that prohibit abuse, neglect, involuntary seclusion. Injuries of unknown source, exploitation, and misappropriation of property. ... 4. Actions to prevent abuse, neglect, exploitation, or mistreatment, including injuries of unknown source and misappropriation of resident property ... 5. Staff will identify events - such as suspicious bruising of patients, occurrences, patterns, and trends that may constitute abuse --- and determine the direction of the investigation ... 5.1 Anyone who witnesses an incident of suspected abuse, neglect, involuntary seclusion, injuries of unknown origin, or misappropriation of patient property is to tell the abuser to stop immediately and report the incident to his/her supervisor immediately. 5.1.1 The notified supervisor will report the suspected abuse immediately to the Center Executive Director (CED) or designee and other officials in accordance with state law ... 5.1.2 The employee alleged to have committed the act of abuse will be immediately removed from duty, pending investigation. 5.1.3 All reports of suspected abuse must also be reported to the patient's family and attending physician ... 5.3 Injuries of unknown origin will be investigated to determine if abuse or neglect is suspected. 6.	F 607		

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F 607	Continued From page 73 Upon receiving information concerning a report of suspected or alleged abuse, mistreatment, or neglect, the CED or designee will perform the following. 6.1 Enter allegation into the Risk Management System (RMS). 6.2 Report allegations involving abuse (physical, verbal, sexual, mental) not later than two hours after the allegation is made. 6.3 Report allegations involving neglect, exploitation or mistreatment (including injuries of unknown source) and misappropriation of resident property not later than two hours after the allegation is made if the event results in serious bodily injury ...6.4 Report allegations involving neglect, exploitation or mistreatment (including injuries of unknown source) and misappropriation of resident property within 24 hours if the event does not result in serious bodily injury. 6.5 Notify local law enforcement, Licensing Boards and Registries, and other agencies as required ... 6.7 Initiate an investigation within 24 hours of an allegation of abuse that focuses on: 6.7.1 whether abuse or neglect occurred and to what extent; 6.7.2 clinical examination for signs of injuries, if indicated; 6.7.3 causative factors; and 6.7.4 interventions to prevent further injury. 6.8 The investigation will be thoroughly documented.... Ensure that documentation of witnessed interviews is included. 7. The Center will protect patients from further harm during an investigation. 7.1 Provide the patient with a safe environment by identifying persons with whom he/she feels safe and conditions that would feel safe ...8. The CED or designee will: 8.1 Take all necessary corrective action depending on the results of the investigation; 8.2 Report findings of all completed investigations within fire (5) working days to the Department of Health using the state on-line reporting system or state-approved forms ...10.	F 607		

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All documentation related to allegations of abuse will be maintained at the Center for not less than three (3) years."

No further information was provided by completion of the survey process
2. The facility staff failed to implement their abuse policies and procedures when Resident #12 had two separate incidents of injuries with unknown origin.

Resident #12 was admitted to the facility on 11/15/10 with a readmission on 5/5/16 with diagnoses that included, but were not limited to; dementia, osteoporosis (weakening of the bones), anemia (low red blood cells), acid reflux disease, depression, difficulty swallowing, and cognitive deficit.

Resident #12's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 11/17/17, revealed, in part, that Resident #12 was unable to answer the questions on the BIMS (brief interview of mental status) and was coded on the staff assessment as being severely impaired to make decisions regarding tasks of daily life. Resident #12 was further coded as being dependent on staff for activities of daily living. Resident #12 was further coded that there were no falls since admission/entry or prior assessment.

Resident #12 was observed during the survey process to have an abrasion on her forehead above her right eye. There was no documentation in Resident #12's clinical record concerning the abrasion.

A review of Resident #12's clinical record,

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F 607	Continued From page 75 revealed, in part, a progress note documenting the following; ""Effective Date: 11/8/17 23:20 (11:20 p.m.) Type: Change in Condition. Note: A change in condition has been noted. The symptoms include: Skin wound or ulcer 11/8/2017. Change reported to Primary Care Clinician: (name of clinician notified) 11/8/2017 4:00 p.m. Name of Family / Healthcare agent notified: SELF 11/8/2017 4:00 p.m." Further review of Resident #12's clinical record revealed, in part, a change in condition document dated 11/8/17 that documented, in part, the following; "Old bruise, fadded (sic) bluish color to right chin." Further review of the clinical record did not reveal any documentation that an investigation had been initiated. A review of Resident #12's comprehensive care plan did not reveal any documentation regarding injuries in November 2017 and December 2017. On 12/7/17 at 12:30 p.m. an interview was conducted with ASM (administrative staff member) #2, the interim director of nursing (DON). ASM #2 was asked to describe the process followed if a resident was seen to have any injury. ASM #2 stated it should be reported and investigated. ASM #2 was asked if she was able to provide an investigation for Resident #12 in regards to bruise on her chin occurring 11/8/17 and the abrasion currently on Resident #12's forehead. ASM #2 stated that she would look into it but that she was not aware of bruise she had seen the abrasion on the forehead but thought it had been there a while. ASM #2 stated that she would start an investigation into the abrasion.	F 607		

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On 12/7/17 at 3:00 p.m. ASM #2 approached this writer and stated that she was unable to find where investigations had been conducted for Resident #12 in regards to the bruise on her chin and the abrasion on her forehead. ASM #2 further stated that the nurses have all changed on that hallway so there was no one who could say what had happened.

On 12/7/17 at 3:10 p.m. an interview was conducted with LPN (licensed practical nurse) #3, a floor nurse. LPN #3 was asked to describe his process if a resident was seen to have an injury of unknown origin. LPN #3 stated, "I notify the DON and Administrator. I would look to see if anyone had reported it on the last 24-hour report. I would document a description and try to interview the resident. We need to rule out abuse so an investigation would be initiated."

On 12/7/17 at 3:42 p.m. ASM #2 approached this writer and stated that she remembered that Resident #12's the issue of the bruise on her chin was brought to the daily clinical meeting and there was a concern. ASM #2 stated, "I asked the unit manager to investigate this but he never did get back to me." ASM #2 was asked if she had followed up. ASM #2 stated that she did not. ASM #2 was asked if she knew what had caused bruise, ASM #2 stated that she did not. ASM #2 was asked whether or not this was an injury of unknown origin and should have been reported to the state agency, ASM #2 stated that it should have been. ASM #2 was unable to explain the abrasion to Resident #12's head and was unable to state how long it had been there. A FRI (facility reported incident) had not been submitted for either injury.

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F 607	Continued From page 77 An end of day meeting occurred on 12/7/17 at 4:45 p.m. with ASM #1, the executive director, ASM #2, the interim DON, and ASM #3, the clinical quality specialist. ASM #1, ASM #2 and ASM #3 were made aware of the above concerns. No further information provided prior to the end of the survey process.	F 607		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State	F 609	1. Investigations were not completed on these past events for residents # 66 and # 12. Resident #66 still resides in the facility without further incident. Accused CNA received abuse training as part of this Plan of Correction. Resident # 12 was seen by the Nurse Practitioner to examine both identified areas and addressed accordingly (forehead and chin). No further injuries noted for this resident. All future investigations will be completed thoroughly, timely and per policy and regulation. Administrator and Director of Nursing are responsible for investigating and reporting. 2. All residents have potential to be affected. An audit was completed by the Nursing Leadership team with a review of the 24 hour reports, eInteract Change of Condition and	

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F 609	Continued From page 78 Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview and clinical record review, it was determined that the facility staff failed to report allegations of abuse and injuries of unknown origin for two of 29 residents in the survey sample, Residents # 66 and # 12. 1. The facility staff failed to report an allegation of abuse for Resident # 66 to the state agency and other officials in accordance with State law through established procedures. 2. The facility staff failed to report injuries of unknown origin when Resident #12 was observed to have a bruise to her chin on 11/8/17 and an abrasion to her forehead (date undetermined) to the state agency and other officials in accordance with State law through established procedures. . The findings include: 1. The facility staff failed to report an allegation of abuse for Resident # 66 to the state agency and other officials in accordance with State law through established procedures. On 12/8/17 at approximately 12:30 p.m., all allegations of abuse since the previous survey were requested from the administrator. At approximately 12:40 p.m. the allegations were provided and one resident was selected for review, Resident #66.	F 609	Incident Reporting for the past 30 days to ensure all events were investigated appropriately with follow up, conclusion and reported accordingly. 3. Education was provided to the nursing staff by the Nurse Practice Educator related to reporting any identified injury, bruising ect. Abuse Policy and Procedure also reviewed with facility staff. 4. Nurse Management team to audit 24 hour reports, eInteract Change of Conditions, and Incident Reports in Clinical Morning Meeting to ensure all events have appropriate follow up investigations completed and reported according to policy and regulation. Results of these audits will be brought before the Quality Assurance and Performance Improvement Committee monthly for review.	1/17/18

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F 609	Continued From page 79 Resident # 66 was admitted to the facility on 1/16/17 with diagnoses that included but were not limited to: hypertension, rheumatoid arthritis, gout, and anxiety. Resident # 66's most recent MDS (minimum data set) assessment, a Quarterly Assessment, with an ARD (assessment reference date) of 11/3/17 coded Resident # 66 as usually understood by others and as able to usually understand others. Resident # 66 was coded as being moderately impaired for making daily decisions, scoring 10 out of 15 on the BIMS (brief interview for mental status). A Review of the FRI (facility reported incident) Incident for Resident #66 dated: 3/27/2017, revealed the following was documented on the FRI form: "Incident type: Allegation of abuse/mistreat. Describe incident, including location, and action taken: On 3/27/2017: (name of Resident # 66) alleged that she was slapped by CNA (certified nurse's assistant) about a month ago. She also stated that she slapped the CNA back. The resident's face was assessed for injuries and no injuries were noted. On 3/27/2017: Resident told her daughter that she was slapped by CNA and received a skin tear on her arm, from fingernails while she was being restrained. Initial investigation: The resident was combative in bed and was transferred to a wheelchair using a mechanical lift by two CNAs. The injury sustained during transfer was a skin tear to the RT (right) Forearm measuring 6 cm (centimeter). She is on anticoagulation therapy and has fragile skin. Name of employee(s) involved and their positions: CNA # 12 LPN (licensed practical nurse) # 14 (initial investigator), LPN # 5	F 609		

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F 609	Continued From page 80 Final Report on (Name of Resident # 66) dated 4/2/2017 Notation made that the Office of Licensure and Certification received a copy. Documented in part below: Initial investigation: "On 3/27/2017: The resident was combative in bed and was transferred to a wheelchair using a mechanical lift by two staff members. The injury sustained during transfer was a skin tear to the right forearm measuring 6 cm. She is on anticoagulation therapy, Lovenox (a blood thinner) 30 s.c. (sic) [subcutaneous] daily and has fragile skin. She is also susceptible to bruising. Investigation and Actions Taken: 3/27/2017: Resident's skin was assessed and she had sustained a skin tear on the right forearm and there was purple and yellow bruising around the area. On 3/27/2017: Statements were obtained from all individuals involved. 3/28/2017: An interview of residents who were deemed competent was conducte[illegible] the Unit Social Worker. All residents interviewed reported proper care on the evening shift; no reports of any instances of neglect or mishandling by staff." "Conclusion: Allegations of abuse were unsubstantiated. The dates and times reported by the resident were not consistent. No evidentiary data collected from the allegation of being slapped was identified. Investigation of the incident revealed that the resident sustained a skin tear during transfer; no injury to resident's face. She was transferred from bed to chair because of her level of agitation. The transfer was conducted by two individuals per facility policy & procedure." On 12/8/17 at 12:50 CNA (certified nursing assistant) #12's employee record was requested from ASM (Administrative Staff Member) #1, the	F 609		

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F 609	Continued From page 81 Executive Director. The file was reviewed and did not reveal any concerns. 12/8/17 at 1:00 p.m., an interview was conducted with ASM #1, regarding the allegation of abuse for Resident #66. ASM #1 stated, "Have no supporting documents, I can find nothing. I can't give you a confirmation of the fax (indicating this allegation had been reported to the state agency and other officials)." When asked about the witness statements, ASM #1 stated, "I can find nothing. I can't find evidence it was thoroughly investigated to show it (the allegation of abuse) was unsubstantiated." At this time CNA #12's time card for 3/27/17 forward was requested. On 12/8/17 at 1:20 p.m., ASM #1 provided the time card for CNA #12 and stated, "It gets even better, she was working." A review of CNA #12's time card documented in part the following: "Time period 3/27/2017 -4/2/2017: Sun (Sunday) 3/26+ in: 11:01 PM 5509/Direct Care/Dove/ Out 7:16 AM Mon (Monday)3/27+ In: 11:02 PM 5509/Direct Care/Dove/ Out 7:45 AM Tue (Tuesday) 3/28+ In: 11:06 PM 5509/Direct Care/Dove/ Out 8:18 AM Wed (Wednesday) 3/29+ In: 10:55 PM 5509/Direct Care/Dove/ Out 7:01 AM Thur (Thursday) 3/30+ In: 11:06 PM 5509/Direct Care/Dove/ Out 7:20 AM Fri (Friday) 3/31+ In: 11:05 PM Out: 7:39 AM Sat (Saturday) 4/01+ In: 11:12 PM 5509/Direct Care/Dove/ Out: 7:24 AM Sun (Sunday) 4/02 (no time in or out documented)."	F 609		

