STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495318	A. BUILDING _____ B. WING _____	C 11/08/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BERRY HILL NURSING HOME	621 BERRY HILL ROAD SOUTH BOSTON, VA 24592

(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 11/06/18 through 11/08/18. Corrections are required for compliance with CFR 483.73, the Federal requirements for Emergency Preparedness in Long Term Care facilities.	E 000		
E 009 SS=C	Local, State, Tribal Collaboration Process CFR(s): 483.73(a)(4) [(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do the following:] (4) Include a process for cooperation and collaboration with local, tribal, regional, State, and Federal emergency preparedness officials' efforts to maintain an integrated response during a disaster or emergency situation, including documentation of the facility's efforts to contact such officials and, when applicable, of its participation in collaborative and cooperative planning efforts. * [For ESRD facilities only at §494.62(a)(4)]: (4) Include a process for cooperation and collaboration with local, tribal, regional, State, and Federal emergency preparedness officials' efforts to maintain an integrated response during a disaster or emergency situation, including documentation of the dialysis facility's efforts to contact such officials and, when applicable, of its participation in collaborative and cooperative planning efforts. The dialysis facility must contact the local emergency preparedness agency at least annually to confirm that the agency is aware of the dialysis facility's needs in the event of an emergency.	E 009		12/23/18

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

Electronically Signed | 11/26/2018

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E 009	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on review of the facility's Emergency Preparedness Plan and staff interview, the facility failed to contact Emergency officials and failed to invite their participation in a collaborative and cooperative planning effort in an emergency event. Findings included: The facility's Emergency Preparedness Plan was reviewed on 11/08/18 at approximately 9:00 a.m. No documentation was located in the Emergency Preparedness binder regarding the facility's efforts in contacting Emergency officials and inviting their participation in a collaborative and cooperative planning effort. The Administrator was interviewed on 11/08/18 at approximately 11:00 a.m. The Administrator stated, "I don't have this." No further information was received by the survey team prior to the exit conference on 11/08/18.	E 009	The facility administrator will contact Emergency Officials and invited them to participate in an active shooter training/planning event by 12/23/18 with documentation of contact and invitation placed in the Emergency Preparedness book. The Corporate Facility Consultant will review the Emergency Preparedness notebook by 12/23/18 to ensure it include a process for cooperation and collaboration with emergency preparedness officials□, documentation of the facility□s efforts to contact officials and invite to participate in planning efforts. The Administrator will be in serviced on Emergency Preparedness: the requirements for developing and maintain an emergency disaster plan to include contacting emergency officials, invite their participation in a collaborative and cooperative planning effort in an emergency event, and annual update by the Corporate Facility Consultant by 12/23/18. The Corporate Facility Consultant will review the emergency preparedness notebook quarterly x 1 to ensure documentation is completed and maintained to include facility□s efforts to contact officials and invite to participate in planning efforts utilizing an emergency preparedness notebook audit tool. The Corporate Facility Consultant will retrain the Administrator for any identified areas of concern.	

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E 009	Continued From page 2	E 009	The Administrator will forward the results of the emergency preparedness notebook audit tool to the Executive QA Committee quarterly x 1. The Executive QA committee will meet and review the emergency preparedness notebook audit tool quarterly x 1 and address any issues, concerns and\or trends and to make changes as needed, to include continued frequency of monitoring.	
E 020 SS=C	Policies for Evac. and Primary/Alt. Comm. CFR(s): 483.73(b)(3) [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. At a minimum, the policies and procedures must address the following:] Safe evacuation from the [facility], which includes consideration of care and treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s); and primary and alternate means of communication with external sources of assistance. *[For RNHCs at §403.748(b)(3) and ASCs at §416.54(b)(2):] Safe evacuation from the [RNHCI or ASC] which includes the following: (i) Consideration of care needs of evacuees. (ii) Staff responsibilities.	E 020		12/23/18

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E 020	Continued From page 3 (iii) Transportation. (iv) Identification of evacuation location(s). (v) Primary and alternate means of communication with external sources of assistance. * [For CORFs at §485.68(b)(1), Clinics, Rehabilitation Agencies, OPT/Speech at §485.727(b)(1), and ESRD Facilities at §494.62(b)(2):] Safe evacuation from the [CORF; Clinics, Rehabilitation Agencies, and Public Health Agencies as Providers of Outpatient Physical Therapy and Speech-Language Pathology Services; and ESRD Facilities], which includes staff responsibilities, and needs of the patients. * [For RHCs/FQHCs at §491.12(b)(1):] Safe evacuation from the RHC/FQHC, which includes appropriate placement of exit signs; staff responsibilities and needs of the patients. This REQUIREMENT is not met as evidenced by: Based on review of the facility's Emergency Preparedness Plan and staff interview, the facility failed to develop a plan for safe evacuation from the facility that included all of the required elements during an emeergency event. Findings included: The facility's Emergency Preparedness Plan was reviewed on 11/08/18 at approximately 9:00 a.m. No documentation was located in the Emergency Preparedness binder regarding a plan for safe evacuation from the facility that included all of the required elements. The Administrator was interviewed on 11/08/18 at	E 020	The facility administrator will develop a plan for safe evacuation from the facility that includes all required elements by 12/23/18. The Corporate Facility Consultant will review the Emergency Preparedness notebook by 12/23/18 to ensure it includes a plan for safe evacuation from the facility that includes all of the required elements during an emergency event. The Administrator will be in serviced on Emergency Preparedness: the requirements for developing a plan for safe evacuation from the facility to include	

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E 020	Continued From page 4 approximately 12:00 p.m. The Administrator stated, "I do not have a policy for evacuation." No further information was received by the survey team prior to the exit conference on 11/08/18.	E 020	consideration of care and treatment, needs of evacuees, staff responsibilities, transportation, identification of evacuation locations, and primary and alternate means of communications with external sources of assistance by the Corporate Facility Consultant by 12/23/18. The Corporate Facility Consultant will review the emergency preparedness notebook quarterly x 1 to ensure documentation is completed and maintained to include a plan for safe evacuation from the facility that includes all of the required elements during an emergency utilizing an emergency preparedness notebook audit tool. The Corporate Facility Consultant will retrain the Administrator for any identified areas of concern. The Administrator will forward the results of the emergency preparedness notebook audit tool to the Executive QA Committee quarterly x 1. The Executive QA committee will meet and review the emergency preparedness notebook audit tool quarterly x 1 and address any issues, concerns and\or trends and to make changes as needed, to include continued frequency of monitoring.	
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,	E 024		12/23/18

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E 024	Continued From page 5 and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. At a minimum, the policies and procedures must address the following:] (6) [or (4), (5), or (7) as noted above] The use of volunteers in an emergency or other emergency staffing strategies, including the process and role for integration of State and Federally designated health care professionals to address surge needs during an emergency. *[For RNHCIs at §403.748(b):] Policies and procedures. (6) The use of volunteers in an emergency and other emergency staffing strategies to address surge needs during an emergency. *[For Hospice at §418.113(b):] Policies and procedures. (4) The use of hospice employees in an emergency and 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. This REQUIREMENT is not met as evidenced by: Based on review of the facility's Emergency Preparedness Plan and staff interview, the facility failed to develop a plan to address the use of volunteers and other staffing strategies during an emergency event. Findings included: The facility's Emergency Preparedness Plan was reviewed on 11/08/18 at approximately 9:00 a.m. No documentation was located in the Emergency	E 024	The facility administrator will develop a plan to address the use of volunteers and other staffing strategies during an emergency event and included this in the emergency preparedness book by 12/23/18. The Corporate Facility Consultant will review the Emergency Preparedness notebook by 12/23/18 to ensure it includes a plan to address the use of volunteers	

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E 024	Continued From page 6 Preparedness binder on the use of volunteers and other staffing strategies during an emergency event. The Administrator was interviewed on 11/08/18 at approximately 11:40 a.m. The Administrator stated, "We do not have an actual policy specifying the use of volunteers. We just have this list of who volunteers can be." No further information was received by the survey team prior to the exit conference on 11/08/18.	E 024	and other staffing strategies during an emergency event. The Administrator will be in serviced on Emergency Preparedness: the requirements for developing a plan to address the use of volunteers and other staffing strategies during an emergency event by the Corporate Facility Consultant by 12/23/18. The Corporate facility Consultant will review and initial the emergency preparedness notebook quarterly x 1 to ensure documentation is completed and maintained to include a plan to address the use of volunteers and other staffing strategies during an emergency event utilizing an emergency preparedness notebook audit tool. The Corporate Facility Consultant will retrain the Administrator for any identified areas of concern. The Administrator will forward the results of the emergency preparedness notebook audit tool to the Executive QA Committee quarterly x 1. The Executive QA committee will meet and review the emergency preparedness notebook audit tool quarterly x 1 and address any issues, concerns and\or trends and to make changes as needed, to include continued frequency of monitoring.	
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		12/23/18

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E 026	Continued From page 7 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 review of the facility's Emergency Preparedness Plan and staff interview, the facility failed to develop a plan to address the facility's role in providing care and treatment at alternate care sites under an 1135 waiver during an emergency event. Findings included: The facility's Emergency Preparedness Plan was reviewed on 11/08/18 at approximately 9:00 a.m. No documentation was located in the Emergency Preparedness binder on the facility's role in providing care and treatment at alternate care sites under an 1135 waiver during an emergency	E 026	The facility administrator will developed a plan to address the facilities role in providing care and treatment at alternate care sites under an 1135 waiver during an emergency event by 12/23/18. The Corporate Facility Consultant will review the Emergency Preparedness notebook by 12/23/18 to ensure it includes a plan to address the facilities role in providing care and treatment at alternate care sites under an 1135 waiver during an emergency event. The Administrator will be in serviced on Emergency Preparedness: the	

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E 026	Continued From page 8 event. The Administrator was interviewed on 11/08/18 at approximately 11:40 a.m. The Administrator stated, "I don't have that." No further information was received by the survey team prior to the exit conference on 11/08/18.	E 026	requirements for developing a plan to address the facilities role in providing care and treatment at alternate care sites under an 1135 waiver during an emergency event by the Corporate Facility Consultant by 12/23/18. The Corporate Facility Consultant will review and initial the emergency preparedness notebook quarterly x 1 to ensure documentation is completed and maintained to include a plan to address the facilities role in providing care and treatment at alternate care sites under an 1135 waiver during an emergency event utilizing an emergency preparedness notebook audit tool. The Corporate Facility Consultant will retrain the Administrator for any identified areas of concern. The Administrator will forward the results of the emergency preparedness notebook audit tool to the Executive QA Committee quarterly x 1. The Executive QA committee will meet and review the emergency preparedness notebook audit tool quarterly x 1 and address any issues, concerns and\or trends and to make changes as needed, to include continued frequency of monitoring.	
E 029 SS=C	Development of Communication Plan CFR(s): 483.73(c) (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. This REQUIREMENT is not met as evidenced	E 029		12/23/18

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E 029	Continued From page 9 by: Based on review of the facility's Emergency Preparedness Plan and staff interview, the facility failed to develop a written communication plan for use during an emergency event and therefore was not available for review. Findings included: The facility's Emergency Preparedness Plan was reviewed on 11/08/18 at approximately 9:00 a.m. No documentation was located in the Emergency Preparedness binder regarding a written communication plan for use during an emergency event and therefore was not available for review. The Administrator was interviewed on 11/08/18 at approximately 11:40 a.m. The Administrator stated, "I can't find it. I don't have that." No further information was received by the survey team prior to the exit conference on 11/08/18.	E 029	The facility administrator will develop a written communication plan for use during an emergency event by 12/23/18. The Emergency Preparedness will be updated to include the written communication plan for use during an emergency event by 12/23/18. The Corporate Facility Consultant will review the Emergency Preparedness notebook by 12/23/18 to ensure it includes a written communication plan for use during an emergency even. The Administrator will be in serviced on Emergency Preparedness: the requirements for developing a written communication plan for use during an emergency event by the Corporate Facility Consultant by 12/23/18. The Corporate Facility Consultant will review and initial the emergency preparedness notebook quarterly x 1 to ensure documentation is completed and maintained to include a written communication plan for use during an emergency event utilizing an emergency preparedness notebook audit tool. Corporate Facility Consultant for any identified areas of concern. The Administrator will forward the results of the emergency preparedness notebook audit tool to the Executive QA Committee quarterly x 1. The Executive QA committee will meet and review the emergency preparedness notebook audit tool quarterly x 1 and address any issues,	

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E 029	Continued From page 10	E 029	concerns and\or trends and to make changes as needed, to include continued frequency of monitoring.	
E 030 SS=C	Names and Contact Information CFR(s): 483.73(c)(1) [(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:] (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians (iv) Other [facilities]. (v) Volunteers. *[For RNHCIs at §403.748(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Next of kin, guardian, or custodian. (iv) Other RNHCIs. (v) Volunteers. *[For ASCs at §416.45(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement.	E 030		12/23/18

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E 030	Continued From page 11 (iii) Patients' physicians. (iv) Volunteers. *[For Hospices at §418.113(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Hospice employees. (ii) Entities providing services under arrangement. (iii) Patients' physicians. (iv) Other hospices. *[For HHAs at §484.102(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians. (iv) Volunteers. *[For OPOs at §486.360(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Volunteers. (iv) Other OPOs. (v) Transplant and donor hospitals in the OPO's Donation Service Area (DSA). This REQUIREMENT is not met as evidenced by: Based on review of the facility's Emergency Preparedness Plan and staff interview, the facility failed to ensure all Facility contacts were included in the written communication plan.	E 030	The facility administrator will develop a written communication plan to include all facility contacts and placed in the emergency preparedness notebook by 12/23/18.	