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F 609	Continued From page 82 On 12/8/17 at approximately 1:35 p.m. the FRI for Resident #66 was reviewed with ASM #1 for the time the allegation was reported on 3/27/17. ASM #1 reviewed the FRI and stated, "I do not see a time." When asked if CNA #12 should have continued working and caring for residents after the allegation of abuse was reported, ASM #1 stated, "Absolutely should have been put on admin (administrative) leave pending investigation. Should have completed our investigation and if substantiated would have terminated the employee and reported her to the licensing board. If it was unsubstantiated, then would have abuse identification education. The RP (responsible party), MD (medical doctor), ombudsman, Licensing office (OLC [Office of Licensure and Certification]) would be notified and a fax sent. I have no evidence to support this (notification) was completed." When asked if the facility policy and procedures for abuse prevention had been followed, ASM #1 stated, "Based on this evidence, no. There is no evidence of investigation, such as interviews, no supporting documents showing the investigation was done. The FRI documents individual interviews were done, but I am unable to produce them." On 12//8/17 at approximately 1:45 p.m., a copy of the facility abuse prevention policy and procedures were obtained. ASM #1 was informed of the concern and stated, "It is pretty straight forward." Review of the facility policy "Abuse Prohibition" documented the following: Under "POLICY:" Genesis HealthCare Centers will prohibit abuse, mistreatment, neglect, misappropriation of resident property, and exploitation for all	F 609		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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residents. This include, but is not limited to, freedom from corporal punishment, involuntary seclusion, and any physical or chemical restraint not required to treat the patient's medical symptoms. The Center will implement an abuse prohibition program through the following:
Screening of potential hires;
Training of employees (both new employees and ongoing training for all employees);
Prevention of occurrences;
Identification of possible incidents or allegations which need investigation; Investigation of incidents and allegations;
Protection of patients during investigations; and
Reporting of incidents, investigations, and Center response to the results of their investigations."

Under "PURPOSE" The following was documented in part: "To ensure Center staff are doing all that is within their control to prevent occurrences of abuse, mistreatment, neglect, exploitation, involuntary seclusion, injuries of unknown source, and misappropriation of property for all patients." Under "PROCESS: 1. The Center Executive Director, or designee is responsible for operationalizing policies and procedures that prohibit abuse, neglect, involuntary seclusion. Injuries of unknown source, exploitation, and misappropriation of property. ... 4. Actions to prevent abuse, neglect, exploitation, or mistreatment, including injuries of unknown source and misappropriation of resident property ... 5.1.1 The notified supervisor will report the suspected abuse immediately to the Center Executive Director (CED) or designee and other officials in accordance with state law ... 5.1.2 The employee alleged to have committed the act of abuse will be immediately removed from duty, pending investigation. 5.1.3 All reports of

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F 609	Continued From page 84 suspected abuse must also be reported to the patient's family and attending physician ... 5.3 Injuries of unknown origin will be investigated to determine if abuse or neglect is suspected. 6. Upon receiving information concerning a report of suspected or alleged abuse, mistreatment, or neglect, the CED or designee will perform the following. 6.1 Enter allegation into the Risk Management System (RMS). 6.2 Report allegations involving abuse (physical, verbal, sexual, mental) not later than two hours after the allegation is made. 6.3 Report allegations involving neglect, exploitation or mistreatment (including injuries of unknown source) and misappropriation of resident property not later than two hours after the allegation is made if the event results in serious bodily injury ...6.4 Report allegations involving neglect, exploitation or mistreatment (including injuries of unknown source) and misappropriation of resident property within 24 hours if the event does not result in serious bodily injury. 6.5 Notify local law enforcement, Licensing Boards and Registries, and other agencies as required ... 8.2 Report findings of all completed investigations within fire (5) working days to the Department of Health using the state on-line reporting system or state-approved forms ...10. All documentation related to allegations of abuse will be maintained at the Center for not less than three (3) years." 2. The facility staff failed to report injuries of unknown origin when Resident #12 was observed to have a bruise to her chin on 11/8/17 and an abrasion to her forehead (date undetermined). Resident #12 was admitted to the facility on	F 609		

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F 609	Continued From page 85 11/15/10 with a readmission on 5/5/16 with diagnoses that included, but were not limited to; dementia, osteoporosis (weakening of the bones), anemia (low red blood cells), acid reflux disease, depression, difficulty swallowing, and cognitive deficit. Resident #12's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 11/17/17, revealed, in part, that Resident #12 was unable to answer the questions on the BIMS (brief interview of mental status) and was coded on the staff assessment as being severely impaired to make decisions regarding tasks of daily life. Resident #12 was further coded as being dependent on staff for activities of daily living. Resident #12 was further coded that there were no falls since admission/entry or prior assessment. Resident #12 was observed during the survey process to have an abrasion on her forehead above her right eye. There was no documentation in Resident #12's clinical record concerning the abrasion. A review of Resident #12's clinical record, revealed, in part, a progress note documenting the following; ""Effective Date: 11/8/17 23:20 (11:20 p.m.) Type: Change in Condition. Note: A change in condition has been noted. The symptoms include: Skin wound or ulcer 11/8/2017. Change reported to Primary Care Clinician: (name of clinician notified) 11/8/2017 4:00 p.m. Name of Family / Healthcare agent notified: SELF 11/8/2017 4:00 p.m." Further review of Resident #12's clinical record revealed, in part, a change in condition document	F 609		

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F 609	Continued From page 86	F 609		

dated 11/8/17 that documented, in part, the following; "Old bruise, fadded (sic) bluish color to right chin."

Further review of the clinical record did not reveal any documentation that an investigation had been initiated.

A review of Resident #12's comprehensive care plan did not reveal any documentation regarding injuries in November 2017 and December 2017.

On 12/7/17 at 12:30 p.m. an interview was conducted with ASM (administrative staff member) #2, interim director of nursing (DON). ASM #2 was asked to describe the process if a resident was seen to have any injury. ASM #2 stated that it should be reported and investigated. ASM #2 was asked if she was able to provide an investigation for Resident #12 in regards to a bruise on her chin occurring 11/8/17 and the abrasion currently on Resident #12's forehead. ASM #2 stated that she would look into it but that she was not aware of a bruise she had seen the abrasion on the forehead but thought it had been there a while. ASM #2 stated that she would start an investigation into the abrasion.

On 12/7/17 at 3:00 p.m. ASM #2 approached this writer and stated that she was unable to find where investigations had been conducted for Resident #12 in regards to the bruise on her chin and the abrasion on her forehead. ASM #2 further stated that the nurses have all changed on that hallway so there was no one who could say what had happened.

On 12/7/17 at 3:10 p.m. an interview was conducted with LPN (licensed practical nurse) #3,

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F 609	Continued From page 87 a floor nurse. LPN #3 was asked to describe his process if a resident was seen to have an injury of unknown origin. LPN #3 stated, "I notify the DON and Administrator. I would look to see if anyone had reported it on the last 24-hour report. I would document a description and try to interview the resident. We need to rule out abuse so an investigation would be initiated." On 12/7/17 at 3:42 p.m. ASM #2 approached this writer and stated that she remembered that Resident #12's the issue of the bruise on her chin was brought to the daily clinical meeting and there was a concern. ASM #2 stated, "I asked the unit manager to investigate this but he never did get back to me." ASM #2 was asked if she had followed up. ASM #2 stated that she did not. ASM #2 was asked if she knew what had caused the bruise, ASM #2 stated that she did not. ASM #2 was asked whether or not this was an injury of unknown origin and should have been reported to the state agency, ASM #2 stated that it should have been. ASM #2 was unable to explain the abrasion to Resident #12's head and was unable to state how long it had been there. A FRI (facility reported incident) had not been submitted for either injury. An end of day meeting occurred on 12/7/17 at 4:45 p.m. with ASM #1, the executive director, ASM #2, the interim DON, and ASM #3, the clinical quality specialist. ASM #1, ASM #2 and ASM #3 were made aware of the above concerns. A copy of the facility abuse policy was requested at this time. No further information provided prior to the end of the survey process.	F 609		

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F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview and clinical record review, it was determined that the facility staff failed to thoroughly investigate an allegation of abuse and injuries of unknown origin for two of 29 residents in the survey sample, Residents # 66 and # 12. 1. The facility staff failed to provide documentation that an allegation of abuse for Resident # 66 was thoroughly investigated. 2. The facility staff failed to thoroughly investigate two injuries of unknown origin that were found on Resident #12. The findings include:	F 610	1. Investigations were not completed on these past events for residents #66 and #12. Resident #66 still resides in the facility without further incident. Accused CNA received abuse training as part of this Plan of Correction. Resident # 12 was seen by the Nurse Practitioner to examine both identified areas and addressed accordingly (forehead and chin). No further injuries noted for this resident. All future investigations will be completed thoroughly, timely and per policy and regulation. Administrator and Director of Nursing are responsible for investigating and reporting. 2. All residents have potential to be affected. An audit was completed by the Nursing Leadership team with a review of the 24 hour reports, eInteract Change of Condition and Incident Reporting for the past 30 days to ensure all events were investigated appropriately with follow up, conclusion and reported accordingly. 3. Education was provided to the nursing staff by the Nurse Practice Educator related to reporting any identified injury, bruising ect. Abuse Policy and Procedure also reviewed with facility staff.	

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F 610	Continued From page 89 1. The facility staff failed to provide documentation that an allegation of abuse for Resident # 66 was thoroughly investigated. On 12/8/17 at approximately 12:30 p.m., all allegations of abuse since the previous survey were requested from the administrator. At approximately 12:40 p.m. the allegations were provided and one resident was selected for review, Resident #66. Resident # 66 was admitted to the facility on 1/16/17 with diagnoses that included but were not limited to: hypertension, rheumatoid arthritis, gout, and anxiety. Resident # 66's most recent MDS (minimum data set) assessment, a Quarterly Assessment, with an ARD (assessment reference date) of 11/3/17 coded Resident # 66 as usually understood by others and as able to usually understand others. Resident # 66 was coded as being moderately impaired for making daily decisions, scoring 10 out of 15 on the BIMS (brief interview for mental status). A Review of the FRI (facility reported incident) Incident for Resident #66 dated: 3/27/2017, revealed the following was documented on the FRI form: "Incident type: Allegation of abuse/mistreat. Describe incident, including location, and action taken: On 3/27/2017: (name of Resident # 66) alleged that she was slapped by CNA (certified nurse's assistant) about a month ago. She also stated that she slapped the CNA back. The resident's face was assessed for injuries and no injuries were noted. On 3/27/2017: Resident told her daughter that she was slapped by CNA and received a skin tear on her arm, from	F 610	4. Nurse Management team to audit 24 hour reports, eInteract Change of Conditions, and Incident Reports in Clinical Morning Meeting to ensure all events have appropriate follow up investigations completed and reported according to policy and regulation. Results of these audits will be brought before the Quality Assurance and Performance Improvement Committee monthly for review.	1/17/18

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fingernails while she was being restrained. Initial investigation: The resident was combative in bed and was transferred to a wheelchair using a mechanical lift by two CNAs. The injury sustained during transfer was a skin tear to the RT (right) Forearm measuring 6 cm (centimeter). She is on anticoagulation therapy and has fragile skin. Name of employee(s) involved and their positions: CNA # 12
LPN (licensed practical nurse) # 14 (initial investigator), LPN # 5

Final Report on (Name of Resident # 66) dated 4/2/2017 Notation made that the Office of Licensure and Certification received a copy. Documented in part below:
Initial investigation: "On 3/27/2017: The resident was combative in bed and was transferred to a wheelchair using a mechanical lift by two staff members. The injury sustained during transfer was a skin tear to the right forearm measuring 6 cm. She is on anticoagulation therapy, Lovenox (a blood thinner) 30 s.c. (sic) [subcutaneous] daily and has fragile skin. She is also susceptible to bruising. Investigation and Actions Taken: 3/27/2017: Resident's skin was assessed and she had sustained a skin tear on the right forearm and there was purple and yellow bruising around the area. On 3/27/2017: Statements were obtained from all individuals involved. 3/28/2017: An interview of residents who were deemed competent was conducted by the Unit Social Worker. All residents interviewed reported proper care on the evening shift; no reports of any instances of neglect or mishandling by staff."
"Conclusion: Allegations of abuse were unsubstantiated. The dates and times reported by the resident were not consistent. No evidentiary data collected from the allegation of

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being slapped was identified. Investigation of the incident revealed that the resident sustained a skin tear during transfer; no injury to resident's face. She was transferred from bed to chair because of her level of agitation. The transfer was conducted by two individuals per facility policy & procedure."