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E 030	Continued From page 12 Findings included: The facility's Emergency Preparedness Plan was reviewed on 11/08/18 at approximately 9:00 a.m. No documentation was located in the Emergency Preparedness binder regarding all Facility contacts being included in the written communication plan. The Administrator was interviewed on 11/08/18 at approximately 11:40 a.m. The Administrator stated, "I can't find it. I don't have that." No further information was received by the survey team prior to the exit conference on 11/08/18.	E 030	The Corporate Facility Consultant will review the Emergency Preparedness notebook by 12/23/18 to ensure it includes a written communication plan with all required names and contact information for use during an emergency event. The Administrator will be in serviced on Emergency Preparedness: the requirements for developing a communication plan that includes names and contact information for staff, entities providing services under arrangement, patient□s physicians, other facilities, next of kin, guardian, or custodian, and volunteers for use during an emergency event by the Corporate Facility Consultant by 12/23/18. The Corporate Facility Consultant will review and initial the emergency preparedness notebook quarterly x 1 to ensure documentation is completed and maintained to include a written communication plan with all required names and contact information for use during an emergency event utilizing an emergency preparedness notebook audit tool. The Corporate Facility Consultant will retrain the Administrator for any identified areas of concern. The Administrator will forward the results of the emergency preparedness notebook audit tool to the Executive QA Committee quarterly x 1. The Executive QA committee will meet and review the emergency preparedness notebook audit tool quarterly x 1 and address any issues, concerns and\or trends and to make	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BERRY HILL NURSING HOME	621 BERRY HILL ROAD SOUTH BOSTON, VA 24592

(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 030	Continued From page 13	E 030	changes as needed, to include continued frequency of monitoring.	
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 review of the facility's Emergency Preparedness Plan and staff interview, the facility failed to ensure the written communication plan included primary and alternate means for communicating with facility staff, Federal, State, tribal, regional and local emergency management agencies. Findings included: The facility's Emergency Preparedness Plan was reviewed on 11/08/18 at approximately 9:00 a.m. No documentation was located in the Emergency Preparedness binder that the written	E 032	The facility administrator will develop a communication plan including primary and alternate means for communicating with facilitiy staff, Federal, State, regional and local emergency management agencies by 12/23/18. The Corporate Facility Consultant will review the Emergency Preparedness notebook by 12/23/18 to ensure it includes a written communication plan with primary and alternate means for communicating with facility staff, Federal, State, regional and local emergency management	12/23/18

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E 032	Continued From page 14 communication plan included primary and alternate means for communicating with facility staff, Federal, State, tribal, regional and local emergency management agencies. The Administrator was interviewed on 11/08/18 at approximately 11:40 a.m. The Administrator stated, "I can't find it. I don't have that." No further information was received by the survey team prior to the exit conference on 11/08/18.	E 032	agencies for use during an emergency event. The Administrator will be in serviced on Emergency Preparedness: the requirements for developing a communication plan that includes primary and alternate means for communicating with facility staff, Federal, State, regional and local emergency management agencies for use during an emergency event by the Corporate Facility Consultant by 12/23/18. The Corporate Facility Consultant will review and initial the emergency preparedness notebook quarterly x 1 to ensure documentation is completed and maintained to include a written communication plan that include primary and alternate means for communicating with facility staff, Federal, State, regional and local emergency management agencies utilizing an emergency preparedness notebook audit tool. The Corporate Facility Consultant will retrain the Administrator for any identified areas of concern. The Administrator will forward the results of the emergency preparedness notebook audit tool to the Executive QA Committee quarterly x 1. The Executive QA committee will meet and review the emergency preparedness notebook audit tool quarterly x 1 and address any issues, concerns and\or trends and to make changes as needed, to include continued frequency of monitoring.	
E 034	Information on Occupancy/Needs	E 034		12/23/18

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E 034 SS=C	Continued From page 15 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 review of the facility's Emergency Preparedness Plan and staff interview, the facility failed to ensure the written communication plan included a means of providing information about the facility's needs, and ability to provide assistance, to the authority having jurisdiction, the Incident Command Center, or designee; and failed to include a means of providing information about their occupancy.	E 034	The facility administrator will develop a written communication plan that includes a means of providing information about the facilities needs and ability to provide assistance to the authority havingjurisdiction, the incident command center or designee to include a means of providing information about their occupancy by 12/23/18. The Corporate Facility Consultant will	

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E 034	Continued From page 16 Findings included: The facility's Emergency Preparedness Plan was reviewed on 11/08/18 at approximately 9:00 a.m. No documentation was located in the Emergency Preparedness binder that the written communication plan included a means of providing information about the facility's needs, and ability to provide assistance, to the authority having jurisdiction, the Incident Command Center, or designee; and failed to include a means of providing information about their occupancy. The Administrator was interviewed on 11/08/18 at approximately 11:40 a.m. The Administrator stated, "I can't find it. I don't have that." No further information was received by the survey team prior to the exit conference on 11/08/18.	E 034	review the Emergency Preparedness notebook by 12/23/18 to ensure it includes a written communication plan with means of providing information about the facilities needs and ability to provide assistance to the authority having jurisdiction, the incident command center or designee to include a means of providing information about their occupancy for use during an emergency event. The Administrator will be in serviced on Emergency Preparedness: the requirements for developing a communication plan that includes primary and alternate means for communicating with means of providing information about the facilities needs and ability to provide assistance to the authority having jurisdiction, the incident command center or designee to include a means of providing information about their occupancy for use during an emergency event by the Corporate Facility Consultant by 12/23/18. The Corporate Facility Consultant will review and initial the emergency preparedness notebook quarterly x 1 to ensure documentation is completed and maintained to include a written communication plan that include means of providing information about the facilities needs and ability to provide assistance to the authority having jurisdiction, the incident command center or designee to include a means of providing information about their occupancy utilizing an emergency preparedness notebook audit tool. The Corporate Facility Consultant will	

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E 034	Continued From page 17	E 034	retrain the Administrator for any identified areas of concern. The Administrator will forward the results of the emergency preparedness notebook audit tool to the Executive QA Committee quarterly x 1. The Executive QA committee will meet and review the emergency preparedness notebook audit tool quarterly x 1 and address any issues, concerns and\or trends and to make changes as needed, to include continued frequency of monitoring.	
E 037 SS=C	EP Training Program CFR(s): 483.73(d)(1) (1) Training program. The [facility, except CAHs, ASCs, PACE organizations, PRTFs, Hospices, and dialysis facilities] must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected role. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. *[For Hospitals at §482.15(d) and RHCs/FQHCs at §491.12:] (1) Training program. The [Hospital or RHC/FQHC] must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing on-site services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at	E 037		12/23/18

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E 037	Continued From page 18	E 037		

least annually.
(iii) Maintain documentation of the training.
(iv) Demonstrate staff knowledge of emergency procedures.

*[For Hospices at §418.113(d):] (1) Training. The hospice must do all of the following:
(i) Initial training in emergency preparedness policies and procedures to all new and existing hospice employees, and individuals providing services under arrangement, consistent with their expected roles.
(ii) Demonstrate staff knowledge of emergency procedures.
(iii) Provide emergency preparedness training at least annually.
(iv) Periodically review and rehearse its emergency preparedness plan with hospice employees (including nonemployee staff), with special emphasis placed on carrying out the procedures necessary to protect patients and others.

*[For PRTFs at §441.184(d):] (1) Training program. The PRTF must do all of the following:
(i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles.
(ii) After initial training, provide emergency preparedness training at least annually.
(iii) Demonstrate staff knowledge of emergency procedures.
(iv) Maintain documentation of all emergency preparedness training.

*[For PACE at §460.84(d):] (1) The PACE

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E 037	Continued From page 19	E 037		

organization must do all of the following:
(i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing on-site services under arrangement, contractors, participants, and volunteers, consistent with their expected roles.
(ii) Provide emergency preparedness training at least annually.
(iii) Demonstrate staff knowledge of emergency procedures, including informing participants of what to do, where to go, and whom to contact in case of an emergency.
(iv) Maintain documentation of all training.

*[For CORFs at §485.68(d):](1) Training. The CORF must do all of the following:
(i) Provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles.
(ii) Provide emergency preparedness training at least annually.
(iii) Maintain documentation of the training.
(iv) Demonstrate staff knowledge of emergency procedures. All new personnel must be oriented and assigned specific responsibilities regarding the CORF's emergency plan within 2 weeks of their first workday. The training program must include instruction in the location and use of alarm systems and signals and firefighting equipment.

*[For CAHs at §485.625(d):] (1) Training program. The CAH must do all of the following:
(i) Initial training in emergency preparedness policies and procedures, including prompt reporting and extinguishing of fires, protection,

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E 037	Continued From page 20 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 review of the facility's Emergency Preparedness Plan and staff interview, the facility failed to ensure documentation of the facility's initial emergency preparedness training and annual emergency preparedness training offering, and failed to ensure documentation that facility staff have received initial and annual emergency preparedness training. Findings included: The facility's Emergency Preparedness Plan was	E 037	The Administrator will train all staff on emergency preparedness by 12/23/18. Documentation of the training will be placed in the emergency preparedness notebook by the Administrator by 12/23/18. The Corporate Facility Consultant will review the Emergency Preparedness notebook by 12/23/18 to ensure it includes documentation of the facility□s initial training with all staff.	