On 12/8/17 at 12:50 CNA (certified nursing assistant) #12's employee record was requested from ASM (Administrative Staff Member) #1, the Executive Director. The file was reviewed and did not reveal any concerns.

12/8/17 at 1:00 p.m., an interview was conducted with ASM #1, regarding the allegation of abuse for Resident #66. ASM #1 stated, "Have no supporting documents, I can find nothing. I can't give you a confirmation of the fax (indicating this allegation had been reported to the state agency and other officials)." When asked about the witness statements, ASM #1 stated, "I can find nothing. I can't find evidence it was thoroughly investigated to show it (the allegation of abuse) was unsubstantiated." At this time CNA #12's time card for 3/27/17 forward was requested.

On 12/8/17 at 1:20 p.m., ASM #1 provided the time card for CNA #12 and stated, "It gets even better, she was working."

A review of CNA #12's time card documented in part the following:
"Time period 3/27/2017 -4/2/2017:
Sun (Sunday) 3/26+ in: 11:01 PM 5509/Direct Care/Dove/ Out 7:16 AM
Mon (Monday)3/27+ In: 11:02 PM 5509/Direct Care/Dove/ Out 7:45 AM
Tue (Tuesday) 3/28+ In: 11:06 PM 5509/Direct

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Care/Dove/ Out 8:18 AM
Wed (Wednesday) 3/29+ In: 10:55 PM 5509/Direct Care/Dove/ Out 7:01 AM
Thur (Thursday) 3/30+ In: 11:06 PM 5509/Direct Care/Dove/ Out 7:20 AM
Fri (Friday) 3/31+ In: 11:05 PM Out: 7:39 AM
Sat (Saturday) 4/01+ In: 11:12 PM 5509/Direct Care/Dove/ Out: 7:24 AM
Sun (Sunday) 4/02 (no time in or out documented)."

On 12/8/17 at approximately 1:35 p.m. the FRI for Resident #66 was reviewed with ASM #1 for the time the allegation was reported on 3/27/17. ASM #1 reviewed the FRI and stated, "I do not see a time." When asked if CNA #12 should have continued working and caring for residents after the allegation of abuse was reported, ASM #1 stated, "Absolutely should have been put on admin (administrative) leave pending investigation. Should have completed our investigation and if substantiated would have terminated the employee and reported her to the licensing board. If it was unsubstantiated, then would have abuse identification education. The RP (responsible party), MD (medical doctor), ombudsman, Licensing office (OLC [Office of Licensure and Certification]) would be notified and a fax sent. I have no evidence to support this (notification) was completed." When asked if the facility policy and procedures for abuse prevention had been followed, ASM #1 stated, "Based on this evidence, no. There is no evidence of investigation, such as interviews, no supporting documents showing the investigation was done. The FRI documents individual interviews were done, but I am unable to produce them."

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On 12//8/17 at approximately 1:45 p.m., a copy of the facility abuse prevention policy and procedures were obtained. ASM #1 was informed of the concern and stated, "It is pretty straight forward."

Review of the facility policy "Abuse Prohibition" documented the following: Under "POLICY:" Genesis HealthCare Centers will prohibit abuse, mistreatment, neglect, misappropriation of resident property, and exploitation for all residents. This include, but is not limited to, freedom from corporal punishment, involuntary seclusion, and any physical or chemical restraint not required to treat the patient's medical symptoms. The Center will implement an abuse prohibition program through the following:
Screening of potential hires;
Training of employees (both new employees and ongoing training for all employees);
Prevention of occurrences;
Identification of possible incidents or allegations which need investigation; Investigation of incidents and allegations;
Protection of patients during investigations; and
Reporting of incidents, investigations, and Center response to the results of their investigations."

Under "PURPOSE" The following was documented in part: "To ensure Center staff are doing all that is within their control to prevent occurrences of abuse, mistreatment, neglect, exploitation, involuntary seclusion, injuries of unknown source, and misappropriation of property for all patients." Under "PROCESS: 1. The Center Executive Director, or designee is responsible for operationalizing policies and procedures that prohibit abuse, neglect, involuntary seclusion. Injuries of unknown source,

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F 610	Continued From page 94 exploitation, and misappropriation of property. ...5.1.1 The notified supervisor will report the suspected abuse immediately to the Center Executive Director (CED) or designee and other officials in accordance with state law ... 5.1.3 All reports of suspected abuse must also be reported to the patient's family and attending physician ... 5.3 Injuries of unknown origin will be investigated to determine if abuse or neglect is suspected. ... 6.7 Initiate an investigation within 24 hours of an allegation of abuse that focuses on: 6.7.1 whether abuse or neglect occurred and to what extent; 6.7.2 clinical examination for signs of injuries, if indicated; 6.7.3 causative factors; and 6.7.4 interventions to prevent further injury. 6.8 The investigation will be thoroughly documented.... Ensure that documentation of witnessed interviews is included. 7. The Center will protect patients from further harm during an investigation. 7.1 Provide the patient with a safe environment by identifying persons with whom he/she feels safe and conditions that would feel safe ...8. The CED or designee will: 8.1 Take all necessary corrective action depending on the results of the investigation; 8.2 Report findings of all completed investigations within fire (5) working days to the Department of Health using the state on-line reporting system or state-approved forms ...10. All documentation related to allegations of abuse will be maintained at the Center for not less than three (3) years." No further information was provided by completion of the survey process. 2. The facility staff failed to thoroughly investigate two injuries of unknown origin that were found on Resident #12. Resident #12 was admitted to the facility on	F 610		

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F 610	Continued From page 95 11/15/10 with a readmission on 5/5/16 with diagnoses that included, but were not limited to; dementia, osteoporosis (weakening of the bones), anemia (low red blood cells), acid reflux disease, depression, difficulty swallowing, and cognitive deficit. Resident #12's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 11/17/17, revealed, in part, that Resident #12 was unable to answer the questions on the BIMS (brief interview of mental status) and was coded on the staff assessment as being severely impaired to make decisions regarding tasks of daily life. Resident #12 was further coded as being dependent on staff for activities of daily living. Resident #12 was further coded that there were no falls since admission/entry or prior assessment. Resident #12 was observed during the survey process to have an abrasion on her forehead above her right eye. There was no documentation in Resident #12's clinical record concerning the abrasion. A review of Resident #12's clinical record, revealed, in part, a progress note documenting the following; ""Effective Date: 11/8/17 23:20 (11:20 p.m.) Type: Change in Condition. Note: A change in condition has been noted. The symptoms include: Skin wound or ulcer 11/8/2017. Change reported to Primary Care Clinician: (name of clinician notified) 11/8/2017 4:00 p.m. Name of Family / Healthcare agent notified: SELF 11/8/2017 4:00 p.m." Further review of Resident #12's clinical record revealed, in part, a change in condition document	F 610		

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dated 11/8/17 that documented, in part, the following; "Old bruise, fadded (sic) bluish color to right chin."

Further review of the clinical record did not reveal any documentation that an investigation had been initiated.

A review of Resident #12's comprehensive care plan did not reveal any documentation regarding injuries in November 2017 and December 2017.

On 12/7/17 at 12:30 p.m. an interview was conducted with ASM (administrative staff member) #2, director of nursing (DON). ASM #2 was asked to describe the process if a resident was seen to have any injury. ASM #2 stated that it should be reported and investigated. ASM #2 was asked if she was able to provide an investigation for Resident #12 in regards to a bruise on her chin occurring 11/8/17 and the abrasion currently on Resident #12's forehead. ASM #2 stated that she would look into it but that she was not aware of a bruise she had seen the abrasion on the forehead but thought it had been there a while. ASM #2 stated that she would start an investigation into the abrasion.

On 12/7/17 at 3:00 p.m. ASM #2 approached this writer and stated that she was unable to find where investigations had been conducted for Resident #12 in regards to the bruise on her chin and the abrasion on her forehead. ASM #2 further stated that the nurses have all changed on that hallway so there was no one who could say what had happened.

On 12/7/17 at 3:10 p.m. an interview was conducted with LPN (licensed practical nurse) #3,

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F 610	Continued From page 97 a floor nurse. LPN #3 was asked to describe his process if a resident was seen to have an injury of unknown origin. LPN #3 stated, "I notify the DON and Administrator. I would look to see if anyone had reported it on the last 24-hour report. I would document a description and try to interview the resident. We need to rule out abuse so an investigation would be initiated." On 12/7/17 at 3:42 p.m. ASM #2 the interim director of nursing (DON)approached this writer and stated that she remembered that Resident #12's the issue of the bruise on her chin was brought to the daily clinical meeting and there was a concern. ASM #2 stated, "I asked the unit manager to investigate this but he never did get back to me." ASM #2 was asked if she had followed up. ASM #2 stated that she did not. ASM #2 was asked if she knew what had caused bruise, ASM #2 stated that she did not. ASM #2 was asked whether or not this was an injury of unknown origin and should have been reported to the state agency, ASM #2 stated that it should have been. ASM #2 was unable to explain the abrasion to Resident #12's head and was unable to state how long it had been there. A FRI (facility reported incident) had not been submitted for either injury. An end of day meeting occurred on 12/7/17 at 4:45 p.m. with ASM #1, the executive director, ASM #2, the interim DON, and ASM #3, the clinical quality specialist. ASM #1, ASM #2 and ASM #3 were made aware of the above concerns. A copy of the facility abuse policy was requested at this time. No further information provided prior to the end of	F 610		

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	495246	A. BUILDING ______ B. WING ______	C 12/08/2017

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F 610	Continued From page 98 the survey process.	F 610		
F 623 SS=D	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;	F 623	1. Resident # 83 is currently in the facility. 2. Any residents with a transfer within or out of the facility has potential to be affected. No transfers prior to this survey had notification to the Ombudsman per regulation. 3. Education was completed with the Licensed Nursing staff and Social Services by the Nurse Practice Educator on notification to the Ombudsman of any internal transfers or transfers out of the facility. 4. Director of Nursing will audit all transfers out of the facility for the next 30 days and then randomly thereafter to ensure Ombudsman was notified in writing of the transfer. Social Services to audit all internal transfers for the next 30 days and then randomly thereafter to ensure Ombudsman was notified in writing of the transfer. Results of these audits will be brought before the Quality Assurance and Performance Improvement Committee monthly for review.	1/17/18

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F 623	Continued From page 99 (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy	F 623		

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for Mentally Ill Individuals Act.

§483.15(c)(6) Changes to the notice.
If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available.

§483.15(c)(8) Notice in advance of facility closure
In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l).
This REQUIREMENT is not met as evidenced by:
Based on staff interview, facility document review and clinical record review, it was determined that the facility staff failed to provide written notification of transfer to a resident/representative and the ombudsman for one of 29 residents in the survey sample, Resident #83.

Resident #83 transferred to the hospital on 10/28/17. The facility staff failed to provide written notification of the transfer to Resident #83, the resident's representative and the ombudsman.

The findings include:

Resident #83 was admitted to the facility on 9/24/17. Resident #83's diagnoses included but were not limited to: pain in the right knee, muscle

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weakness and high blood pressure. Resident #83's most recent MDS (minimum data set), a 30 day Medicare assessment with an ARD (assessment reference date) of 11/28/17, coded the resident as cognitively intact.

Review of Resident #83's clinical record revealed the resident was transferred to the hospital on 10/28/17. Further review of the clinical record failed to reveal Resident #83, the resident's representative, or the ombudsman was provided any written notification regarding the transfer. Resident #83 was readmitted to the facility on 11/2/17.

On 12/7/17 at 10:53 a.m. an interview was conducted with OSM (other staff member) #21 (a social worker). OSM #21 stated the social services department does not issue written notification of transfer or discharge to residents, residents' families or the ombudsman.

On 12/7/17 at 10:55 a.m. an interview was conducted with OSM #5 (the admissions director). OSM #5 stated she does not provide any information in writing when residents go to the hospital. OSM #5 stated she does complete a follow up phone call after residents are transferred and admitted to the hospital but she does not issue written notification to the residents, families or ombudsman. OSM #5 stated the nurses do send documentation with residents who are transferred to the hospital but she didn't know what information the documentation contained.

On 12/7/17 at 10:59 a.m. an interview was conducted with RN (registered nurse) #2. RN #2 was asked if nurses provide written notification to

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residents' families after residents transfer to the hospital. RN #2 stated, "No." RN #2 stated documents such as an E-Interact form (a form that documents the resident's medical information and synopsis of why the resident is sent to the hospital), history/physical, lab tests, medication list and face sheet are sent with the residents and are to be provided to the staff at the hospital. RN #2 stated the only notification provided to families is over the phone. When asked if the ombudsman is provided notification, RN #2 stated, "No."

On 12/7/17 at 2:23 p.m. ASM (administrative staff member) #1 (the executive director), ASM #2 (the interim director of nursing) and ASM #3 (the clinical quality specialist) were made aware of the above concern.