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E 037	Continued From page 21 reviewed on 11/08/18 at approximately 9:00 a.m. No documentation was located in the Emergency Preparedness binder of the facility's initial emergency preparedness training and annual emergency preparedness training offering, and failed to ensure documentation that facility staff have received initial and annual emergency preparedness training. The Administrator was interviewed on 11/08/18 at approximately 12:00 p.m. The Administrator stated, "I don't have this. On hire they actually only receive the fire plan procedure and active shooter training. They don't get the whole book. I don't know why because the person who did emergency preparedness training on hire is no longer here." No further information was received by the survey team prior to the exit conference on 11/08/18.	E 037	The Administrator and Staff Facilitator will be in serviced on Emergency Preparedness: Requirements for initial staff training upon hire and annual emergency preparedness training with all staff and documentation of proof of offering and receiving training in the emergency preparedness notebook by the Corporate Facility Consultant by 12/23/18. The Corporate Facility Consultant will review the emergency preparedness notebook quarterly x 1 to ensure documentation is completed and maintained to include initial emergency preparedness training for new hires with documentation of offering and receiving utilizing an emergency preparedness notebook audit tool. The Corporate Facility Consultant will retrain the Administrator and/or staff facilitator for any identified areas of concern. The Administrator will forward the results of the emergency preparedness notebook audit tool to the Executive QA Committee quarterly x 1. The Executive QA committee will meet and review the emergency preparedness notebook audit tool quarterly x 1 and address any issues, concerns and\or trends and to make changes as needed, to include continued frequency of monitoring.	
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	E 039		12/23/18

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E 039	Continued From page 22	E 039		

test the emergency plan at least annually. The [facility, except for RNHCIs and OPOs] must do all of the following:

*[For LTC Facilities at §483.73(d):] (2) Testing. The LTC facility must conduct exercises to test the emergency plan at least annually, including unannounced staff drills using the emergency procedures. The LTC facility must do all of the following:]

(i) Participate in a full-scale exercise that is community-based or when a community-based exercise is not accessible, an individual, facility-based. If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in a community-based or individual, facility-based full-scale exercise for 1 year following the onset of the actual event.
(ii) Conduct an additional exercise that may include, but is not limited to the following:
(A) A second full-scale exercise that is community-based or individual, facility-based.
(B) A tabletop exercise that includes a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or 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]

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E 039	Continued From page 23 must conduct exercises to test the emergency plan. The [RNHCI and OPO] must do the following: (i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group discussion led by a facilitator, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (ii) Analyze the [RNHCI's and OPO's] response to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCI's and OPO's] emergency plan, as needed. This REQUIREMENT is not met as evidenced by: Based on review of the facility's Emergency Preparedness Plan and staff interview, the facility failed to ensure documentation of the facility's efforts to identify a full-scale community based exercise. Findings included: The facility's Emergency Preparedness Plan was reviewed on 11/08/18 at approximately 9:00 a.m. No documentation was located in the Emergency Preparedness binder to include documentation of the facility's efforts to identify a full-scale community based exercise. The Administrator was interviewed on 11/08/18 at approximately 11:00 a.m. The Administrator stated, "I don't have that." No further information was received by the survey team prior to the exit conference on 11/08/18.	E 039	A full-scale community based exercise will be developed and scheduled by the Administrator with documentation in the emergency preparedness notebook by 12/23/18. The Corporate Facility Consultant will review the Emergency Preparedness notebook by 12/23/18 to ensure it includes documentation of the facility□s efforts to identify a full-scale community base exercise. The Administrator will be in serviced on Emergency Preparedness: Requirements for Testing to include conducting exercises to test the emergency plan at least annually, unannounced staff drills, participation in a full-scale exercise that is community based, analyzing the response and maintaining documentation of all drills, tabletop exercises, and emergency events, and revisions to the emergency plan as needed by the Corporate Facility	

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E 039	Continued From page 24	E 039	Consultant by 12/23/18. The Corporate Facility Consultant will review the emergency preparedness notebook quarterly x 1 to ensure documentation is completed and maintained to the facility□s efforts to identify a full-scale community base exercise utilizing an emergency preparedness notebook audit tool. The Corporate Facility Consultant will retrain the Administrator for any identified areas of concern. The Administrator will forward the results of the emergency preparedness notebook audit tool to the Executive QA Committee quarterly x 1. The Executive QA committee will meet and review the emergency preparedness notebook audit tool quarterly x 1 and address any issues, concerns and\or trends and to make changes as needed, to include continued frequency of monitoring.	
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 11/06/2018 through 11/08/2018. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. One complaint was investigated during the survey. The census in this 120 certified bed facility was 73 at the time of the survey. The survey sample consisted of 18 current resident reviews and three (3) closed record reviews.	F 000		
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3)	F 558		12/23/18

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F 558	Continued From page 25 §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: Based on observation, clinical record review, resident interview and staff interview, the facility staff failed to ensure a functional wheelchair to accommodate the needs for one of 21 residents, Resident #50. Resident #50 stated that her wheelchair wheels were "dry rotted" and "not safe for me to get in." Findings were: Resident #50 was originally admitted to the facility on 06/29/2017, and most recently readmitted on 09/10/2018. Her diagnoses included, but were not limited to: Urinary tract infection, acute respiratory infection, chronic pain syndrome, major depressive disorder, type II diabetes mellitus, hypothyroidism, mood disorder due to psychological condition, hypertension, and irritable bowel syndrome with diarrhea. The most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 09/27/2018, assessed Resident #50 as moderately impaired in her cognitive status with a summary score of "09". On 11/06/2018, at approximately 11:45 a.m., Resident #50 was lying in bed watching television. She was asked about life at the facility.	F 558	Maintenance replaced the wheels on the wheel chair of resident #50 on 11/7/18. A 100% audit will be conducted of all wheelchairs in use by residents, to include resident # 50 by maintenance on 11/15/18. Any negative findings will be corrected during the audit by the Maintenance Director. All staff will be re-educated by the Administrator by 12/23/18 on completing of maintenance work orders for any needed equipment repairs to include wheelchairs. Maintenance staff will conduct inspections of resident wheel chairs to include resident #50 for functionality, using the wheelchair check list weekly x 8 weeks then monthly x 1 month. Maintenance Director will forward the results of the wheelchair check list Audit Tools to the Executive Quality Assurance (QA) Committee monthly x 3 months. The Executive QA committee will meet and review the wheelchair checklist and address any issues, concerns and\or trends and to make changes as needed, to include continued frequency of monitoring monthly x 3 months.	

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When discussing her activities at the facility she stated, "I don't go to activities...it's too much trouble for them to get me up and when they do I don't have a wheelchair." Resident #50 was asked about the wheelchair. She stated, "I've got one, it's in the bathroom but the wheels on it are dry rotted...It's not safe for me to get in." Resident #50 was asked if anyone had talked to her about getting a new one. She stated, "I can't get a new one." She was asked why, and she stated, "I don't know, I just can't...it's okay I watch TV in here and eat and take naps...I'm okay." Resident #50 was asked if she would go to activities if she had a wheelchair. She stated, "Yes, I probably would." Resident #50 was asked if this surveyor could look in her bathroom at her wheelchair. She stated, "Yes." The wide seat wheelchair was observed in the bathroom. The tires were worn, with small visible cracks in the rubber.

The clinical record was reviewed on 11/07/2018 and contained the following information in a mental health therapy note dated 10/30/2018: "Cl [client] does not currently attend activites, but is interested...Recommendations/Plan: Staff: Facilitator... Please follow-up wiht Cl re: wheelchair, she reports that she is no longer able to sit in the seat due to size and the wheels have rotted..."

On 11/07/2018 at approximately 4:00 p.m., one of the physical therapists, OS (other staff) #3 was interviewed about Resident #50's wheelchair. He stated that he had worked with Resident #50 on walking and strengthening, but she was no longer receiving services. He stated that he had not looked at the tires on her wheelchair, but that he had measured her and the wheelchair seat and

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the size of the wheelchair was appropriate. He stated that OT (Occupation Therapy) would be who would be able to address the tires/wheels but the OT who had worked with Resident #50 was gone for the day.

The above information was discussed during an end of the day meeting with the administrator and the DON (director of nursing) on 11/07/2018 at approximately 5:45 p.m.

On 11/08/2018 at approximately 8:20 a.m., the OT who had worked with Resident #50 came to the conference room. She was asked about Resident #50's wheelchair. She stated that she had worked with Resident #50 a "couple of months ago." She stated that she was unaware of any issues with the wheelchair. She stated, "We wouldn't really do anything with the tires, that would be maintenance." The OT was asked how maintenance would know to do anything with the wheelchair. She stated, "Nursing would communicate that." The OT was asked if she would look at the wheelchair and see if anything needed repairing/replacing.

The OT left the conference room and came back with the maintenance director. The OT stated, "[Name of Resident #50] told me the tires were dry rotted...I don't really know what dry rotted tires look like, but that is the chair that I put her in over the summer because she 'outgrew' the other one...I looked at the tires and they do look a little worn, but [name of maintenance director] said he replaced them last night."

The maintenance director was asked about replacing the wheelchair tires. He stated, "I replaced them last night." He was asked why

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F 558	Continued From page 28 they had been replaced. He stated, "They were worn and needed to be replaced...that's not her chair, it belongs to the facility so I had tires here for it." He was asked how long new tires had been available. He stated, "About a year." He was asked why he was just now putting them on the chair. He stated, "They needed to be replaced." He was asked if the administrator had told him to go look at the tires after her meeting with the survey team the night before. He stated, "Yes, ma'am." The OT was asked to provide a date that the resident was placed in the chair and the maintenance director was asked to provide the date the tires were ordered. The OT provided information that Resident #50 had been placed in the wheelchair on 07/08/2018 and the Maintenance Director presented an invoice that the wheelchair tires had purchased on 03/26/2012. On 11/08/2018 at approximately 9:30 a.m., Resident #50 was interviewed regarding her wheelchair. She was asked if she knew she had gotten new tires. She stated, "Yes, isn't that something? They put them on there last night." Resident #50 was asked if she was going to get up and give them a try. She stated, "Probably so, we'll see, my back is hurting today." The above information was discussed during a meeting with the DON and the administrator on 11/08/2018 at approximately 12:00 p.m. No further information was obtained prior to the exit conference on 11/08/2018.	F 558		
F 567 SS=B	Protection/Management of Personal Funds CFR(s): 483.10(f)(10(i)(ii)	F 567		12/23/18

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§483.10(f)(10) The resident has a right to manage his or her financial affairs. This includes the right to know, in advance, what charges a facility may impose against a resident's personal funds.
(i) The facility must not require residents to deposit their personal funds with the facility. If a resident chooses to deposit personal funds with the facility, upon written authorization of a resident, the facility must act as a fiduciary of the resident's funds and hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility, as specified in this section.
(ii) Deposit of Funds.
(A) In general: Except as set out in paragraph (f)(l0)(ii)(B) of this section, the facility must deposit any residents' personal funds in excess of $100 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.) The facility must maintain a resident's personal funds that do not exceed $100 in a non-interest bearing account, interest-bearing account, or petty cash fund.
(B) Residents whose care is funded by Medicaid: The facility must deposit the residents' personal funds in excess of $50 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.) The facility must maintain personal funds that do not exceed $50 in a noninterest bearing account,

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F 567	Continued From page 30 interest-bearing account, or petty cash fund. This REQUIREMENT is not met as evidenced by: Based on observations, group interview, individual resident interviews, and staff interview, the facility failed to ensure residents had reasonable and ready access to their personal funds in their individual resident fund accounts. Residents could only make withdrawals for a two hour period Monday through Friday. There were no official banking hours on the weekend. The findings were: At 10:00 a.m. on 11/7/18, 10 residents met with a member of the survey team for a group interview. During the course of the interview, the residents were asked about access to their personal funds if they wanted money for incidentals, or for a special occasion. All of the residents knew they could obtain money from the Business Office, but only from 2:00 p.m. to 4:00 p.m. Monday through Friday. Asked if they could get money on the weekends, the residents all said they could not because the Business Office was closed on weekends. "I wish we could," several of the residents said. A sign on the door at the Business Office noted the following: Office Banking Hours for Residents 2:00 p.m. to 4:00 p.m. Monday thru Friday At 3:00 p.m. on 11/7/18, the Bookkeeper in the Business Office was interviewed about the residents' access the their personal funds. The	F 567	Residents will have access to funds 7 days per week by seeing the business office Monday-Friday or manager on duty on weekends. The posted sign has been updated to reflect such by the Administrator on 11/21/18. All residents will be educated on access to funds 7 days per week during the resident council meeting to be held 11/28/18 by the Activities Director. Any resident not in attendance were notified in writing of how to access their trust funds 7 days a week by the Activities staff. The Business office Manager and Mangers on weekend duty were educated that residents can access their personal funds/trust funds by seeing the business office or manager on duty, 7 days per week. 10% of Residents participating in the Resident Trust Account will be interviewed by the Administrator to ensure Resident funds are available upon request utilizing a Resident Fund QI Tool weekly x 8 weeks then monthly x 1 month. The Business office manager or manager on duty will be in serviced by the Administrator for any identified areas of concern. The Administrator will forward the results of the Resident Fund QI Tools to the Executive Quality Assurance (QA) Committee monthly x 3 months. The Executive QA committee will meet and	

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F 567	Continued From page 31 Bookkeeper stated, "They can come in Monday through Friday, from 2 to 4. On weekends we have a Manager here and they can go to the Manager and ask for money. The Manager will call the Administrator and she will come to the building and get the box with the money." When asked if the residents knew about contacting the Manager, the Bookkeeper said, "They should." The sign posted at the Business Office with the banking hours did not include any information about contacting the Manager to access funds on the weekend. Six of the residents were contacted individually and asked if they knew about going to the Manager on weekends if they needed money. Their responses included: "I did not know about going to the Manager on weekends. Never heard that, the office is closed on weekends. Never heard that. The office is closed on weekends. You can't get money on weekends. The office is closed on weekends. We can't get any money." One resident said he thought he heard about it, but he gets his money on Friday to make sure he has some. During an end of day meeting at 5:45 p.m. on 11/7/18, that included the Administrator, the Director of Nursing, and the survey team, the Administrator was asked how the residents can obtain money on weekends. The Administrator confirmed what the Bookkeeper said about	F 567	review the Resident Fund QI Tools and address any issues, concerns and\or trends and to make changes as needed, to include continued frequency of monitoring monthly x 3 months.	

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F 567	Continued From page 32 contacting the Manager. Asked if she would come to the building if called by the Manager, the Administrator said, "Yes." The Administrator was then advised that some of the residents were unaware they could go to the Manager on weekends for money.	F 567		
F 584 SS=B	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv);	F 584		12/23/18

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F 584	Continued From page 33 §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 observations, resident interviews, and staff interviews, the facility failed to provide a dignified, homelike dining experience in the Dining Room. Meals in the Dining Room were served on trays, with the plates, bowls, cups, glasses, etc., remaining on the trays as the resident ate. The findings were: At 11:55 a.m. on 11/6/18, observation of the noon meal (Lunch) in the Dining Room was conducted. At the time of the observation, approximately 29 residents were seated at tables. Each resident was served Lunch on a tray, with the plates, bowls, cups, glasses, etc., remaining on the trays as the resident ate. During the course of the meal, two residents, both of whom were alert, oriented, and cognitively intact, were asked about eating their meal off trays. "We get all our meals on trays," one resident said. Asked if she would like to have her plates, bowls, cups, glasses, etc., placed on the table instead of remaining on the tray, the resident said, "That would be nice." The second resident, when asked the same questions,	F 584	Residents were provided a dignified dining experience on 11/8/18 by being served by items being removed from the tray and beverages in containers being poured into glasses with oversite by the Administrator. Breakfast, lunch, and dinner meal service will be observed by the Director of Nursing and/or RN Supervisor by 12/23/18 to ensure a homelike dining experience was provided to include removing all items to include plates, bowls, cups, and glasses from the tray prior to the residents eating. All nurses, nursing assistants, scheduler, geriatric care attendants and activity staff will be educated regarding ensuring a homelike dining experience during meal service to include removing plates, bowls, cups, and glasses from the tray prior to the residents eating by the Director of Nursing on or before 12/23/18. The Director of Nursing, Assistant Director of Nursing, Staff Facilitator, MDS Nurse, Quality Improvement Nurse, or Registered Nurse Supervisor will observe	

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F 584	Continued From page 34 replied, "It would be different. Maybe they could try it." At 7:55 a.m. on 11/7/18, observation of the morning meal (Breakfast) in the Dining Room was conducted. There were approximately 22 resident seated at tables. As with the noon meal on 11/6/18, each resident was served Breakfast on a tray, with the plates, bowls, cups, glasses, etc., remaining on the trays as the resident ate. During the course of the observation, the following staff members were asked why the residents were served on trays and ate off the trays. Their responses included: The Staffing Scheduler - "That's the way I was taught to do. That's the way we've always done it." The Activities Director - "That's the way we've always done it." LPN # 5 (Licensed Practical Nurse) - "I don't know why. It's just how we've always done it." The Director of Nursing - "I've only been here six days. I just kind of followed suit. Monkey see, monkey do." The surveyor shared the meal observations during an end of day meeting at 5:45 p.m. on 11/7/18, that included the Administrator, the Director of Nursing, and the survey team.	F 584	3 meals per weekly to include breakfast, lunch, and dinner x 8 weeks the monthly x 1 month to ensure a homelike dining experience was provided to include removing all items to include plates, bowls, cups, and glasses from the tray prior to the residents eating utilizing a dining observation audit tool. The Director of Nursing, Assistant Director of Nursing, Staff Facilitator, MDS Nurse, Quality Improvement Nurse, or Registered Nurse Supervisor will reeducate the staff member not removing the tray for any identified areas of concern. The Administrator will forward the results of the Dining Observation Audit Tools to the Executive Quality Assurance (QA) Committee monthly x 3 months. The Executive QA committee will meet and review the Dining Observation Audit Tools and address any issues, concerns and\or trends and to make changes as needed, to include continued frequency of monitoring monthly x 3 months.	
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	F 641		12/23/18

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F 641	Continued From page 35 by: Based on observation, staff interview, and clinical record review, the facility staff failed to ensure the accuracy of assessments. The facility staff failed to ensure an MDS (minimum data set) assessment accurately reflected the status of Resident # 61. Findings include: Resident #61 was admitted to the facility originally on 08/23/13, with the most current readmission on 01/12/18. Diagnoses for Resident #61 included, but was not limited to: acute respiratory failure, lack of coordination, repeated falls, abnormal weight loss, muscle weakness, abnormal gait and mobility, muscle wasting, hypothyroidism, atrial fibrillation, anxiety disorder, and unsteadiness on feet. The resident's most current complete MDS (minimum data set) was a quarterly assessment dated 10/05/18. This MDS documented the resident's cognitive status as a "3" indicating the resident was severely impaired for daily decision making skills. The resident was assessed as requiring supervision with one person assist for bed mobility, transfers and extensive assistance for dressing with one person assist. The resident was also assessed as requiring supervision with set up only for eating. The resident was assessed as requiring supervision for toileting and personal hygiene with one person assist. A comparison quarterly MDS was reviewed dated 07/04/18. This MDS assessed the resident's cognitive status as an "11" indicating the resident had moderate impairment in daily decision	F 641	A significant change MDS was completed for resident #61 on 11/22/18 by the Clinical Quality Reimbursement Director Assistant to accurately reflect the resident□s current functional status. An audit of all resident□s to include resident # 61 most recent MDS section G was conducted by Clinical Quality/Reimbursement Director Assistant on or before 11/21/18 to ensure the assessment accurately reflects the resident. Any identified areas of concern were addressed by completion of an assessment modification by the Clinical Quality/Reimbursement Director Assistant. The MDS Coordinator will be trained on MDS coding to accurately reflect the resident on or before 11/20/18. The Administrator will complete an audit of section G of the MDS for 10% of the MDS completed weekly x 8 weeks then monthly x 1 month to ensure the MDS coding accurately reflects the resident utilizing a MDS Coding Audit Tool. The Administrator will reeducate the MDS nurse during the time of the audit for any identified areas of concern. The Administrator will forward the results of the MDS Coding Audit Tools to the Executive Quality Assurance (QA) Committee monthly x 3 months. The Executive QA committee will meet and review the MDS Audit Tools and address any issues, concerns and\or trends and to	

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F 641	Continued From page 36	F 641		

making skills. This MDS documented the resident required extensive assistance with one person assist for bed mobility. The resident was assessed as requiring supervision with one person physical assist for transfers and eating and as requiring extensive assistance with one person physical assist for dressing, toileting, and personal hygiene. The resident was totally dependent for bathing with one person.

During the survey process from 11/06/18 though 11/08/18, the resident was observed multiple times and in various settings. The resident was frail and thin. The resident had O2 (oxygen) via a NC (nasal canula) at 2LPM (liters per minute). During each observation the resident was using accessory muscles to breath and struggled to breath.

On 11/06/18 at approximately 11:20 a.m., the resident was observed sitting in her room alone in a wheelchair. The resident was thin and frail, with O2 via NC, and was using accessory muscles to breath. The resident gave a slight smile when spoken to. The resident was asked how she doing. The resident could barely respond. The resident was informed that it was ok not to speak.

At approximately 11:30 a.m., RN (Registered Nurse) # 1 was interviewed regarding this resident and was asked if this was how this resident was normally. The RN stated that this was "normal" for this resident and was not new. The RN stated that the resident had severe CHF (congestive heart failure) and had been this way for a while and stated that the resident often takes the oxygen off.

CNA (certified nursing assistant) # 1 was then

make changes as needed, to include continued frequency of monitoring monthly x 3 months.

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observed taking water into the resident's room. The CNA stated that the resident had a hard time breathing and was easily tired doing even the simplest things, such as talking. The CNA asked how long the resident had been this way. The CNA stated that she didn't know, but if she had to guess, "maybe 6 months."

Resident #61 was observed again around 12:30 p.m., the resident was asked if she was going to eat lunch. The resident did not respond.

At approximately 2:00 p.m., CNA #1 stated that the resident refused to eat and that she normally doesn't eat and if she does it is very little and that has been going on for a while.

Resident #61 was observed in the dining room on 11/07/18 at approximately 12:00 p.m., the resident was at a table with other residents, in her wheelchair, with her O2 on via NC. The resident had her tray in front of her. The resident just sat there with her arms in her lap, using her accessory muscles to breath. The resident was asked if she was going to eat and the resident barely spoke, saying yes and gave a slight nod in a yes manner. A resident sitting beside Resident #61 stated that she (Resident #61) is very slow.

On 11/07/18 at 3:31 PM, RN #1, who was the MDS coordinator, was interviewed regarding Resident #61. The RN was made aware of the MDS comparisons and of the observations of Resident #61. The RN stated that resident has had improvements and declines and went on to say that the resident had a lot of medication changes. The RN stated that the resident had gone into the hospital in January for respiratory failure and when she returned to the facility, the

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resident was taken off most all of her psychiatric medications and did not do well; that the resident would start improving and then had periods of where she wouldn't do anything. The RN stated that she felt like they (the facility) had finally got her medications straight. The RN stated that the resident has had improvements and declines since the last MDS. The RN was then made aware of the observations of the resident being frail and thin and using accessory muscles to breath, and not doing anything other than sitting and trying to breath, in relation to the most current MDS assessment. The RN was made aware that these observations and the MDS did not correlate a true reflection of the resident's actual status. The RN was then asked why a significant change assessment was not completed on this resident. The RN stated that she did not feel the MDS dated 10/05/18 accurately captured the resident's true status, indicating that the resident was actually worse than the MDS documented. The RN stated that a significant change MDS was currently in progress to show the decline. She further stated that the facility had identified a problem about a month ago with care tracker documentation, which is used for MDS completion, and that the documentation for some residents was not an accurate reflection of the resident status. CNA's were educated on correctly coding and imputing the resident's status into the computer system. The RN stated, "I can only go by the documentation." The RN stated that that she thought that she had already completed a significant change for this resident, but had not. The RN was then asked if the facility had identified an issue, had all the staff been educated on this. The RN stated, "No, I have about 4 or 5 people of different shifts that I

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F 641	Continued From page 39 haven't been able to educate yet." On 11/07/18 at approximately 5:30 p.m., the DON (director of nursing) and administrator were made aware of the above information in a meeting with the survey team. The administrator stated that the facility identified this problem. The administrator was asked to present the information. On 11/08/18 at approximately 7:30 a.m., information was presented on the above. The information did not show evidence that all staff were educated to date to ensure the problem was corrected. No further information and or documentation was presented prior to the exit conference on 11/08/18 at 1:45 p.m.	F 641		
F 644 SS=E	Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2) §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible	F 644		12/23/18