The facility policy titled, "Discharge and Transfer" documented, "A Center must immediately inform the resident/resident representative, consult with the resident's physician, and notify consistent with below, when there is a decision to transfer or discharge the resident from the Center. The resident and resident representative must be notified in writing and in a language and manner they understand...For residents transferred to a hospital: 5.1 For unplanned, acute transfers, resident, family, and legal representative will be notified verbally. 5.1.1 Written notice must be provided if the Center will not take the resident back from the hospital..."

No further information was presented prior to exit.

F 625 SS=D Notice of Bed Hold Policy Before/Upon Trnsfr
CFR(s): 483.15(d)(1)(2)

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§483.15(d) Notice of bed-hold policy and return-

§483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies-
(i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility;
(ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any;
(iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and
(iv) The information specified in paragraph (e)(1) of this section.

§483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section.
This REQUIREMENT is not met as evidenced by:
Based on staff interview, facility document review and clinical record review, it was determined that the facility staff failed to provide a written bed hold notification at the time of transfer or within 24 hours of being transferred to the hospital for two of 29 residents in the survey sample; Residents #84 and #83.

1. The facility staff failed to provide Resident #84

F 625

1. Resident #84 has discharged from the facility. Resident #83 remains in the facility; any future transfers will have written bed-hold notification provided within 24 hours of transfer.

2. All residents transferring to the hospital have potential to be affected. Prior to the survey, no written notification was provided for any resident transfer out of the facility to the hospital.

3. Education was provided by the Administrator to the Admissions Team regarding this regulation. Admissions Liaison at the hospitals will provide written notice of bed-hold to residents and/or their representative, who transfer to the hospital.

4. Administrator/designee will audit hospital transfers for the next 30 days, and randomly thereafter, to ensure written notification is provided. This audit will be conducted by placing a phone call to the resident or representative to ensure they have received. Results of these audits will be brought before the QAPI Committee monthly for review.

1/17/18

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or the representative a copy of the bed hold policy upon or within 24 hours of a family-initiated transfer to the hospital.

2. The facility staff failed to provide Resident #83 or the resident's representative written notification of the bed hold policy when the resident was transferred to the hospital on 10/28/17.

The findings include:

1. The facility staff failed to provide Resident #84 or the representative a copy of the bed hold policy upon or within 24 hours of a family-initiated transfer to the hospital.

Resident # 84 was admitted to the facility on 7/6/17 and discharged on 9/11/17 to the hospital, with the diagnoses of but not limited to pressure ulcers, stroke, dementia, dysphagia, high blood pressure, diabetes, and chronic kidney disease. The most recent MDS (Minimum Data Set) prior to discharge was 60-day assessment with an ARD (Assessment Reference Date) of 8/31/17. The resident was coded as being severely cognitively impaired in ability to make daily life decisions, scoring a 5 out of a possible 15 on the BIMS (Brief Interview for Mental Status) exam. The resident was coded as requiring extensive to total care for all areas of activities of daily living.

A review of the clinical record failed to reveal any evidence the resident and/or responsible party was provided with a copy of the Bed Hold policy at the time of or within 24 hours of transfer to the hospital.

On 12/07/17 at 12:50 p.m., in an interview with OSM #5 (Other Staff Member, the Admissions

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F 625	Continued From page 105 Director) she stated the resident or family is followed up with at the hospital 1 to 2 days after transfer to the hospital, and notified of the bed hold policy via phone. OSM #5 stated no one goes to the hospital to provide a written copy. She stated she would check with the company's in-hospital liaison about whether or not that individual had been providing the written bed hold notification after the resident arrived to the hospital. On 12/07/17 at 02:04 PM, OSM #5 stated the hospital liaison for the company had not been providing the written bed hold policy on site at the hospital, so no one was providing the resident or responsible party with a written bed hold notice at the time of or within 24 hours of transfer to the hospital. On 12/07/17 at 02:01 PM, ASM #3 (Administrative Staff Member - the corporate Clinical Quality Specialist) provided the facility's policy for "Discharge and Transfer" which documented, "5. For residents transferred to a hospital: 5.1 For unplanned, acute transfers, resident, family, and legal representative will be notified verbally .....5.4 The Bed Hold Notice of Policy & Authorization form will be provided per the Accounts Receivable Policies and Procedures, Bed Holds policy." The facility policy titled, "Bed Holds" documented, "When a resident/patient ('resident') is transferred out of the service location to a hospital or on therapeutic leave, the designee will provide the resident/resident representative with the written Bed Hold Policy Notice & Authorization form (name of form)- regardless of payer. If the resident representative is not present to receive	F 625		

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F 625	Continued From page 106 the written notice upon transfer, the notice is delivered via email or hard copy via mail..." A review of the "Bed Hold Information" from the new admission packet, documented, "There may be instances when a resident of a (name of facility) Nursing Center leaves the Center for medical or therapeutic reasons. You may request that we hold your bed while you are absent from the Center for therapeutic leave or temporary stays in an acute care hospital. If you pay the Center to hold your bed open, the Center guarantees availability of the bed on your return to the Center. You must request any desired bed hold within 24 hours of receiving the notice of discharge or transfer. Bed hold for days of absence in excess of the payer's bed hold limit are considered non-covered services. If the center is not required and/or paid to hold a bed and the center is able to meet your care needs, the center will admit you to your previous room if available or immediately upon the first availability of a bed in a semi-private room if you still require the center's services and your condition warrants re-admission after you leave the Center." On 12/7/17 at approximately 5:00 p.m. at the end-of-day meeting, ASM #1 (the Administrator), ASM #2 (the interim Director of Nursing) and ASM #3 were made aware of the findings. No further information was provided by the end of the survey. 2. The facility staff failed to provide Resident #83 or the resident's representative written notification of the bed hold policy when the resident was transferred to the hospital on 10/28/17. Resident #83 was admitted to the facility on	F 625		

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F 625	Continued From page 107 9/24/17. Resident #83's diagnoses included but were not limited to: pain in the right knee, muscle weakness and high blood pressure. Resident #83's most recent MDS (minimum data set), a 30 day Medicare assessment with an ARD (assessment reference date) of 11/28/17, coded the resident as cognitively intact. Review of Resident #83's clinical record revealed the resident was transferred to the hospital on 10/28/17. Further review of the clinical record failed to reveal Resident #83 or the resident's representative was provided notification of the facility bed hold policy when the resident was transferred. Resident #83 was readmitted to the facility on 11/2/17. On 12/7/17 at 10:53 a.m. an interview was conducted with OSM (other staff member) #21 (a social worker). OSM #21 stated the social services department does not issue information regarding the bed hold policy. On 12/7/17 at 10:55 a.m. an interview was conducted with OSM #5 (the admissions director). OSM #5 stated the facility bed hold policy is provided to residents/representatives in the admission packet when residents are admitted to the facility. OSM #5 stated she does not provide any information in writing when residents go to the hospital but does complete a follow up phone call after residents are admitted to the hospital. OSM #5 stated the nurses send documentation with residents who are transferred to the hospital but she didn't know if that documentation contains the bed hold policy. On 12/7/17 at 10:59 a.m. an interview was conducted with RN (registered nurse) #2. RN #2	F 625		

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F 625	Continued From page 108 stated documents such as an E-Interact form (a form that documents the resident's medical information and synopsis of why the resident is sent to the hospital), history/physical, lab (laboratory) tests, medication list and face sheet are sent with the residents who are transferred to the hospital. When asked if the facility bed hold policy is issued to residents/representatives when residents are transferred to the hospital, RN #2 stated, "No." On 12/7/17 at 11:55 a.m. OSM #5 stated she makes a follow up phone call with the resident or family when a resident is transferred to the hospital. OSM #5 stated she documents the resident's/representative's wish to hold a bed or not hold a bed in the facility computer system but does not provide the policy unless the resident/representative chooses to hold a bed. On 12/7/17 at 2:23 p.m. ASM (administrative staff member) #1 (the executive director), ASM #2 (the interim director of nursing) and ASM #3 (the clinical quality specialist) were made aware of the above concern. No further information was presented prior to exit.	F 625		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, it was determined that	F 641	1. Resident #40 MDS was modified by the MDS Coordinator to reflect accurate coding. 2. The Director of Nursing or designee shall audit MDS's in progress to ensure Oxygen N0100C is accurately coded prior to ARD.	

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F 641	Continued From page 109 the facility staff failed to maintain a complete and accurate clinical record for one of 29 residents in the survey sample, Resident #40. The facility staff failed to accurately code the MDS (minimum data set) assessment, a quarterly assessment, with an ARD (assessment reference date) of 11/3/17, for the use of oxygen for Resident #40. The findings include: Resident #40 was admitted to the facility on 8/8/17 with diagnoses that included, but were not limited to: stroke, dementia, dysphagia, (difficulty swallowing (1)), diabetes, and high blood pressure. The most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 11/3/17, coded the resident as being severely cognitively impaired to make daily decisions. Resident #40 was coded as requiring extensive assistance to being totally dependent of one or more staff members for all of her activities of daily living. In Section O - Special treatments, Procedures and Programs, Resident #40 was not coded as having received oxygen during the past 14-day lookback period. A physician order dated, 8/9/17 and signed by the physician on 10/12/17, documented, "Oxygen via nasal cannula @ (at) 2 L (liters) for shortness of breath." Review of Resident #40's comprehensive care plan dated 8/16/17 failed to evidence the use of oxygen.	F 641	3. Clinical Reimbursement Manager (Regional MDS Nurse) will educate Clinical Reimbursement Coordinator (Facility MDS Nurse) on the Resident Assessment Instrument (RAI) for MDS for Section N 0100C by 12/31/17. 4. Director of Nursing will audit 10% of weekly MDS for Section N0100C for accuracy prior to transmission x2 months and then randomly thereafter to determine compliance. Director of Nursing will submit results of audits to the monthly QAPI meeting for review.	1/17/18

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F 641	Continued From page 110 Resident #40's October 2017 MAR (medication administration record) documented O2 (oxygen) 2L/min (minute) via NC (nasal cannula) (a tube with two prongs that insert into the resident's nostrils)." The October MAR documented that Resident #40 received oxygen on 11 days of the 14-day look back period for the 11/3/17 quarterly MDS assessment. Resident #40's November 2017 MAR documented, "O2 2L/min via NC." The was no documentation of the use of oxygen from 11/1/17 through 11/3/17, during the look-back period, for the 11/3/17 quarterly MDS assessment, the spaces on the MAR were blank. The nurse's note dated 11/1/17 at 2:10 a.m. documented in part, "On O2 therapy." The nurse's notes dated, 11/2/17 at 9:21 p.m. documented in part, "Respiration even and non labored (sic) on 2L/min via NC continuously." On 12/07/17 8:48 a.m. an interview was conducted with RN (registered nurse) #7, the MDS nurse. Resident #40's quarterly MDS with an ARD of 11/3/17 was reviewed with RN #7. Resident #40's MARs for October and November 2017 were reviewed with RN #7. RN #7 confirmed the oxygen should have been coded in Section O. RN #7 stated this MDS was not completed by her but was completed by the corporate travel MDS staff member. A copy of the policy for completing Section O of the MDS was requested. Administrative staff member (ASM) #3, the clinical quality specialist, stated the facility did not have a policy for completing the MDS, they follow the RAI (resident assessment instrument) manual for completing	F 641		

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F 641	Continued From page 111 the MDS. A copy of the RAI manual was provided for completing Section O that documented, "Coding Instructions for Column 2: Check all treatments, procedures and programs received or performed by the resident after admission/entry or reentry to the facility and within the 14 - day look - back period. Oxygen therapy: Code continuous or intermittent oxygen administered via mask, cannula, etc. delivered to a resident to relive hypoxia in this item." The ASM (administrative staff member) #1, executive director, ASM #2, interim director of nursing and ASM #3, were made aware of the above concern on 12/7/17 at 4:45 p.m. No further information was provided prior to exit. (1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman; page 178.	F 641		
F 655 SS=E	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to-	F 655	1. Resident # 184 has been discharged from the facility. Residents # 234, # 284 and # 39 have had baseline care plans completed to meet their current needs, by the Unit Manager. 2. All newly admitted residents since survey exit have baseline care plans in place according to regulation to meet their needs, as evidenced by audit completed by Unit Manager. 3. Education was completed with the Clinical Management Team by the	

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F 655	Continued From page 112 (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, and clinical record review it was determined, the facility staff failed to develop a baseline care plan to meet the resident's needs for four of 29 residents in the survey sample; Residents #234, #284, #39, and #184. 1. The facility staff failed to develop a baseline care plan for Resident #234 to address	F 655	Regional Nurse related to this regulation and ensuring that new residents have a baseline care plan developed within 48 hours to properly provide care for the resident. 4. Clinical Management Team will review all new admissions during the Clinical Morning Meeting to ensure that the Baseline Care Plan is completed and meets the resident's needs. The results of these audits will be brought before the Quality Assurance and Performance Improvement Committee monthly for review.	1/17/18

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resident-specific needs present on admission.

2. The facility staff failed to develop a baseline care plan for Resident # 284 to address the care needs for Resident # 284's feeding tube, colostomy and indwelling catheter.