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F 644	Continued From page 40 serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. This REQUIREMENT is not met as evidenced by: Based on clinical record review and staff interview, the facility staff failed to implement PASRR recommendations for one of 21 residents, Resident #50. Resident #50 was hospitalized at a State mental health institute from 03/23/2017 through 06/29/2017. A Level II PASRR was completed and the recommendations were made to the facility for rehabilitative services to include psychiatric consultation with psychotropic medication management, crisis intervention and targeted case management. These services were not initiated at the time of admission to the facility on 06/29/2017. Mental Health Services were not provided by the facility until 10/01/2018, over 15 months after her admission to the facility. Findings were: Resident #50 was originally admitted to the facility on 06/29/2017, and most recently readmitted on 09/10/2018. Her diagnoses included, but were not limited to: Urinary tract infection, acute respiratory infection, chronic pain syndrome, major depressive disorder, type II diabetes mellitus, hypothyroidism, mood disorder due to psychological condition, hypertension, and irritable bowel syndrome with diarrhea. The most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 09/27/2018, assessed Resident #50 as moderately impaired in her	F 644	The social worker will make a referral to the Community Services Board for resident #50 per the level II PASRR on 11/27/2018. The social worker will complete an audit of all resident□s PASSAR on or before 12/15/18 to identify any other resident that may have had recommendations that were not followed through with. The Social Worker was educated by the Administrator on/or before 11/30/18 of ensuring that any recommendations on the PASSAR are followed through. The Administrator will review 10% of resident□s with Level II PASSAR weekly x 8 weeks then monthly x 1 month to ensure that all recommendations are followed utilizing a Level II PASRR Audit Tool. The Administrator will reeducate the social worker for any identified areas of concern during the audit. The Administrator will forward the results of the Level II PASRR Audit Tool to the Executive Quality Assurance (QA) Committee monthly x 3 months. The Executive QA committee will meet and review the Level II PASRR Audit Tool and address any issues, concerns and\or trends and to make changes as needed, to include continued frequency of	

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F 644	Continued From page 41 cognitive status with a summary score of "09". Review of the medical record included a discharge summary from a State mental health institute which included the following mental health diagnoses: Major Depressive Disorder, recurrent, Severe, with Psychotic Features, Unspecified Anxiety Disorder, Possible Post Traumatic Stress Disorder, Generalized Anxiety Disorder, Unspecified Mood Disorder, Borderline Personality Disorder, Dependant Personality Disorder and Histrionic Personality Disorder. On 11/06/2018 at approximately 3:30 p.m., a Level II PASRR was observed in the record. The date of completion for the PASRR was 10/04/2017. The PASRR contained the following information: "[Resident #50 name] is a 66 year old female with the qualifying PASRR diagnosis of Unspecified Mood Disorder, Unspecified Psychotic Disorder, Unspecified Anxiety Disorder, Borderline Personality Disorder, and Histrionic Personality Disorder with Dependant Traits, who was initially admitted to [name of the nursing home facility) on 6/29/17. Admission was sought post psychiatric discharge from [name of State Mental Health Institute] where she had been receiving inpatient care since 3/23/17 under a TDO [temporary detention order] due to psychotic symptomology and depression...DETERMINATION SUMMARY: Continued nursing facility admission is appropriate for [name of Resident #50] based on her current medical needs...Rehabilitative services are recommended to include...psychiatric consultation with psychotropic medication management, crisis intervention, and targeted case management...Continued psychiatric engagement	F 644	monitoring monthly x 3 months.	

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through telemedicine will be needed due to her current diagnoses, medication regimen, and to provide continuity of care. [Name of Resident #50] may benefit from the completion of a crisis management plan, as she has experienced 3 psychiatric inpatient admissions this year and has a history of mental health decompensation. Targeted case management is recommended to connect with supportive services and assess the potential for her needs to be met in a least restrictive environment, as medically able. Collaboration with the Community Service Board (CSB) is encouraged to identify supports that may allow a transition to the community, as [name of Resident #50] has expressed a desire to do so when she is medically able. Supports may include supportive housing, intensive outpatient psychiatric services..."

On 11/07/2018 at approximately 9:30 a.m., the SW (social worker) for the facility was interviewed regarding Resident #50's psychiatric services. She was asked if she had looked at Resident #50's PASSR recommendations. She stated, "I never saw that, it didn't come to me." She was asked if she was the person at the facility that would make referrals for psych services and had she done so for Residen t#50. She stated, "I referred her to [name of company] they do our psych treatment and evals...she was on the case load at [name of company] but they changed over to [name of company]..when the company changed they had to get medicaid authorization so there was a break in services." The SW was asked how long Resident #50 went without services. She stated, "I don't really know." The SW was asked to provide that information and also any psych notes from the original company.

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The psychiatric notes were presented starting with an evaluation note date 10/09/2018. The SW asked where the notes were from the time of Resident #50's admission (06/29/2017) until she was picked up in October 2018 by the new company. She stated, "I was mistaken...I thought she was being seen...she and her mother share a room so it may have been her mother who was being seen...I referred her to [name of company] in June of this year...here is my documentation." The SW presented emails and a referral form that were not part of the medical record.

The initial referral form was dated 06/07/2018 and did not include the PASRR recommendations. The reason listed for the referral was "Confusion."

An email was presented dated 06/13/2018 from the company which stated: "Medicaid is still pending and we're not able to take Medicaid primary residents at this time...Given [initials of Resident #50] concerns, do you feel that her responsible party or the facility might be interested in paying a discounted rate for our services until we get a response from Medicaid? It can be used as a temporary solution or long term one, but it's completely customizable. If you feel that it might be a good alternative, please let me know and I'll send the list of discounted rates to you."

Another referral was also presented dated 9/12/2018. The reason listed on the referral was "Psycho-Medication Monitoring and Depressive Symptoms." Attached to the referral was a pharmacy recommendation dated 8/27/2018 to decrease Resident #50's Risperdal dosage. The physician signed the recommendation on 9/13/2018 and wrote: "Agree-let psych decide

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F 644	Continued From page 44 about pts (patient's) Risperdal dose." On 11/08/2018, at approximately 8:30 a.m., the SW was interviewed regarding CSB involvement with Resident #50 as recommended on her PASRR. She stated, "I don't know, I will find out." She returned at approximately 10:30 a.m., and stated, "She was followed by the CSB in [name of city] starting in December of 2016. They stopped her services on 6/29/2017 and did a referral to the CSB here in [name of town]." She was asked if the local CSB had followed up. She stated, "I don't know, I'll call them." She returned to the conference room and stated, "I called them and they said she is not in their computer...they may have gotten a referral but there is no way to confirm that." The email regarding the discounted therapy rates was shown to the SW. She was asked if she had discussed that possibility with the administrator or Resident #50's family. She stated, "I thought I talked to the administrator but it must not have been approved because I don't have the rates." The above information was discussed during a meeting with the DON and the administrator on 11/08/2018 at approximately 12:00 p.m. Concerns were voiced that the PASARR recommendations made for Resident #50 had not been carried out. The administrator was also asked if the SW had discussed the facility paying a discounted rate for Resident #50 to receive pscyh services. She stated, "Not that I recall." No further information was obtained prior to the exit conference on 11/08/2018.	F 644		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)	F 656		12/23/18

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§483.21(b) Comprehensive Care Plans
§483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following -
(i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and
(ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).
(iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.
(iv)In consultation with the resident and the resident's representative(s)-
(A) The resident's goals for admission and desired outcomes.
(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.
(C) Discharge plans in the comprehensive care

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F 656	Continued From page 46 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 clinical record review, resident interview and staff interview, the facility staff failed to develop an activities care plan for one of 21 residents, Resident #50. Resident #50 had a decrease in attendance for group activities. No care plan was developed to address her need for indvidual activities in her room. Findings were: Resident #50 was originally admitted to the facility on 06/29/2017, and most recently readmitted on 09/10/2018. Her diagnoses included, but were not limited to: Urinary tract infection, acute respiratory infection, chronic pain syndrome, major depressive disorder, type II diabetes mellitus, hypothyroidism, mood disorder due to psychological condition, hypertension, and irritable bowel syndrome with diarrhea. The most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 09/27/2018, assessed Resident #50 as moderately impaired in her cognitive status with a summary score of "09". On 11/06/2018, at approximately 11:45 a.m., Resident #50 was lying in bed watching television. She was asked about life at the facility. When discussing her activities at the facility she stated, "I don't go to activities...it's too much trouble for them to get me up and when they do I	F 656	An activities careplan was developed for resident #50 by the MDS Coordinator on 11/24/18. An audit will be conducted on or before 12/15/2018 by the Administrator of all resident□s activity attendance for the past 16 days to identify other residents at risk for needing an activity careplan. The careplan for all identified residents will be reviewed by the Administrator on/or before 12/15/2018 to ensure they have an activities careplan in place. The MDS Coordinator and Activities Director will educated on the requirement to have an activities careplan for any resident who has little to no activity participation by the Corporate Facility Consultant on or before 11/30/2018. The Administrator will review 10% of resident activity participation weekly x 8 weeks then monthly x 1 month to ensure all resident□s with little or no activity participation are reflected on the care plan utilizing a Care Plan Audit Tool. The Administrator will retrain the Activity Director for any identified areas of concern. The Administrator will forward the results of the Care Plan Audit Tool to the Executive Quality Assurance (QA) Committee monthly x 3 months. The Executive QA committee will meet and review the Care Plan Audit Tool and address any issues, concerns and\or	

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F 656	Continued From page 47 don't have a wheelchair." Resident #50 was asked what she did to pass the time. She stated. "I watch TV in here and eat and take naps...I'm okay." On 11/07/2018 at approximately 9:00 a.m., Resident #50's annual assessment with an ARD Date of 03/27/2018 was reviewed. Section F, "Preferences for Customary Routing and Activities", coded the following activity preferences as "1-Very Important...Do things with groups of people; do your favorite activities; go outside to get fresh air when the weather is good; and participate in religious services or practices." Resident #50 began to receive mental health services on 10/01/2018. The diagnostic evaluation contained the following information: "...Hx [history] of mood symptoms-reports depression and anxiety...duration: 3 weeks or longer... CI [client] does not currently attend activities but is interested...Recommendations/Plan: Staff Assist CI in attending at least one activity weekly." A follow-up therapy note dated 10/23/2018 contained the following: "CI does not currently attend activities but is interested...Recommendations: Staff...Can you please look into copying CI some word search/cross word puzzles for CI. If possible, locate a Bible for CI to read...Care Coordination: Please bring word search/cross work puzzles with ink pen/pencil...Session Content: CI presents with anxious mood...she reports that she often prays to help her feel better...Although she is unable to attend activities at this time, CI is willing to complete cross word puzzles and word search."	F 656	trends and to make changes as needed, to include continued frequency of monitoring monthly x 3 months.	

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F 656	Continued From page 48	F 656		

A follow-up note dated 10/30/2018 contained the following: "CI does not currently attend activities, but is interested...Recommendations/Plan: Staff: Facilitator dropped copies of activities for CI-could you please disperse? Please follow-up with CI re: wheelchair, she reports that she is no longer able to sit in the seat due to size and the wheels have rotted...Session Content: CI says she has not yet received the cross word puzzles. Therapist will follow-up with staff to disperse material. CI recounted history of attending Sunday morning Bible study, noting she was raised a Baptist. She discussed the importance of religion to her. CI shared thoughts of the book of Psalms, explaining why the specific book is her favorite..."

At approximately 9:45 a.m., Resident #50 was interviewed regarding the above information. She was asked if she had received a Bible, cross word puzzles or word searches to do in her room. She stated, "No, I don't have those." She was asked if those items were something she would be interested in doing in her room. She stated, "Yes, I would like that."

On 11/07/2018 at approximately 10:00 a.m., the activities director was interviewed regarding Resident #50. She stated, "She use to come to group activities all the time, she always participated..sometimes she beat me there." The activities director was asked what changed. She stated, "I don't know, she quit coming a couple of months ago...then she was just always in her room and didn't want to come." The activities director was asked if Resident #50 had been care planned for activities. She stated, "No, she doesn't have an activities care plan she didn't trigger for one." The mental health

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	495318	A. BUILDING _____ B. WING _____	C 11/08/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BERRY HILL NURSING HOME	621 BERRY HILL ROAD SOUTH BOSTON, VA 24592

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F 656	Continued From page 49	F 656		

recommendations regarding activities were discussed. The activities director stated, "I didn't know anything about that...I know when we do one-to-one she likes to have her nails done, but she's never expressed anything about books." The activities director was asked to provide any information regarding Resident #50's activity attendance that was available.

Review of Resident #50's activity attendance records from 04/01/2018 through 11/07/2018 showed the following information. From 04/01/2018 through 08/25/2018, Resident #50 attended a minimum of 3 group activities per week, some weeks she attended as many as 19 group activities. From 08/26/2018 through 11/07/2018, Resident #50 attended a total of five group activities. The individual activities listed for her were TV, one family visit and one arts/craft activity in her room.

At approximately 9:30 a.m., the activity director was interviewed regarding the activity record for Resident #50. She stated, "Yeah, like I said, she use to beat me there a lot of times for activities...her husband would bring her a lot of times. He took sick a couple of months ago and hasn't been here as much...I go in her room and ask her if she wants to come and she just says she doesn't feel like it." The activity director was asked if a care plan should be created for Resident #50 regarding activities since there had been such a change in her activity needs. She stated, "Yeah, she probably needs one."

The above information was discussed during a meeting with the DON and the administrator on 11/08/2018 at approximately 12:00 p.m.

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F 656	Continued From page 50 No further information was obtained prior to the exit conference on 11/08/2018.	F 656		
F 661 SS=D	Discharge Summary CFR(s): 483.21(c)(2)(i)-(iv) §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. (ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative. (iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter). (iv) A post-discharge plan of care that is developed with the participation of the resident and, with the resident's consent, the resident representative(s), which will assist the resident to adjust to his or her new living environment. The post-discharge plan of care must indicate where the individual plans to reside, any arrangements that have been made for the resident's follow up care and any post-discharge medical and non-medical services. This REQUIREMENT is not met as evidenced by: Based on clinical record review and staff interview, the facility staff failed to ensure a discharge summary was completed by the	F 661	The physician responsible for the discharge summary on resident # 35 is no longer employed with the facility as of	12/23/18

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F 661	Continued From page 51 physician for one of 21 residents in the survey sample: Resident # 35. Findings include: Resident # 35 was admitted to the facility 9/2/17 with a readmission date of 8/8/18. Diagnoses for Resident # 35 included, but was not limited to: anxiety disorder, high blood pressure, diabetes, acute kidney failure, and dialysis. The most recent MDS (minimum data set) was the admission assessment dated 8/15/18. The resident was coded as having severe impairment in cognition with a total summary score of 03 out of 15. On 11/08/18 at 7:45 a.m. the clinical record reviewed. The clinical record progress notes revealed the resident was discharged from the facility 6/4/18, and readmitted 8/8/18. The record reviewed failed to include discharge information by the physician. On 11/8/18 at 8:00 a.m. the administrator was asked for the discharge information. The administrator stated "That information is usually kept in medical records. Let me see what I can find for you." The medical records staff provided a copy of a nursing discharge summary; the portion of the discharge form for the physician to document was blank. The form "Discharge Summary" part II. "Physician's Discharge: A. Final Diagnosis on Transfer/Discharge...D. Attending Physician Signature...Date." The areas did not contain any documentation by the physician. The medical records staff stated "That's all I have; if the doctor did any discharge summary, he did not get it to me to scan in to the electronic record. I	F 661	September 4, 2018. An audit will be conducted of all discharges in the past 30 days by the Medical Records Designee on/or before 12/23/18 to ensure that a discharge summary from the physician is in place. Any deficient findings were corrected by the current physician. The physician will be educated of this requirement by the Administrator on or before 12/23/18. Medical Records will conduct an audit of 10% of all discharged residents weekly x 8 weeks then monthly x 1 month to ensure a discharge summary was completed by the physician utilizing a discharge summary audit tool. The physician will be immediately notified by medical records for any identified areas of concern during the audit. The Administrator will forward the results of the Discharge Summary Audit Tool to the Executive Quality Assurance (QA) Committee monthly x 3 months. The Executive QA committee will meet and review the Discharge Summary Audit Tool and address any issues, concerns and\or trends and to make changes as needed, to include continued frequency of monitoring monthly x 3 months.	

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F 661	Continued From page 52 have nothing else from him." On 11/7/18 at 10:15 a.m. the administrator was made aware of the above findings. The administrator stated "Yes, [name of medical records staff] came and showed me the form and told me the discharge summary wasn't done..." No further information was provided prior to the exit conference.	F 661		
F 679 SS=E	Activities Meet Interest/Needs Each Resident CFR(s): 483.24(c)(1) §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. This REQUIREMENT is not met as evidenced by: Based on clinical record review, resident interview and staff interview, the facility staff failed to provide activities for resident interests for one of 21 residents, Resident #50. The facility staff failed to implement individualized activities for Resident #50 to do in her room when she stopped going to group activities. The facility staff also failed to implement recommendations as listed on psychotherapy notes. Findings were:	F 679	Activities specific to resident #50 interests was provided on 11/13/2018 with documentation in the clinical records. An audit will conducted by the Administrator or designee on or before 12/23/2018 using section F of each resident□s most recent MDS assessment compared to their activity attendance to ensure the facility is providing activities for resident interest. The Activity Director will update the resident□s care plan for any identified areas of concern.	12/23/18

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F 679	Continued From page 53 Resident #50 was originally admitted to the facility on 06/29/2017, and most recently readmitted on 09/10/2018. Her diagnoses included, but were not limited to: Urinary tract infection, acute respiratory infection, chronic pain syndrome, major depressive disorder, type II diabetes mellitus, hypothyroidism, mood disorder due to psychological condition, hypertension, and irritable bowel syndrome with diarrhea. The most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 09/27/2018, assessed Resident #50 as moderately impaired in her cognitive status with a summary score of "09". On 11/06/2018, at approximately 11:45 a.m., Resident #50 was lying in bed watching television. She was asked about life at the facility. When discussing her activities at the facility she stated, "I don't go to activities...it's too much trouble for them to get me up and when they do I don't have a wheelchair." Resident #50 was asked what she did to pass the time. She stated. "I watch TV in here and eat and take naps...I'm okay." On 11/07/2018 at approximately 9:00 a.m., Resident #50's annual care plan with an ARD Date of 03/27/2018 was reviewed. Section F, "Preferences for Customary Routing and Activities", coded the following activity preferences as "1-Very Important...Do things with groups of people; do your favorite activities; go outside to get fresh air when the weather is good; and participate in religious services or practices." Resident #50 began to receive mental health	F 679	The Administrator will in service the Activity Director on 11/27/2018- regarding providing activities for resident□s interests with documentation in the clinical records. 10% of all resident□s to include resident #50 documentation of activity participation will reviewed by the Administrator weekly x 8 weeks then monthly x 1 month to ensure activities are being provided for resident interest utilizing a Activity Interest Audit Tool. The Administrator will reeducate the Activity Director for any identified areas of concern during the audit. The Administrator will forward the results of the Activity Interest Audit Tool to the Executive Quality Assurance (QA) Committee monthly x 3 months. The Executive QA committee will meet and review the Activity Interest Audit Tool and address any issues, concerns and\or trends and to make changes as needed, to include continued frequency of monitoring monthly x 3 months.	

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F 679	Continued From page 54	F 679		

services on 10/01/2018. The diagnostic evaluation contained the following information: "...Hx [history] of mood symptoms-reports depression and anxiety...duration: 3 weeks or longer... Cl [client] does not currently attend activities but is interested...Recommendations/Plan: Staff Assist Cl in attending at least one activity weekly."

A follow-up therapy note dated 10/23/2018 contained the following: "Cl does not currently attend activities but is interested...Recommendations: Staff...Can you please look into copying Cl some word search/cross word puzzles for Cl. If possible, locate a Bible for Cl to read...Care Coordination: Please bring word search/cross work puzzles with ink pen/pencil...Session Content: Cl presents with anxious mood...she reports that she often prays to help her feel better...Although she is unable to attend activities at this time, Cl is willing to complete cross word puzzles and word search."

A follow-up note dated 10/30/2018 contained the following: "Cl does not currently attend activities, but is interested...Recommendations/Plan: Staff: Facilitator dropped copies of activities for Cl-could you please disperse? Please follow-up with Cl re: wheelchair, she reports that she is no longer able to sit in the seat due to size and the wheels have rotted....Session Content: Cl says she has not yet received the cross word puzzles. Therapist will follow-up with staff to disperse material. Cl recounted history of attending Sunday morning Bible study, noting she was raised a Baptist. She discussed the importance of religion to her. Cl shared thoughts of the book of Psalms, explaining why the specific book is her favorite..."

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F 679	Continued From page 55	F 679		

At approximately 9:45 a.m., Resident #50 was interviewed regarding the above information. She was asked if she had received a Bible, cross word puzzles or word searches to do in her room. She stated, "No, I don't have those." She was asked if those items were something she would be interested in doing in her room. She stated, "Yes, I would like that."

On 11/07/2018 at approximately 10:00 a.m., the activities director was interviewed regarding Resident #50. She stated, "She use to come to group activities all the time, she always participated..sometimes she beat me there." The activities director was asked what changed. She stated, "I don't know, she quit coming a couple of months ago...then she was just always in her room and didn't want to come." The activities director was asked if Resident #50 had been care planned for activities. She stated, "No, she doesn't have an activities care plan, she didn't trigger for one." The mental health recommendations regarding activities were discussed. The activities director stated, "I didn't know anything about that...I know when we do one-to-one she likes to have her nails done, but she's never expressed anything about books." The activities director was asked to provide any information regarding Resident #50's activity attendance that was available.

Review of Resident #50's activity attendance records from 04/01/2018 through 11/07/2018 showed the following information. From 04/01/2018 through 08/25/2018, Resident #50 attended a minimum of 3 group activities per week, some weeks she attended as many as 19 group activities. From 08/26/2018 through

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F 679	Continued From page 56 11/07/2018, Resident #50 attended a total of five group activities. The individual activities listed for her were TV, one family visit and one arts/craft activity in her room. The above information was discussed during an end of the day meeting with the administrator and the DON (director of nursing) on 11/07/2018 at approximately 5:45 p.m. On 11/08/2018 at approximately 9:00 a.m. the activity director was observed in Resident #50's room. She gave her a word search book and a small hand held size Book of Psalms. This surveyor asked Resident #50 if she would be able to read the small print in the Book of Psalms. She looked at it and said, "No, I can't see that." The activity director stated that she would go to her car and get her personal larger print Bible and bring it in for her (Resident #50). At approximately 9:30 a.m., the activity director was interviewed regarding the activity record for Resident #50. She stated, "Yeah, like I said, she used to beat me there a lot of times for activities...her husband would bring her a lot of times. He took sick a couple of months ago and hasn't been here as much...I go in her room and ask her if she wants to come and she just says she doesn't feel like it." The above information was discussed during a meeting with the DON and the administrator on 11/08/2018 at approximately 12:00 p.m. No further information was obtained prior to the exit conference on 11/08/2018.	F 679		
F 684	Quality of Care	F 684		12/23/18

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F 684 SS=D	Continued From page 57 CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to ensure one of 21 residents, Resident #68 had a coordinated care plan for hospice services. The facility staff failed to develop a hospice care plan for Resident #68 in a timely manner and failed to ensure the hospice provider's care plan was included in the resident's medical record, and readily available for facility staff. Findings included: Resident #68 was admitted to the facility on 04/17/18. Diagnoses for Resident #68 included, but were not limited to: dementia, osteoporosis, glaucoma, high blood pressure and heart disease. The most current MDS (minimum data set) was a quarterly review dated 07/18/18. This MDS assessed the resident with a cognitive score of 3, indicating the resident had severe impairment in daily decision making skills. During clinical record review the resident's	F 684	Resident #68 care plan was updated to reflect hospice service by the MDS Coordinator on 11/6/18. The hospice provider care plan was received and placed in resident #68 clinical records, readily available for staff on 11/26/2018. An audit was conducted on or before 12/15/2018 by Administrator or designee of all resident's receiving hospice services to ensure that the resident's care plan reflect hospice services and the hospice provider care plan is in the medical record. All areas of concern will be addressed by Administrator during the audit. The MDS Coordinator will be in serviced on or before 12/15/2018 regarding ensuring the care plan is updated when a resident is placed on hospice service. All hospice providers were in serviced by the Administrator or designee on or before 12/23/2018 to ensure that the hospice provider plan of care is sent to the facility immediately upon completion. The Administrator or designee will	