3. The facility staff failed to develop a baseline care plan to address the needs of Resident #39 receiving dialysis.

4. The facility staff failed to develop a baseline care plan to address Resident #184's use of oxygen.

The findings include:

1. The facility staff failed to develop a baseline care plan for Resident #234 to address resident-specific needs present on admission.

Resident #234 was admitted to the facility on 12/4/17 with the diagnoses of but not limited to: MRSA (methicillin-resistant Staphylococcus aureus) [1] in a wound, Chronic Obstructive Pulmonary Disease, chronic back pain, scoliosis, opiate addiction, chronic pain syndrome, and aortic valve endocarditis. An MDS (minimum data set) assessment had not yet been completed. A review of the admission nursing assessment dated 12/4/17 documented the resident as being cognitively intact. The resident was documented as being able to participate in activities of daily living. The resident was also documented as having a PICC (peripherally inserted central catheter) [2] line and requiring oxygen therapy.

A review of Resident #234's baseline (interim)

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F 655	Continued From page 114 care plan on 12/8/17 at approximately 9:30 a.m., revealed Resident #234's baseline care plan included interventions for activities of daily living (ADL) and discharge. There was no evidence the resident was care planned for resident-centered care needs of oxygen therapy, having a MRSA infection, and having a PICC line for antibiotic therapy. On 12/08/17 at 09:40 a.m., in an interview with RN #2 (Registered Nurse), she stated the baseline care plan should include pain, falls, skin, ADL, and patient-specific needs. RN #2 stated the oxygen, wound with MRSA and the presence and use of the PICC line should have been care planned. She stated that the baseline care plan should be fully developed within 48 hours of admission, and each of these areas should have been on the resident's baseline care plan by the evening of 12/6/17. RN #2 verified these areas were not care planned as of 12/08/17 at 9:40 a.m. A review of the facility policy, "Person-Centered Care Plan" documented, "1. Baseline care plan: 1.1 Must be developed within 48 hours and include the minimum healthcare information necessary to properly care for a patient including but not limited to: 1.1.1 Initial goals based on admission orders; 1.1.2 physician orders; 1.1.3 dietary orders; 1.1.4 therapy services...." On 12/8/17 at 10:14 a.m., ASM #2 (Administrative Staff Member - the interim director of nursing) and ASM #3 (the corporate Clinical Quality Specialist) were made aware of the findings; and on 12/8/17 at 10:50 AM, ASM #1 (the executive director), was made aware of the findings. No further information was provided by the end of	F 655		

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the survey.

[1] MRSA stands for methicillin-resistant Staphylococcus aureus. It causes a staph infection that is resistant to several common antibiotics. There are two types of infection. Hospital-associated MRSA happens to people in health care settings. Community-associated MRSA happens to people who have close skin-to-skin contact with others, such as athletes involved in football and wrestling.
Infection control is key to stopping MRSA in hospitals. To prevent community-associated MRSA
*Practice good hygiene
*Keep cuts and scrapes clean and covered with a bandage until healed
*Avoid contact with other people's wounds or bandages
*Avoid sharing personal items, such as towels, washcloths, razors, or clothes
*Wash soiled sheets, towels, and clothes in hot water with bleach and dry in a hot dryer
If a wound appears to be infected, see a health care provider. Treatments may include draining the infection and antibiotics.
Information obtained from https://medlineplus.gov/mrsa.html

[2] PICC stands for peripherally inserted central catheter. A long catheter that extends from an arm or leg vein into the largest vein (superior vena cava or inferior vena cava) near the heart and typically provides central IV access for several weeks. Unlike a standard intravenous catheter (IV) which is for short term use, a PICC is more durable and does not easily become blocked or infected. It may remain in place for several months so that blood can be repeatedly

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drawn or medication and nutrients can be routinely injected into the patient's bloodstream. Information obtained from https://www.radiologyinfo.org/en/info.cfm?pg=vasc_access

2. The facility staff failed to develop a baseline care plan for Resident # 284 to address the care needs for Resident 284's feeding tube, colostomy and indwelling catheter.

Resident # 284 was admitted to the facility on 11/30/17 with diagnoses that included but were not limited to: atrial fibrillation (1), dysphagia, (2), osteoporosis (3), attention of ileostomy (4) and attention to gastrostomy.

Resident # 284's most recent MDS (minimum data set), an admission assessment was not due at the time of survey.

The facility's "Nursing Assessment-Initial" for Resident # 284 dated 11/30/17 documented, "Orientation to person, place and time; Judgement/Insight-intact and clear speech." Further review of the "Nursing Assessment-Initial" for Resident # 284 documented, "Feeding tube, Colostomy and Indwelling catheter."

Review of Resident # 284's EHR (electronic health record) and the paper clinical record failed to evidence a baseline care plan to address the care needs for Resident # 284's feeding tube, colostomy and indwelling catheter.

Further review revealed a comprehensive care plan dated 12/04/17. Review of the comprehensive care plan failed to evidence a care plan to address Resident # 284's feeding

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tube, colostomy and indwelling catheter.

On 12/07/17 at 2:40 p.m. an interview was conducted with RN (registered nurse) # 9 regarding the baseline plan of care (IPOC) for Resident # 284. When asked about the timeframe for the development of the baseline plan of care RN # 9 stated, "It's done in 48 hours of admission." When asked who is responsible for the development of the baseline plan of care RN # 9 stated, "The MDS (Minimum Data Set) coordinator."

12/07/17 at 2:50 p.m. and interview was conducted with ASM (administrative staff member) # 2, interim director of nursing and ASM # 3 clinical quality specialist. When asked who is responsible for the development of the baseline care plan for Residents # 284, ASM # 2 stated, "Everyone, the IDT (interdisciplinary team)."

The facility's policy "Person-Centered Care Plan" documented, "The Center must develop and implement a baseline person-centered care plan within 48 hours for each patient that includes the instructions needed to provide effective and person-centered care that meet professional standards of quality care."

On 12/06/17 at approximately 5:00 p.m. ASM (administrative staff member) # 1, executive director, ASM # 2, interim director of nursing and ASM # 3, clinical quality specialist, were made aware of the findings.

No further information was obtained prior to exit.

References:
(1) A swallowing disorder. This information was

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obtained from the website: https://www.nlm.nih.gov/medlineplus/swallowingdisorders.html.

(2) Makes your bones weak and more likely to break. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/osteoporosis.html.

(3) An ileostomy is used to move waste out of the body. This surgery is done when the colon or rectum is not working properly. This information was obtained from the website: https://medlineplus.gov/ency/article/007378.htm.

(4) A gastrostomy feeding tube insertion is the placement of a feeding tube through the skin and the stomach wall. It goes directly into the stomach. This information was obtained from the website: https://medlineplus.gov/ency/article/002937.htm.

3. The facility staff failed to develop a baseline care plan to address the needs of Resident #39 receiving dialysis.

Resident #39 was admitted to the facility on 10/3/17 with diagnosis that included but were not limited to: high blood pressure, diabetes, seizure disorder, below the knee amputation, infection of the right lower leg and end stage renal failure requiring hemodialysis.

Hemodialysis is a procedure used in toxic conditions and renal failure in which wastes and impurities are removed from the blood by a special machine. The blood is shunted to and from a dialyzer where, through diffusion and

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ultrafiltration, wastes are removed." (1)

The most recent MDS (minimum data assessment), a Medicare 60-day assessment, with an assessment reference date of 11/28/17, coded the resident as being cognitively intact to make daily decisions. In Section O - Special Treatments, Procedures and Programs, the resident was coded as receiving dialysis while a resident at the facility.

Review of the clinical record failed to reveal a baseline care plan related to the resident being on dialysis. Further review revealed a comprehensive care plan dated, 10/13/17. Review of the comprehensive care plan failed to evidence any documentation related to the resident being on hemodialysis.

An interview was conducted with LPN (licensed practical nurse) #3 on 12/7/17 at 11:44 a.m. When asked if a resident on dialysis should have a care plan that addresses the care to be provided for a dialysis resident, LPN #3 stated that it should be addressed on the care plan. When asked if a resident on dialysis has an immediate need for his care plan to be initiated upon admission, LPN #3 stated, "I would think any medical condition that requires treatment would be addressed on the care plan. I usually only initiate the five basics upon admission; pain, skin, constipation, advanced directive and falls. The MDS nurse should address all of the other areas."

An interview was conducted with LPN #4 on 12/6/17 at 2:40 p.m. When asked if all of Resident #39's dialysis care needs; the catheter site observation, the clamp at the bedside, things

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to watch for a resident receiving dialysis should be on the care plan, LPN # 4 stated, "Yes, I would think so." When asked if she initiated care plans and updated care plan, LPN #4 stated she only initiates a care plan if they come in with a wound, that's the only one I have ever done." When asked who updates or develops the baseline care plan, LPN #4 stated MDS nurse does that."

An interview was conducted with administrative staff member (ASM) #3, clinical quality specialist, on 12/7/17 at 3:00 p.m. When asked if the facility utilizes a baseline care plan, ASM #3 stated, "We do not utilize a paper baseline care plan, it is the expectation of the admitting nurse to initiate the care plan for the resident's needs upon admission."

The facility policy, "Person - Centered Care Plan" documented in part, "The Center must develop and implement a baseline person-centered care plan within 48 hours for each patient that includes the instructions needed to provide effective and person-centered care that meet professional standards of quality care."

Administrative staff member (ASM) #1, the executive director, ASM #2, the interim director of nursing, and ASM #3, were made aware of the above concern on 12/7/17 at 4:45 p.m.

No further information was obtained prior to exit.

(1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman; page 266.

4. The facility staff failed to develop a baseline care plan to address the needs of Resident #184

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F 655	Continued From page 121 for the use of oxygen. Resident #184 was admitted to the facility on 11/30/17 with diagnoses that included, but were not limited to: fracture of the left humerus, chronic obstructive pulmonary disease (general term for chronic nonreversible lung disease that is usually a combination of emphysema and chronic bronchitis (1)), atrial fibrillation (a condition characterized by rapid and random contraction of the atria of the heart causing irregular beats of the ventricles and resulting in decreased heart output and frequently clot formation in the atria (2)), pulmonary fibrosis (pulmonary fibrosis is a condition in which the tissue deep in your lungs becomes scarred over time. This tissue gets thick and stiff. That makes it hard for you to catch your breath, and your blood may not get enough oxygen (3)), diabetes and high blood pressure. There was no completed MDS (minimum data set) assessment as of the dates of the survey. The Initial Nursing Assessment, dated 11/30/17, documented Resident #184 was alert and oriented to person, place and time. The form documented under "Respiration - regular Method: oxygen via nasal." The review of the baseline care plan dated 12/4/17 failed to evidence any documentation related to the use of oxygen for Resident #184. An interview was conducted with RN (registered nurse) #7 on 12/6/17 at 2:22 p.m. When asked who completes the baseline care plan, RN #7 stated that there is a IPOC (baseline plan of care) in the computer program." When asked who creates the baseline care plan, RN #7 stated, "It	F 655		

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F 655	Continued From page 122	F 655		

should be done by the nurses upon admission." When asked if the use of oxygen should be on the baseline care plan, RN #7 stated, "Yes, it should be on there."

An interview was conducted with LPN (licensed practical nurse) #3 on 12/6/17 at 2.34 p.m. When asked if a resident on oxygen should have a care plan that addresses the use of the oxygen, LPN #3 stated that it should be addressed on the care plan. When asked if a resident on oxygen has an immediate need for his care plan to be initiated upon admission, LPN #3 stated, "I suppose so. I usually only initiate the five basics upon admission; pain, skin, constipation, advanced directive and falls. The MDS nurse should address all of the other areas."

An interview was conducted with administrative staff member (ASM) #3, clinical quality specialist, on 12/7/17 at 3:00 p.m. When asked if the facility utilizes a baseline care plan, ASM #3 stated, "We do not utilize a paper baseline care plan, it is the expectation of the admitting nurse to initiate the care plan for the resident's needs upon admission."

Administrative staff member (ASM) #1, the executive director, ASM #2, the interim director of nursing, and ASM #3, were made aware of the above concern on 12/7/17 at 4:45 p.m..

No further information was obtained prior to exit.

(1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman; page 124.
(2) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and

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F 655	Continued From page 123 Chapman; page 55. (3) This information was obtained from the following website: https://medlineplus.gov/pulmonaryfibrosis.html	F 655		
F 656 SS=E	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for	F 656	1. Residents # 40, # 286 and # 43 have all had care plans revised to include use of Oxygen. Resident # 39 Care Plan was updated to include Dialysis. Resident # 284 Care Plan updated to include ileostomy. Resident # 284 no longer has an Indwelling Catheter or a Tube Feeding. Resident # 64 is being offered showers 2 X week per care plan. Resident # 19 has heel boots in place and is being offered showers 2 X week per care plan. These corrections were completed by the Unit Manager. 2. All residents have the potential to be affected. Audits completed by Unit Managers for residents with Oxygen, Ileostomies, Dialysis, Tube Feedings, and Indwelling Catheters to ensure that they have an appropriate care plan. All residents are being offered showers 2 X week. Audit completed of care planned interventions for heel boots to ensure that they are in place.	