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F 684	Continued From page 58 physician orders revealed Resident #68 was put on hospice on 10/18/18 for exacerbation of dementia. The resident's care plan was reviewed. The resident had a care plan developed by the facility on 11/06/18, almost 4 weeks after admitting to hospice. The care plan documented, "...hospice care due to terminal illness...consult hospice...pain...encourage fluid intake...encourage and assist with good oral hygiene...no treatment modalities...provide support..." A care plan could not be found from hospice services. On 11/08/18 at approximately 9:00 a.m., the resident's "hospice book" was reviewed. A care plan for or by hospice could not be located. RN (Registered Nurse) #3 was then asked to locate the resident's care plan for hospice. RN #1 was interviewed at approximately 9:30 a.m. The RN stated that she and hospice develop care plans together for residents on hospice. The RN stated that this resident had a care plan developed on 11/06/18. The RN was made aware that a hospice care plan developed by hospice was not found. The RN was asked if she had met with hospice regarding this resident. The RN stated that she had not. The RN was asked why the facility care plan was developed until almost 4 weeks after the resident was put on hospice. The RN stated that the resident had a change and was on palliative care and then switched to hospice and wasn't sure. At approximately 11:00 a.m., RN #3 presented a	F 684	review 10% of resident's receiving hospice services to ensure that the resident's care plan reflect hospice services and the hospice provider care plan is in the medical record weekly x 8 weeks then monthly x 1 month utilizing a Hospice Service Audit Tool. The Administrator will retrain the MDS Coordinator or hospice providers for any identified areas of concern. The Administrator will forward the results of the Hospice Service Audit Tool to the Executive Quality Assurance (QA) Committee monthly x 3 months. The Executive QA committee will meet and review the Hospice Service Audit Tool and address any issues, concerns and\or trends and to make changes as needed, to include continued frequency of monitoring monthly x 3 months.	

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F 684	Continued From page 59 care plan developed by hospice. The RN was asked where this care plan was located. The RN stated that it was at the hospice office, not at the facility and stated that hospice had to be called and they emailed it over. The hospice careplan dated 10/18/18 documented, "...hospice nurse to provide instructions related to nutrition and hydration status...instruct on bowel protocol...hospice nurse to coordinate plan of care with facility staff...hospice nurse to administer pain medications...hospice nurse to evaluate patient and develop a plan of care to be signed by physician..." The hospice care plan was not at the facility, not in the resident's clinical record, not signed by the physician and was not coordinated with the facility staff. On 11/08/18 at approximately 12:15 p.m., the DON (director of nursing) and the administrator were made aware of the above information. The DON stated that the resident's careplan should be updated as soon as possible with a change in condition and that it should not take any longer than 24 to 48 hours to have the facility and hospice care plan coordinated. No further information and/or documentation was presented prior to the exit conference on 11/08/18 at 1:45 p.m.	F 684		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers.	F 686		12/23/18

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F 686	Continued From page 60 Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, clinical record review, resident interview and staff interview, the facility staff failed to ensure pressure reducing devices were in place for one of 21 residents, Resident #50. Resident #50 was not wearing "bunny boots" as indicated on her care plan, on 11/07/2018. Findings were: Resident #50 was originally admitted to the facility on 06/29/2017, and most recently readmitted on 09/10/2018. Her diagnoses included, but were not limited to: Urinary tract infection, acute respiratory infection, chronic pain syndrome, major depressive disorder, type II diabetes mellitus, hypothyroidism, mood disorder due to psychological condition, hypertension, and irritable bowel syndrome with diarrhea. The most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 09/27/2018, assessed Resident #50 as moderately impaired in her	F 686	Bunny Boots were placed on resident # 50 as indicated on the care plan on 11/8/18 by the Director of Nursing. 100% of all resident care plans will be reviewed by the Administrator or designee to identify residents that required bunny boots. The Administrator or designee observed all identified residents to ensure bunny boots were in place as indicated on the care plan. All areas of concerns were addressed during the audit. All nurses to include the treatment nurse and nursing assistants were in serviced on ensuring bunny boots are on per the resident care plan and notifying the nurse if a resident refuses. The Administrator or designee will observe 10% of resident's indicated to wear bunny boots per the resident care plan to ensure bunny boots are in place weekly x 8 weeks then monthly x 1 month utilizing a Bunny Boot Audit Tool. The Administrator will retrain the staff for any identified areas of concern. The Administrator will forward the results	

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F 686	Continued From page 61 cognitive status with a summary score of "09". On 11/07/2018 the electronic record was reviewed. The following information was listed on her care plan, "Ulceration or interference with structural integrity of layers of skin caused by prolonged pressure related to: immobility...Bunny boots to feet as tolerated." At approximately 12:30 p.m., Resident #50 was observed lying in bed. She was asked if she was wearing her bunny boots on her feet. She stated, "No...I haven't had them on for days...my heels are sore." She pulled the covers off her feet, the bunny boots were not in place. Resident #50 was asked if staff had offered to put them on her that morning. She stated, "No...I don't know why they didn't put them on me, I like them." LPN (licensed practical nurse) #1 was at the nurse's station. She was asked to come look at Resident #50's heels. She went to the to room, lifted Resident #50's feet off of the bed and looked at her heels. No open or reddened areas were observed. She then applied bunny boots. At approximately 12:45 p.m., the wound nurse, RN (registered nurse) #2 came to conference room. She stated, "[Name of Resident #50]'s bunny boots are care planned to be worn "as tolerated"...she doesn't always want them on and doesn't always tolerate them." RN #2 was asked if the boots were offered to Resident #50. She stated, "I don't know." The above information was discussed with the DON (director of nursing) and the administrator during an end of the day meeting on 11/07/2018 at approximately 5:45 p.m.	F 686	of the Bunny Boot Audit Tool to the Executive Quality Assurance (QA) Committee monthly x 3 months. The Executive QA committee will meet and review the Bunny Boot Audit Tool and address any issues, concerns and\or trends and to make changes as needed, to include continued frequency of monitoring monthly x 3 months.	

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F 686	Continued From page 62 No further information was obtained prior to the exit conference on 11/08/2018.	F 686		
F 740 SS=E	Behavioral Health Services CFR(s): 483.40 §483.40 Behavioral health services. Each resident must receive and the facility must provide the necessary behavioral health care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Behavioral health encompasses a resident's whole emotional and mental well-being, which includes, but is not limited to, the prevention and treatment of mental and substance use disorders. This REQUIREMENT is not met as evidenced by: Based on clinical record review, and staff interview the facility staff failed to provide necessary behavioral health care and services to attain the highest practicable physical, mental, and psychosocial well-being for one of 21 residents, Resident #50. The facility staff failed to provide behavioral health care to Resident #50 for over 15 months after her admission to the facility. Resident #50 was hospitalized at a State mental health institute from 03/23/2017 through 06/29/2017. A Level II PASRR was completed and the recommendations were made to the facility for rehabilitative services to include but not limited to: psychiatric consultation with psychotropic medication management, crisis intervention and targeted case management.	F 740	Resident #50 was seen by psychiatric services and was seen 11/16/2018. All residents with Level II PASSR will be completed by the Social worker on or before 12/15/18 to ensure that recommendations for psychiatric consultations with psychotropic medication management, crisis intervention and target case management was completed. All areas of concern will be addressed by the Social worker to include referrals to psych services when indicated. Resident #50 was given a bible and word search puzzles by the Activities Director on 11/8/18.	12/23/18

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F 740	Continued From page 63 Findings were: Resident #50 was originally admitted to the facility on 06/29/2017, and most recently readmitted on 09/10/2018. Her diagnoses included, but were not limited to: Urinary tract infection, acute respiratory infection, chronic pain syndrome, major depressive disorder, type II diabetes mellitus, hypothyroidism, mood disorder due to psychological condition, hypertension, and irritable bowel syndrome with diarrhea. The most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 09/27/2018, assessed Resident #50 as moderately impaired in her cognitive status with a summary score of "09". Review of the medical record included a discharge summary from a State mental health institute which included the following mental health diagnoses: Major Depressive Disorder, recurrent, Severe, with Psychotic Features, Unspecified Anxiety Disorder, Possible Post Traumatic Stress Disorder, Generalized Anxiety Disorder, Unspecified Mood Disorder, Borderline Personality Disorder, Dependant Personality Disorder and Histrionic Personality Disorder. On 11/06/2018 at approximately 3:30 p.m., a Level II PASRR was observed in the record. The date of completion for the PASRR was 10/04/2017. The PASRR contained the following information: "[Resident #50 name] is a 66 year old female with the qualifying PASRR diagnosis of Unspecified Mood Disorder, Unspecified Psychotic Disorder, Unspecified Anxiety Disorder, Borderline Personality Disorder, and Histrionic Personality Disorder with Dependant Traits, who	F 740	A careplan for activities will be written for resident #50 on or before 12/15/2018. Social worker and activities director will be in serviced on before 12/15/2018 regarding following the recommendations of level II PASRR and psychiatric treatment recommendations to include providing activities and in-room supplies for personal interests. The Administrator or designee will audit 10% of residents receiving psychiatric services and residents with level II PASRR utilizing the Level II PASRR Audit tool to ensure they are receiving psychiatric consultations with psychotropic medication management, crisis intervention and target case management as recommended and recommendations are followed weekly x 8 weeks. Monthly x 1 monthly. The Administrator will forward the results of the Level II PASRR Audit Tool to the Executive Quality Assurance (QA) Committee monthly x 3 months. The Executive QA committee will meet and review the Level II PASRR Audit Tool and address any issues, concerns and\or trends and to make changes as needed, to include continued frequency of monitoring monthly x 3 months.	

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was initially admitted to [name of the nursing home facility) on 6/29/17. Admission was sought post psychiatric discharge from [name of State Mental Health Institute] where she had been receiving inpatient care since 3/23/17 under a TDO [temporary detention order] due to psychotic symptomology and depression...DETERMINATION SUMMARY: Continued nursing facility admission is appropriate for [name of Resident #50] based on her current medical needs...Rehabilitative services are recommended to include...psychiatric consultation with psychotropic medication management, crisis intervention, and targeted case management...Continued psychiatric engagement through telemedicine will be needed due to her current diagnoses, medication regimen, and to provide continuity of care. [Name of Resident #50] may benefit from the completion of a crisis management plan, as she has experienced 3 psychiatric inpatient admissions this year and has a history of mental health decompensation. Targeted case management is recommended to connect with supportive services and assess the potential for her needs to be met in a least restrictive environment, as medically able. Collaboration with the Community Service Board (CSB) is encouraged to identify supports that may allow a transition to the community, as [name of Resident #50] has expressed a desire to do so when she is medically able. Supports may include supportive housing, intensive outpatient psychiatric services..."

On 11/07/2018 at approximately 9:30 a.m., the SW (social worker) for the facility was interviewed regarding Resident #50's psychiatric services. She was asked if she had looked at Resident

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#50's PASRR recommendations. She stated, "I never saw that, it didn't come to me." She was asked if she was the person at the facility that would make referrals for psych services and had she done so for Resident#50. She stated, "I referred her to [name of company] they do our psych treatment and evals...she was on the case load at [name of company] but they changed over to [name of company]..when the company changed they had to get medicaid authorization so there was a break in services." The SW was asked how long Resident #50 went without services. She stated, "I don't really know." The SW was asked to provide that information and also any psych notes from the original company.

The psychiatric notes were presented starting with an evaluation note date 10/09/2018. The SW asked where the notes were from the time of Resident #50's admission (06/29/2017) until she was picked up in October 2018 by the new company. She stated, "I was mistaken...I thought she was being seen...she and her mother share a room so it may have been her mother who was being seen...I referred her to [name of company] in June of this year...here is my documentation." The SW presented emails and a referral form that were not part of the medical record.

The initial referral form was dated 06/07/2018 and did not include the PASRR recommendations. The reason listed for the referral was "Confusion."

An email was presented dated 06/13/2018 from the company which stated: "Medicaid is still pending and we're not able to take Medicaid primary residents at this time...Given [initials of Resident #50] concerns, do you feel that her responsible party or the facility might be

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interested in paying a discounted rate for our services until we get a response from Medicaid? It can be used as a temporary solution or long term one, but it's completely customizable. If you feel that it might be a good alternative, please let me know and I'll send the list of discounted rates to you."