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F 656	Continued From page 124 future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review and clinical record review, it was determined the facility staff failed to develop and implement a comprehensive care plan for seven of 29 residents in the survey sample, Resident's #40, #39, # 286, # 284, #64, #19 and #43. 1. The facility staff failed to develop a comprehensive care plan to address Resident #40's use of oxygen. 2. The facility staff failed to develop a comprehensive care plan to address Resident #39's care and services for dialysis. 3. The facility staff failed to develop a comprehensive care plan to address Resident # 286's oxygen. 4. The facility staff failed to develop a comprehensive care plan to address Resident # 284's indwelling catheter (1), ileostomy (colostomy) (3) and feeding tube (4). 5. The facility staff failed to provide Resident #64 showers two times a week per the comprehensive care plan.	F 656	3. Education provided to the Nursing Leadership Team and MDS by the Regional Nurse on the practice and regulation for developing and revising Care Plans. This education included updating the C.N.A's Kardex with interventions on the care plan to ensure that they are followed accordingly. 4. Care Plans will be reviewed by the Clinical Management Team during the Clinical Morning Meeting 5 days per week to ensure that all new orders and changes are addressed accordingly on the Care Plan and that the Kardex gets updated. Results of these audits will be taken to the Quality Assurance and Performance Improvement Committee monthly for review.	1/17/18

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6a. The facility staff failed to apply Resident #19 soft heel boots to her right foot per the comprehensive care plan.

6b. The facility staff failed to provide Resident #19 showers two times a week per the comprehensive care plan.

7. The facility staff failed to follow Resident # 43's comprehensive care plan in regards to oxygen administration.

The findings include:

1. Resident #40 was admitted to the facility on 8/8/17 with diagnoses that included, but were not limited to: stroke, dementia, dysphagia (difficulty in swallowing), diabetes, and high blood pressure.

The most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 11/3/17, coded the resident as being severely cognitively impaired to make daily decisions. Resident #40 was coded as requiring extensive assistance to being totally dependent of one or more staff members for all of her activities of daily living. In Section O - Special treatments, Procedures and Programs, the resident was not coded as having received oxygen during the assessments 14-day look back period.

A physician order dated, 8/9/17 and signed by the physician on 10/12/17, documented, "Oxygen via nasal cannula @ (at) 2 L (liters) for shortness of breath."

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F 656	Continued From page 126 The review of the comprehensive care plan dated 8/16/17 failed to evidence the use of oxygen by Resident #40. Resident #40's October 2017 MAR (medication administration record) documented O2 (oxygen) 2L/min (minute) via NC (nasal cannula) (a tube with two prongs that insert into the resident's nostrils)." The October MAR documented that Resident #40 received oxygen on 11 days of the 14-day look back period for the 11/3/17 quarterly MDS assessment. An interview was conducted with LPN (licensed practical nurse) #4 on 12/7/17 at 2:06 p.m. When asked who does the care plans in this facility, LPN # 4 stated, "I believe (name of corporate travel nurse) helps with that." When asked if the nurses on the floor update the care plans, LPN #4 stated, "Not routinely." An interview was conducted with RN (registered nurse) #7, the MDS nurse on 12/6/17 at 2:52 p.m. When asked who updates the care plans, RN #7 stated that per facility policy, she completes the care plan for the triggered areas on the assessment. She further stated that anyone in the nursing department can update a care plan. When asked if oxygen should be on a care plan, RN #7 stated, "Yes, it should be there." Basic Nursing, Essentials for Practice, 6th edition, (Potter and Perry, 2007, pages 119-127), was a reference for care plans. "A nursing care plan is a written guideline for coordinating nursing care, promoting continuity of care and listing outcome criteria to be used in the evaluation of nursing care. The written care plan communicates nursing care priorities to other health care	F 656		

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professionals. The care plan also identifies and coordinates resources used to deliver nursing care. A correctly formulated care plan makes it easy to continue care from one nurse to another. If the patient's status has changed and the nursing diagnosis and related interventions are no longer appropriate, modify the nursing care plan. An out of date or incorrect care plan compromises the quality of nursing care."

The facility policy, "Person-Centered Care Plan" documented in part, "A comprehensive, individualized care plan will be developed within 7 days after completion of the comprehensive assessment for each patient that includes measurable objectives and timetables to meet a patient's medical, nursing, nutrition, and mental and psychosocial needs that are identified in the comprehensive assessments...Care plans will be reviewed and revised a minimum of quarterly and as needed to reflect the response to care and changing needs and goals."

The ASM (administrative staff member) #1, the executive director, ASM #2, interim director of nursing and ASM #3, clinical quality specialist were made aware of the above findings on 12/7/17 at 4:45 p.m.

No further information was provided prior exit.

(1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman; page 178.

2. The facility staff failed to develop a care plan to address Resident #39's care and services for

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dialysis.

Resident #39 was admitted to the facility on 10/3/17 with diagnosis that included but were not limited to: high blood pressure, diabetes, seizure disorder, below the knee amputation, infection of the right lower leg and end stage renal failure requiring hemodialysis.

Hemodialysis is a procedure used in toxic conditions and renal failure in which wastes and impurities are removed from the blood by a special machine. The blood is shunted to and from a dialyzer where, through diffusion and ultrafiltration, wastes are removed." (1)

The most recent MDS (minimum data assessment), a Medicare 60-day assessment, with an assessment reference date of 11/28/17, coded the resident as being cognitively intact to make daily decisions. In Section O - Special Treatments, Procedures and Programs, the resident was coded as receiving dialysis while a resident at the facility.

Review of the comprehensive care plan dated, 10/13/17, failed to evidence any documentation related to the resident being on hemodialysis.

An interview was conducted with LPN (licensed practical nurse) #3 on 12/7/17 at 11:44 a.m. When asked if a resident on dialysis should have a care plan that addresses the care to be. provided for a dialysis resident, LPN #3 stated that it should be addressed on the care plan.

An interview was conducted with LPN #4 on 12/6/17 at 2:40 p.m. When asked if all of Resident #39's dialysis care needs; the catheter

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site observation, the clamp at the bedside, things to watch for a resident receiving dialysis should be on the care plan, LPN # 4 stated, "Yes, I would think so." When asked if she initiated care plans and updated care plans, LPN #4 stated she only initiates a care plan if they come in with a wound, that's the only one I have ever done." When asked who updates or develops the baseline care plan, LPN #4 stated MDS nurse does that."

Administrative staff member (ASM) #1, the executive director, ASM #2, the interim director of nursing, and ASM #3, were made aware of the above concern on 12/7/17 at 4:45 p.m.

No further information was obtained prior to exit.

(1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman; page 266.

3. The facility staff failed to develop a comprehensive care plan to address Resident # 286's oxygen.

Resident # 286 was admitted to the facility on 02/15/17 with a readmission date of 11/18/17. Diagnosis include but were not limited to muscle weakness, prostate cancer, secondary cancer to bone, type 1(one) diabetes mellitus (1) and kidney disease.

Resident # 286's most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 11/25/17, coded Resident # 286 as scoring a 15 on the brief interview for mental status (BIMS) of a score of 0 - 15, 15 being cognitively for making daily decisions. Resident # 286 was coded as

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F 656	Continued From page 130 requiring extensive assistance to being totally dependent of one staff member for activities of daily living and supervision of one staff member for eating. On 12/04/17 at approximately 11:55 a.m. Resident # 286 was observed in bed receiving oxygen by nasal cannula (2) from oxygen a concentrator. On 12/05/17 at approximately 8:53 a.m. Resident # 286 was observed in bed eating breakfast and receiving oxygen by nasal cannula from oxygen a concentrator. On 12/05/17 at approximately 4:00 p.m. Resident # 286 was observed in bed, awake. Resident # 286 was receiving oxygen by nasal cannula from the oxygen concentrator. On 12/06/17 at 9:05 a.m. Resident # 286 was observed in bed watching television, and was receiving oxygen by nasal cannula from oxygen a concentrator. The physician's Telephone Order dated 11/30/17 documented, "Oxygen via (by) NC (nasal cannula) at 2 (two) Li (liters). Oxygen titrate up to 3.5 (three and a half) liters via NC." Review of Resident # 286's comprehensive care plan dated 11/29/17 failed to evidence a comprehensive care plan to address oxygen. The MAR (medication administration record) for Resident # 286 dated "Dec (December) 2017 documented, "Oxygen via NC at 2L. May titrate up to 3.5L (three and a half liters)." Further review of the MAR revealed Resident # 286 was	F 656		

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F 656	Continued From page 131 receiving oxygen from 12/01/17 through 12/07/17. On 12/06/17 at 2:45 p.m. an interview was conducted with RN (registered nurse) # 7, MDS coordinator regarding the comprehensive care plan for Resident # 286. RN # 7 was asked to review the comprehensive care plan for Resident # 286 dated 11/29/17. When asked if there was care plan to address Resident # 286's oxygen, RN # 7 stated, "There isn't one." When asked who was responsible for developing the oxygen care plan, RN # 7 stated, "The nurse who received the order should have developed the care plan." On 12/07/17 at 10:00 a.m. the facility provided this surveyor with a copy of a care plan to address Resident # 286's oxygen. The care plan documented, "Focus. Resident exhibits or is at risk for cardiovascular symptoms or complications related to diagnosis of CAD (coronary artery disease) atrial fibrillation, HTN (hypertension) hyperlipidemia. Date Initiated: 12/06/2017. Created on: 12/06/2017." Under "Interventions" it documented, "Oxygen as ordered via (by) NC (nasal cannula) may titrate per orders. Date Initiated: 12/06/2017. Created on: 12/06/2017." On 12/07/17 at 2:40 p.m. an interview was conducted with RN (registered nurse) # 9 regarding the comprehensive care plan for Resident # 286. When asked about the timeframe and the responsibility for the development of the comprehensive care plan, RN # 9 stated, "It's done within the first 21 days and by the MDS coordinator." When asked who was responsible for updating the care plan when there is a change in the resident's condition, RN # 9	F 656		

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stated, "Nursing should do it."

On 12/07/17 at approximately 2:50 p.m. and interview was conducted with ASM (administrative staff member) # 2, interim director of nursing and ASM # 3, clinical quality specialist. When asked who is responsible for the development of care plans for residents ASM # 2 stated, "Everyone, the IDT (interdisciplinary team)."

The facility's policy "Person-Centered Care Plan" documented, "2. A comprehensive person-centered care plan must be developed for each patient and must describe the following: 2.1 Services that are to be furnished."

On 12/06/17 at approximately 5:00 p.m. ASM (administrative staff member) # 1, executive director, ASM # 2, interim director of nursingand ASM # 3, clinical quality specialist, were made aware of the findings.

No further information was obtained prior to exit.

References:
(1) A chronic disease in which the body cannot regulate the amount of sugar in the blood. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/ency/article/001214.htm.

(2) Tubing used to deliver oxygen at levels from 1 to 6 L/min. The nasal prongs of the cannula extend approx. 1 cm into each naris and are connected to a common tube, which is then connected to the oxygen source. It is used to treat conditions in which a slightly enriched oxygen content is needed, such as emphysema. The exact percentage of oxygen delivered to the

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patient varies with respiratory rate and other factors. This information was obtained from the website: http://medical-dictionary.thefreedictionary.com/nasal+cannula.

(3) An oxygen concentrator works much like a window air conditioning unit: it takes in air, modifies it and delivers it in a new form. An oxygen concentrator takes in air and purifies it for use by people requiring medical oxygen due to low oxygen levels in their blood. It works by: taking in air from its surroundings, compressing air, while the cooling mechanism keeps the concentrator from overheating, removing nitrogen from the air via filter and sieve beds, adjusting delivery settings with an electronic interface and delivering the purified oxygen via a nasal cannula or mask. This information was obtained from: https://www.inogen.com/resources/oxygen-concentrators/how-does-an-oxygen-concentrator-work/.

4. The facility staff failed to develop a comprehensive care plan to address Resident # 284's indwelling catheter (1), ileostomy (colostomy) (3) and feeding tube (4).

Resident # 284 was admitted to the facility on 11/30/17 with diagnoses that included but were not limited to: atrial fibrillation (2), dysphagia, (5), osteoporosis, attention of ileostomy and attention to gastrostomy (feeding tube).

Resident # 284's most recent MDS (minimum data set), an admission assessment was not due at the time of survey.

The facility's "Nursing Assessment-Initial" for Resident # 284 dated 11/30/17 documented,

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F 656	Continued From page 134 "Orientation to person, place and time; Judgement/Insight-intact and clear speech." Further review of the "Nursing Assessment-Initial" for Resident # 284 documented, "Feeding tube, Colostomy and Indwelling catheter." Review of the resident's comprehensive care plan dated 12/04/17 failed to evidence a care plan to address Resident # 284's feeding tube, colostomy and indwelling catheter. On 12/06/17 at 2:45 p.m. an interview was conducted with RN (registered nurse) # 7, MDS coordinator regarding the comprehensive care plan for Resident # 284. RN # 7 was asked to review the comprehensive care plan for Resident # 284 dated 12/04/17. When asked if there was care plan to address Resident # 284's feeding tube, colostomy and indwelling catheter RN # 7 stated, "There isn't one." When asked who was responsible for developing the oxygen care plan RN # 7 stated, "Nursing." 12/07/17 at 2:50 p.m. and interview was conducted with ASM (administrative staff member) # 2, interim director of nursing and ASM # 3 clinical quality specialist. When asked who is responsible for the development of the interim care plan for Residents # 284 ASM # 2 stated, "Everyone, the IDT (interdisciplinary team)." On 12/06/17 at approximately 5:00 p.m. ASM (administrative staff member) # 1, executive director, ASM # 2, interim director of nursingand ASM # 3, clinical quality specialist, were made aware of the findings. No further information was obtained prior to exit.	F 656		

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F 656	Continued From page 135 References: (1) You have an indwelling catheter (tube) in your bladder. "Indwelling" means inside your body. This catheter drains urine from your bladder into a bag outside your body. Common reasons to have an indwelling catheter are urinary incontinence (leakage), urinary retention (not being able to urinate), surgery that made this catheter necessary, or another health problem. This information was obtained from the website: https://medlineplus.gov/ency/patientinstructions/000140.htm. (2) A swallowing disorder. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/swallowingdisorders.html. (3) An ileostomy (colostomy) is used to move waste out of the body. This surgery is done when the colon or rectum is not working properly. This information was obtained from the website: https://medlineplus.gov/ency/article/007378.htm. (4) A gastrostomy feeding tube insertion is the placement of a feeding tube through the skin and the stomach wall. It goes directly into the stomach. This information was obtained from the website: https://medlineplus.gov/ency/article/002937.htm. (5) Makes your bones weak and more likely to break. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/osteoporosis.html. 5. The facility staff failed to provide Resident #64	F 656		

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showers two times a week per the comprehensive care plan.

Resident #64 was admitted to the facility on 10/05/17 with diagnoses that included but were not limited to atrial fibrillation, heart failure, high blood pressure, renal insufficiency, high cholesterol, thyroid disorder, and post stroke. Resident #64's most recent MDS (minimum data set) assessment was an admission assessment with an ARD (assessment reference date) of 10/12/17. Resident #64 was coded as being cognitively intact in the ability to make daily decisions scoring 15 out of 15 on the BIMS (brief interview for mental status) exam. Resident #64 was coded as requiring extensive assistance from two or more staff with bed mobility, transfers, toileting, and personal hygiene. An "8/8" was coded under the area of "Bathing" indicating that bathing had not occurred over the seven-day look-back period.

On 12/04/17 at 04:31 p.m., an interview was conducted with Resident #64. Resident #64 had stated he does not receive showers at the facility. Resident #64 stated he could only recall one time that he had a shower. Resident #64 stated sometimes staff will wash him with a wash cloth before they dress him every morning.

Review of Resident #64's ADL (activity of daily living) records dated 10/2017 through 12/2017 failed to evidence Resident #64 had received a shower. The only bed bath documented was on 11/7/17.

Review of the shower sheets dated October 2017 through December 2017 revealed Resident #64's shower days were on Thursdays and Mondays.

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F 656	Continued From page 137 Further review of the shower sheets failed to evidence Resident #64 had received showers since his admission to the facility. Review of Resident #64's comprehensive care plan for ADL (activity daily living) dated 10/9/17, documented the following: "Resident is at risk for decreased ability to perform ADLS in bathing, grooming, personal hygiene, dressing, eating, bed mobility, transfer, locomotion...interventions...Resident get a shower 2x a week, Resident needs assist with adls (sic)." On 12/06/17 at 1:40 p.m., an interview was conducted with CNA (certified nursing assistant) # 8, Resident #64's CNA. CNA #8 stated that CNAs were responsible for doing showers and documenting any new areas on a skin sheet. CNA #8 also stated that nail care would be documented on this sheet because nails were cleaned with showers. CNA #8 could not determine when Resident # 64 had a shower last. CNA #8 stated that she rarely worked with him and that his CNA left early that day. On 12/06/17 at 11:33 a.m. an interview was conducted with LPN (licensed practical nurse) #8. When asked how often showers are given, LPN #8 stated, "Showers are given twice a week. The schedules depend on the room. Showers are documented in the shower book. Nursing aides sign off if baths and showers are given. Bed baths should be given every day. They document in their tablet for ADLS. If it is not documented, it was not done." On 12/07/17 at 09:33 a.m., an interview was conducted with CNA (certified nursing assistant)	F 656		

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#15. When asked where resident showers are documented, CNA #15 stated that each unit has a shower book. CNA #15 stated that the shower sheets have a date documented on the top of the sheet and all room numbers listed for residents who receive showers on that assigned day. CNA #15 stated that once a shower is completed, the CNAs should be signing off next to the room number of the residents who received a shower. CNA #15 stated if there is no signature next to the room number, it doesn't necessarily mean the shower was not completed. CNA #15 stated the nursing aide could have forgot to document. CNA #15 stated if a resident refuses a shower, she will tell the nurse. When asked if she has ever missed a resident shower, CNA #15 stated, "Yes, sometimes I can't get to people." When asked if a resident should have to miss their shower, CNA #15 stated that they shouldn't. CNA #15 stated that she was not familiar with Resident #64.

On 12/07/17 at 09:38 a.m., an interview was conducted with LPN (licensed practical nurse) #2. When asked how nurses ensure residents are receiving showers, LPN #2 stated that she would check the shower book. LPN #2 stated if a resident misses their shower on a shift, the shower would be passed on to the next shift. LPN #2 stated a resident may not get a shower on their scheduled shower day. LPN #2 stated when the resident finally receives a shower, it will be documented in the shower book. When asked what blanks meant on the shower logs in the shower book, LPN #2 stated that if the shower was not documented then it wasn't done.

On 12/08/17 at 8:22 a.m., an interview was conducted with RN (registered nurse) #7. When asked the purpose of the care plan, RN #7 stated

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the care plan served as a guide to determine resident's needs. RN #7 was asked what it meant if a resident who has interventions on the care plan to shower 2 x a week, but there is no documented evidence this was being done. RN #7 stated the care plan was not being followed if staff are not providing showers per the plan of care.

On 12/07/17 at 4:45 p.m., ASM (administrative staff member) #1, the executive director, ASM #2, the interim DON (Director of Nursing) and ASM #3, the clinical quality specialist were made aware of the above concerns.

The facility policy titled, "Person Centered Care Plan," documents in part, the following: "Purpose: To attain or maintain the patient's highest practicable physical, mental and psychosocial well-being. To promote positive communication between the patient, resident representative, and team to obtain the patient's and resident representative input into the plan of care, ensure effective communication, and optimize clinical outcome."

No further information was provided prior to exit.

6a. The facility staff failed to apply soft heel boots to Resident #19's right foot per the comprehensive plan of care.

Resident #19 was admitted to the facility on 8/25/16 with diagnoses that included but were not limited to: anemia, high blood pressure, diabetes mellitus, post stroke with aphasia (difficulty speaking), hemiplegia (paralysis on one side of the body), and Parkinson's Disease. Resident

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F 656	Continued From page 140 #19's most recent MDS (minimum data set) assessment was a quarterly assessment with an ARD (assessment reference date) of 9/20/17. Resident #19 was coded as being cognitively intact in the ability to make daily life decisions scoring 12 out of 15 on the BIMS (brief interview for mental status) exam. Resident #12 was coded as requiring extensive assistance from one staff member with dressing, toileting, and personal hygiene; extensive assistance from two or more staff with bed mobility and limited assistance with bathing. On 12/04/17 at 11:46 a.m. an observation was made of Resident #19. Resident #19 was sleeping in bed. A soft heel boot was observed in her chair. On 12/04/17 at 12:23 p.m. an observation was made of Resident #19. Resident #19 was lying in bed. A CNA (certified nursing assistant) entered her room to deliver her lunch tray. A soft heel boot was observed on the chair beside her bed. On 12/06/17 at 09:03 a.m., an observation was made of Resident #19. She was lying in bed asleep. One soft heel boot was observed on the chair next to her bed. On 12/06/17 10:37 a.m., an observation was made of Resident #19. She was lying in bed. She did not have a soft heel boot in place to her right foot. Resident #19 stated her heel boot had not been on her right foot. The heel boot was observed in the chair next to her bed. Review of Resident #19's POS (physician order sheet) dated 12/4/17 documented the following order: "Soft heel boots when in bed for skin	F 656		

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F 656	Continued From page 141 integrity." This order was initiated on 8/25/16. Review of Resident #19's comprehensive skin care plan dated 9/22/16 documented the following: "Resident is at risk for skin breakdown as evidenced by incontinence, limited mobility, moisture/excessive perspiration...Interventions: Soft heel boots as ordered." Review of the December 2017 TAR (Treatment administration record) revealed that nursing was not documenting that the heel boots to Resident #19's feet were in place. The order was written on the TAR as an FYI (For Your Information). Review of the ADLs (activities of daily living) tracker revealed an instruction for soft heels to Resident #19's heels. On 12/06/17 at 11:30 a.m. an interview was conducted with LPN (licensed practical nurse) #8. When asked how CNAs would know what skin preventive measures to put into place for each resident, LPN #8 stated when the nurse puts the skin intervention on the care plan and places it into the computer, the nursing aides should be able to see/view this intervention under the ADLs section of the computer. On 12/06/17 at 1:40 p.m., an interview was conducted with CNA #8. When asked how CNAs would know the needs of each resident, CNA #8 stated that CNAs can look on the ADL tracker on their tablet. CNA #8 stated that she was not familiar with Resident # 19 and could not determine what she needed in place for skin preventive measures. On 12/06/17 at 2:10 p.m., an interview with CNA	F 656		

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#10, Resident #19's CNA. When asked how CNAs would know what skin preventive measures to put into place for each resident, CNA #10 stated that she would look in the residents' closet and instructions for anything to be put into place should be listed in the closet. When asked what skin preventive measures should be put into place for Resident # 19, CNA #10 stated that she does not normally work with Resident # 19 and she normally works on the 200 hall. This writer then followed CNA #10 into Resident # 19's room. No instructions for the heel boots could be found in Resident #19's closet. When asked what the CNA observed in Resident #19's chair, CNA #10 stated that she saw a heel boot. CNA #10 stated, "Maybe it was on and it fell off, so someone put in in the chair." CNA #10 then removed the blankets covering Resident # 19 legs. Her soft heel boot was not on her right foot. When asked if her soft heel boots should be in place, CNA #10 stated, "She should have them on, I would think." When asked where else she can look to see what residents needed in place, CNA #10 stated, "I would go to the nurse and ask."

On 12/06/17 at 2:10 p.m., observation of Resident # 19's right heel was conducted. Her skin was intact and not reddened.

12/07/17 at approximately 8:30 a.m., an interview was conducted with LPN # 9, the wound care nurse. When asked the purpose of soft heel boots, LPN #9 stated that the purpose of soft heel boots was to protect the ankles and heels from getting DTIS (Deep Tissue Injuries). When asked when it would be recommended for residents to wear soft heel boots, LPN #9 stated that if a resident was a moderate risk for skin breakdown,

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F 656	Continued From page 143 then they should be wearing them in bed. On 12/07/17 at approximately 10:18 a.m., an interview was conducted with RN (registered nurse) #4, Resident #19's nurse. When asked the purpose of soft heel boots, RN #4 stated that the point of soft heel boots was to leave the heels free floating, to prevent the calf and heels from rubbing on the bed. RN #4 stated heel boots help to relieve pressure. RN #4 stated the nursing aids usually put soft heel boots on but the nurse should ensure that they are in place. On 12/06/17 at 5:30 p.m. ASM (administrative staff member) #1, the executive director, ASM #2, the interim DON (Director of Nursing) and ASM #3, the clinical quality specialist were made aware of the above concerns. No further information was presented prior to exit. 6b. The facility staff failed to provide Resident #19 showers two times a week per the comprehensive care plan. On 12/04/17 through 12/08/17 several observations were made of Resident #19 lying in bed. Resident #19 was observed to be lying in bed on the following dates and times: 12/4/17 at 11:46 a.m., 12:23 p.m., 1:52 p.m., 3:00 p.m., 12/5/17 08:56 a.m., 09:36 a.m., 12:00 p.m., 2:47 p.m., 12/6/17 07:49 a.m., 9:03 a.m., 11:35 a.m., 3:04 p.m. and 12/7/17 at 9:46 a.m.. On 12/05/17 at 8:56 a.m. an interview was conducted with Resident #19. Resident #19 stated she had not been out of bed in two weeks. Resident #19 stated that no one has ever asked	F 656		

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her if she would like to get out of bed. Resident #19 stated she would like to get of bed but never asks to get out the bed.

On 12/06/17 at 11:35 a.m. further interview was conducted with Resident #19. When asked how Resident #19 receives showers if she never gets out of the bed, Resident #19 stated she does not receive showers at the facility. Resident #19 could not remember the last time she had a shower at the facility. Resident #19 stated she will get washed up in bed.

Review of Resident #19's comprehensive ADL (activities of daily living) care plan dated 9/2/16 and revised 7/6/17 documented the following: "Resident/Patient requires assistance in ADL care related to: chronic illness, compromising functional ability. Goal: Residents/Patients ADL care needs will be anticipated and met through next review period x 90 days...Interventions: Resident gets a shower 2 x (two times) a week."

Review of the shower log sheets revealed Resident #19 was supposed to receive a shower on Wednesdays and Saturdays during the day shift. Further review of the shower logs from August 2017 until December 2017 revealed Resident #19 had not received any showers.

Review of Resident #19's October 2017 through December 2017 ADL (activities of daily living) report revealed that Resident #19 was documented as having a shower on 10/28/17.

On 12/06/17 at 11:33 a.m., an interview was conducted with LPN (licensed practical nurse) #8. When asked how often showers are given, LPN #8 stated, "Showers are given twice a week. The

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schedules depend on the room. Showers are documented in the shower book. Nursing aides sign off if baths and showers are given. Bed baths should be given every day. They document in their tablet for ADLS. If it is not documented, it was not done."

On 12/07/17 at 09:33 a.m., an interview was conducted with CNA (certified nursing assistant) #15. When asked where resident showers are documented, CNA #15 stated that each unit has a shower book. CNA #15 stated that the shower sheets have a date documented on the top of the sheet and all room numbers listed for residents who receive showers on that assigned day. CNA #15 stated once a shower is completed, the CNAs should be signing off next to the room number of the residents who received a shower. CNA #15 stated if there is no signature next to the room number, it doesn't necessarily mean the shower was not completed. CNA #15 stated the nursing aide could have forgot to document. CNA #15 stated that if a resident refuses a shower, she will tell the nurse. When asked if she has ever missed a resident shower, CNA #15 stated, "Yes, sometimes I can't get to people." When asked if a resident should have to miss their shower, CNA #15 stated that they shouldn't. CNA #15 stated that she was not familiar with Resident #19.

On 12/07/17 at 09:38 a.m., an interview was conducted with LPN (licensed practical nurse) #2. When asked how nurses ensure that residents are receiving showers, LPN #2 stated that she would check the shower book. LPN #2 stated that if a resident misses their shower on a shift due, the shower would be passed on to the next shift. LPN #2 stated that a resident may not get a

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F 656	Continued From page 146 shower on their scheduled shower day. LPN #2 stated when the resident finally receives a shower, it will be documented in the shower book. When asked what blanks meant on the shower logs in the shower book, LPN #2 stated that if the shower was not documented then it wasn't done. On 12/08/17 at 8:22 a.m., an interview was conducted with RN (registered nurse) #7. When asked the purpose of the care plan, RN #7 stated the care plan served as a guide to determine resident's needs. RN #7 was asked what it meant if a resident who has interventions on the care plan to shower 2 x a week, but there is no documented evidence this was being done. RN #7 stated the care plan was not being followed if staff are not providing showers per the plan of care. On 12/07/17 at 4:45 p.m., ASM (administrative staff member) #1, the executive director, ASM #2, the interim DON (Director of Nursing) and ASM #3, the clinical quality specialist were made aware of the above concerns. No further information was provided prior to exit. 7. The facility staff failed to follow Resident # 43's comprehensive care plan in regards to oxygen administration. Resident # 43 was admitted to the facility on 7/8/17 and readmitted on 9/19/17 with diagnoses that included but were not limited to: anemia, congestive heart failure, hypertension, diabetes, hyperlipidemia, anxiety, and depression. Resident # 43's most recent MDS (minimum data	F 656		

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WOODMONT CENTER	11 DAIRY LANE FREDERICKSBURG, VA 22405

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F 656	Continued From page 147 set) assessment, a Quarterly Assessment, with an ARD (assessment reference date) of 10/15/17 coded Resident # 43 as understood by others and as able to understand others. Resident # 43 was coded as being cognitively intact for making daily decisions, scoring 15 out of 15 on the BIMS (brief interview for mental status). Review of the comprehensive care plan revealed documentation of the following: Under "Focus: Resident exhibits or is at risk for respiratory complications related to history of CHF (congestive heart failure), PNA (pneumonia) and seasonal allergies. Date Initiated 09/28/17" Under "Interventions ...O2 as ordered via nasal cannula. Date Initiated 09/28/2017" Review of a physician order dated 9/20/17 and most recently signed by the physician on 12/4/17 documented, "OXYGEN 2L/MIN VIA NASAL CANNULA CONTINUOUS." Review of the December 2017 MAR is as follows: "O2 @ 1L/min via nasal cannula Continuous" dated 9/20/17. The following observations were made of Resident # 43's oxygen: 12/04/17 11:59 a.m. Resident # 43 oxygen set at 1.5 liters/minute 12/04/17 05:48 p.m. Resident # 43 oxygen observed to be set at 1.5 liters/minute 12/05/17 08:31 a.m. Resident # 43 oxygen set at 1.5 liters/minute 12/06/17 07:10 a.m. Resident # 43 oxygen noted to be set at 1.5 liters/minute 12/06/17 09:12 a.m. Resident # 43 oxygen set at 1.5 liters/minute	F 656		

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F 656	Continued From page 148 During an interview on 12/6/17 at 3:02 p.m. with LPN (licensed practical nurse) # 3, LPN # 3 was asked the purpose of the care plan. LPN # 3 stated the purpose of the care plan was to give direction on how to care for the resident. During an interview on 12/7/17 at 12:06 p.m. with LPN # 10, LPN # 10 was asked the purpose of the care plan. LPN # 10 said the care plan was a guide to get the patient to their best potential and to try to keep them at that level. Staff would use the care plan to find out how to care for the patient. The care plan would give information on the patient's toileting, eating, transfer status and would even give information on whether or not they were diabetic and how to care for them and perhaps their respiratory status too. During an interview on 12/7/17 at approximately 12:45 p.m. with ASM (Administrative Staff Member) # 1, the Executive Director, ASM # 2, the Interim Director of Nurses, and ASM # 3, the Clinical Quality Specialist, this observation was revealed. Review of the facility policy: "PERSON-CENTERED CARE PLAN" documented Under, "PURPOSE To attain or maintain the patient's highest practicable physical, mental and psychosocial well-being. To promote positive communication between patient, resident representative, and team to obtain the patient's and resident representative input into the plan of care, ensure effective communication, and optimize clinical outcomes." No further information was provided prior to exit.	F 656		

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F 656	Continued From page 149 Basic Nursing, Essentials for Practice, 6th edition, (Potter and Perry, 2007, pages 119-127), was a reference for care plans. "A nursing care plan is a written guideline for coordinating nursing care, promoting continuity of care and listing outcome criteria to be used in the evaluation of nursing care. The written care plan communicates nursing care priorities to other health care professionals. The care plan also identifies and coordinates resources used to deliver nursing care. A correctly formulated care plan makes it easy to continue care from one nurse to another. If the patient's status has changed and the nursing diagnosis and related interventions are no longer appropriate, modify the nursing care plan. An out of date or incorrect care plan compromises the quality of nursing care."	F 656		
F 657 SS=E	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined	F 657	1. Resident #12 has had care plan updated to reflect bruise on chin and area on forehead. Resident # 56 has been discharged from the facility. Residents # 72 and # 62 have had care plans updated to reflect recent falls and new interventions. Resident # 19's care plan was updated to reflect current chair. Resident # 74 Care Plan was updated to reflect Fluid Restrictions. Resident # 47 Care Plan was updated to reflect current wound. These corrections were made by the Unit Managers. 2. All residents have the potential to be affected. Audit was completed by the Unit Managers of all	

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F 657	Continued From page 150 not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review and clinical record review, it was determined the facility staff failed to review and revise the care plan for seven of 29 residents in the survey sample, Resident #12, #56, #72, #62, #19, #74 and #47. 1. The facility staff failed to review and revise Resident #12's comprehensive care plan following injuries of unknown origin, a bruise to her chin and an abrasion to her forehead. 2. The facility staff failed to review and revise the comprehensive care plan when Resident #56's code status changed from a full code to a do not resuscitate. 3. The facility staff failed to review and revise Resident #72's comprehensive care plan following the 9/27/17, 10/2/17 and 10/11/17 falls. 4. The facility staff failed to review and revise Resident #62's comprehensive care plan following the 4/4/17, 4/16/17, 9/9/17 and 10/2/17 falls. 5. The facility staff failed to revise the	F 657	residents with Fluid Restrictions were reviewed to ensure care plans in place. Audit was completed of all residents with pressure ulcers to ensure care plans are in place. Residents with injuries and falls in the last month were reviewed to ensure that care plan was updated accordingly. 3. Education was provided to the Clinical Management Team by the Regional Nurse related to the regulation to ensure that Care Plans are revised with changes. 4. Clinical Management Team will review Care Plans during the Clinical Morning Meeting 5 days per week, to ensure that all falls and changes are addressed accordingly on the Care Plan and that the Kardex gets updated. Results of these audits will be taken to the Quality Assurance and Performance Improvement Committee monthly for review.	1/17/18

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F 657	Continued From page 151 comprehensive care plan after Resident #19 was discharged from occupational therapy with recommendations for a BRODA chair. 6. The facility staff failed to revise Resident #74's comprehensive care plan to include the physician-ordered fluid restriction ordered on 12/1/17. 7. The facility staff failed to review and revise Resident #47's comprehensive care plan after the resident acquired new pressure injuries in November 2017. The findings include: 1. The facility staff failed to review and revise Resident #12's comprehensive care plan following injuries of unknown origin, a bruise to her chin and an abrasion to her forehead. Resident #12 was admitted to the facility on 11/15/10 with a readmission on 5/5/16 with diagnoses that included, but were not limited to; dementia, osteoporosis (weakening of the bones), anemia (low red blood cells), acid reflux disease, depression, difficulty swallowing, and cognitive deficit. Resident #12's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 11/17/17, revealed, in part, that Resident #12 was unable to answer the questions on the BIMS (brief interview of mental status) and was coded on the staff assessment as being severely impaired to make decisions regarding tasks of daily life. Resident #12 was further coded as being dependent on staff for activities of daily living.	F 657		

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Resident #12 was observed during the survey process to have an abrasion on her forehead above her right eye. There was no documentation in Resident #12's clinical record concerning the abrasion.

A review of Resident #12's clinical record, revealed, in part, a progress note documenting the following; ""Effective Date: 11/8/17 23:20 (11:20 p.m.) Type: Change in Condition. Note: A change in condition has been noted. The symptoms include: Skin wound or ulcer 11/8/2017. Change reported to Primary Care Clinician: (name of clinician notified) 11/8/2017 4:00 p.m. Name of Family / Healthcare agent notified: SELF 11/8/2017 4:00 p.m."

Further review of Resident #12's clinical record revealed, in part, a change in condition document dated 11/8/17 that documented, in part, the following; "Old bruise, fadded (sic) bluish color to right chin."

Further review of Resident #12's clinical record did not reveal any documentation that an investigation had been initiated to determine how Resident 12 had sustained the injuries to her chin and forehead.

A review of Resident #12's comprehensive care plan did not reveal any documentation regarding injuries in November 2017 and December 2017.

On 12/07/17 at 10:24 a.m., an interview was conducted with LPN (licensed practical nurse) #3, a floor nurse. LPN #3 was asked to describe the purpose of a comprehensive care plan. LPN #3 stated, "It tells us how to take care of a patient; if

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on oxygen the care plan tells us how to administer O2 whether continuous or PRN." LPN #3 was asked who is responsible for updating the care plans and when would they be updated. LPN #3 stated, "Everybody is responsible for updating care plans. The nurses and MDS. For example, if I got a new order for an antibiotic then I would update the care plan." LPN #3 was asked how a care plan is updated. LPN #3 stated that It is done on the computer.

On 12/7/17 at 12:30 p.m. an interview was conducted with ASM (administrative staff member) #2, the interim director of nursing (DON). ASM #2 was asked who was responsible for updating the comprehensive care plans. ASM #2 stated the care plans were updated by the MDS coordinator or herself. ASM #2 was asked when a care plan would be updated, ASM #2 stated "Anytime there is a change in condition, a change in therapies or a change in preferences." ASM #2 was asked who was responsible for updating the care plan when there was an injury. ASM #2 stated the nurse who initiated the investigation and myself. ASM #2 was asked about the injuries of unknown origin, the bruise on Resident #12's chin identified on 11/8/17 and the abrasion on Resident #12's forehead (for which the time of occurrence was undetermined). ASM #2 stated the care plan was not updated as she was not involved in those incidents. At this time a copy of the facility policy regarding comprehensive care plans was requested.

A review of the facility policy titled "Person-Centered Care Plan" revealed, in part, the following documentation; "The care plan will be reviewed and revised by the interdisciplinary team after each assessment. 5. Care plans will