Another referral was also presented dated 9/12/2018. The reason listed on the referral was "Psycho-Medication Monitoring and Depressive Symptoms." Attached to the referral was a pharmacy recommendation dated 8/27/2018 to decrease Resident #50's Risperdal dosage. The physician signed the recommendation on 9/13/2018 and wrote: "Agree-let psych decide about pts (patient's) Risperdal dose."

Resident #50 began to receive mental health services on 10/01/2018. The diagnostic evaluation contained the following information: "...Hx [history] of mood symptoms-reports depression and anxiety...duration: 3 weeks or longer...Cl [client] does not currently attend activities but is interested...Recommendations/Plan: Staff Assist Cl in attending at least one activity weekly." A follow-up therapy note dated 10/23/2018 contained the following: "Cl does not currently attend activities but is interested...Recommendations: Staff...Can you please look into copying Cl some word search/cross word puzzles for Cl. If possible, locate a Bible for Cl to read...Care Coordination: Please bring word search/cross work puzzles with ink pen/pencil...Session Content: Cl presents with anxious mood...she reports that she often prays to help her feel better...Although she is unable to attend activities at this time, Cl is willing to

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complete cross word puzzles and word search." A follow-up note dated 10/30/2018 contained the following: "CI does not currently attend activities, but is interested...Recommendations/Plan: Staff: Facilitator dropped copies of activities for CI-could you please disperse? Please follow-up with CI re: wheelchair, she reports that she is no longer able to sit in the seat due to size and the wheels have rotted....Session Content: CI says she has not yet received the cross word puzzles. Therapist will follow-up with staff to disperse material. CI recounted history of attending Sunday morning Bible study, noting she was raised a Baptist. She discussed the importance of religion to her. CI shared thoughts of the book of Psalms, explaining why the specific book is her favorite..."

At approximately 9:45 a.m., Resident #50 was interviewed regarding the above information. She was asked if she had received a Bible, cross word puzzles or word searches to do in her room. She stated, "No, I don't have those." She was asked if those items were something she would be interested in doing in her room. She stated, "Yes, I would like that."

On 11/07/2018 at approximately 10:00 a.m., the activities director was interviewed regarding Resident #50. She stated, "She use to come to group activities all the time, she always participated..sometimes she beat me there." The activities director was asked what changed. She stated, "I don't know, she quit coming a couple of months ago..then she was just always in her room and didn't want to come." The activities director was asked if Resident #50 had been care planned for activities. She stated, "No, she doesn't have an activities care plan she didn't trigger for one." The mental health

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recommendations regarding activities were discussed. The activities director stated, "I didn't know anything about that...I know when we do 1:1 she likes to have her nails done, but she's never expressed anything about books." The activities director was asked to provide any information regarding Resident #50's activity attendance that was available.

Review of Resident #50's activity attendance records from 04/01/2018 through 11/07/2018 showed the following information. From 04/01/2018 through 08/25/2018, Resident #50 attended a minimum of 3 group activities per week, some weeks she attended as many as 19 group activities. From 08/26/2018 through 11/07/2018, Resident #50 attended a total of five group activities. The individual activities listed for her were TV, one family visit and one arts/craft activity in her room.

The above information was discussed during an end of the day meeting with the administrator and the DON (director of nursing) on 11/07/2018 at approximately 5:45 p.m.

On 11/08/2018 at approximately 9:00 a.m. the activity director was observed in Resident #50's room. She gave her a word search book and a small hand held size Book of Psalms. This surveyor asked Resident #50 if she would be able to read the small print in the Book of Psalms. She looked at it and said, "No, I can't see that." The activity director stated that she would go to her car and get her personal larger print Bible and bring it in for her (Resident #50).

At approximately 9:30 a.m., the activity director was interviewed regarding the activity record for

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Resident #50. She stated, "Yeah, like I said, she used to beat me there a lot of times for activities...her husband would bring her a lot of times. He took sick a couple of months ago and hasn't been here as much...I go in her room and ask her if she wants to come and she just says she doesn't feel like it." The activities director was asked if she thought Resident #50 was depressed. She stated, "I'm no doctor and I didn't want to say anything, but yeah, that's what I think it is."

The above information was discussed during a meeting with the DON and the administrator on 11/08/2018 at approximately 12:00 p.m.

On 11/08/2018, at approximately 8:30 a.m., the SW was interviewed regarding CSB involvement with Resident #50 as recommended on her PASRR. She stated, "I don't know, I will find out." She returned at approximately 10:30 a.m., and stated, "She was followed by the CSB in [name of city] starting in December of 2016. They stopped her services on 6/29/2017 and did a referral to the CSB here in [name of town]." She was asked if the local CSB had followed up. She stated, "I don't know, I'll call them." She returned to the conference room and stated, "I called them and they said she is not in their computer...they may have gotten a referral but there is no way to confirm that." The email regarding the discounted therapy rates was shown to the SW. She was asked if she had discussed that possibility with the administrator or Resident #50's family. She stated, "I thought I talked to the administrator but it must not have been approved because I don't have the rates."

The above information was discussed during a

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F 740	Continued From page 70 meeting with the DON and the administrator on 11/08/2018 at approximately 12:00 p.m. Concerns were voiced that the PASRR recommendations made for Resident #50 had not been carried out, and she had been at the facility for over a year without any type of psychiatric/behavioral health services. The administrator was also asked if the SW had discussed the facility paying a discounted rate for Resident #50 to receive psych services. She stated, "Not that I recall." The administrator was asked who got the information from the hospitals and outside services such as the teletech psych services, since neither the SW or the activities director had been aware of the information. She stated, "The information comes in to the facility and medical records scans it in...the nurses and the staff are suppose to review the information after it is scanned in. No further information was obtained prior to the exit conference on 11/08/2018.	F 740		
F 759 SS=D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, clinical record review, and facility document review, the facility staff failed to ensure a medication error rate of less than 5% (percent) during the medication pass and pour observation. The facility had 3 medication errors out of 45	F 759	The physician was notified for the Medication error related to resident #70 by 11/7/18 on Director of Nursing. LPN #3 was in serviced on medication administration to include the six rights of medication administration to include	12/23/18

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F 759	Continued From page 71 opportunities, which resulted in a medication error rate of 6.67%. Findings included: A medication pass and pour observation was completed on 11/07/18 with LPN (Licensed Practical Nurse) #3. At approximately 8:40 a.m., LPN #3 prepared medications for Resident #70. Medications prepared included, digoxin 0.125 mcg [micrograms], Flonase 50 mcg (per spray), and two separate premixed nebulizer treatment medications (liquid inhalations); one was the medication Brovana 15 mcg per 1 ml [milliliters] premixed vial and the other was budesonide 1 mg [milligram] per 2 ml premixed vial. The LPN checked the resident's oxygen saturation and pulse via a pulse oximeter, which documented the resident's pulse as 80 and the resident's O2 (oxygen) saturation as 97%. The LPN then used an automatic vital sign machine and obtained the resident's blood pressure, which registered at 156/79, the resident's pulse as 82. The LPN prepared the resident's oral medications including the digoxin 0.125 mcg. The LPN did not obtain an apical or radial pulse for one full minute on this resident, prior to administering the medication digoxin. LPN #3 then prepared the premixed nebulizer treatment medications. The LPN opened the 1 ml vial of Brovana and poured it into the medication chamber of the nebulizer, the LPN then opened the 2 ml vial of the budesonide and poured it into the medication chamber with the Brovana, mixing the medications. The LPN placed the nebulizer in the holder. The LPN	F 759	checking vitals as indicated, mixing medications as appropriate, following physician orders for nasal sprays, and hand washing by Director of Nursing on or before 12/23/2018. Medication pass audits will be conducted by the Director of Nursing or designee by 12/23/18 with 100% of all nurses to ensure nurses pass medications an error rate of less than 5%. 100% of all nurses will be in-serviced by the Director of Nursing or designee regarding the six rights of Medication Administration to include checking vitals as indicated, mixing medications when appropriate, following physician orders for nasal sprays, and hand washing. This in-service will be completed by 12/23/18. 10% of all nurses to include LPN #3 will be observed completing a medication pass by the Director of Nursing or designated RN weekly x 8 weeks then monthly x 1 month to ensure nurses pass medications at a rate of less than 5% to include checking vital signs as indicated, mixing medications when appropriate, following physician orders for nasal sprays, and hand washing utilizing a medication pass audit tool. The Administrator will forward the results of the Medication Pass Audit Tool to the Executive Quality Assurance (QA) Committee monthly x 3 months. The Executive QA committee will meet and review the Medication Pass Audit Tool and address any issues, concerns and\or trends and to make changes as needed, to include continued frequency of monitoring monthly x 3 months.	

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donned gloves and then administered Flonase 50 mcg/spray to the resident, dispensing one spray (50 mcg each) into each nostril.

The LPN then left the resident's bedside, taking off the gloves at the door, exited the room and was at the medication cart. The LPN then walked back into the room to Resident #70 and retrieved the nebulizer from the holder and applied the mask and started the nebulizer treatment for the resident. The LPN then exited the room and began pushing the medication cart up the hall. The LPN stated that she was finished with Resident #70 and proceeded down the hall to the next resident without washing her hands and/or using any type of hand sanitizer, prior to going to the next resident.

On 11/07/18 at 8:52 AM, a medication reconciliation for Resident #70 was completed. The physician's orders dated 11/01/18 thru 11/30/18 documented, "...Lanoxin digoxin tab 0.125 mcg [micrograms] 1 by mouth daily for A-fib [atrial fibrillation] 8 AM Pulse..."

The orders also included an order for, "...Flonase nasal spr [spray]...50 mcg [micrograms] 1 [one] spray nasally daily for allergies ..." The physician's order was for one spray, the LPN administered two to the resident.

RN #2 was asked if the there was a drug handbook to reference. The RN presented the "#1 Nursing Drug Guide Nursing 2018 DRUG HANDBOOK" The RN stated this is the reference we use.

The 2018 drug handbook was revived and documented on page 457, "...457

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digoxin...ADMINISTRATION P.O. [oral]...Before giving drug, take apical -radial pulse for 1 minute..."

The 2018 drug handbook was further reviewed and documented on page 142, "...142 arformoterol tartrate [Brovana]...ADMINISTRATION...Do not mix with other drugs or solutions in the nebulizer..."

Polices and procedures for medication administration and hand hygiene were requested from the administrator at approximately 9:10 a.m.

On 11/07/18 at 2:50 p.m., LPN #3 was interviewed regarding the medication pass. When the LPN was asked about administering the mediations digoxin, the LPN stated, "I was supposed to do an apical pulse, I was just nervous." The LPN was asked about the nebulizer medications being mixed together. The LPN stated that she thought that they could be administered together because they all were scheduled for 8:00 a.m. The LPN was then asked about the Flonase spray. The LPN stated that she did not know why she gave two sprays, she thought it was two. The LPN was asked to look at the MARs to ensure it matched the physician's order, the LPN stated, "It matches." The LPN stated that she realized later that she did not wash her hands.

On 11/08/17 policies were presented for review. A policy on "medication administration" documented, "...No medication shall be administered unless the nurse is familiar with the pharmacology of the drug, its potential toxic effects and contraindications...there shall be a current acceptable medical reference available at

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F 759	Continued From page 74 each nurse's station...MAR (medication administration record) shall be checked...against physician's orders...the right resident...in the right dose...by the right route...by the right method...at the right time..." A policy on "administration of oral (po) medication" documented, "...wash hands..." A policy on "handwashing procedure" was presented and documented, "...you should wash your hands: ...before and after contact with residents..." The DON (director of nursing) and the administrator were made aware of the above observations in a meeting with the survey team on 11/07/18 at approximately 4:00 p.m. The DON (director of nursing) and the administrator were again made aware of the above observations and informed of the medication error rate of 6.67% in a meeting with the survey team on 11/08/18 at approximately 12:00 noon. No further information and/or documentation was presented prior to the exit conference on 11/08/18 at 1:45 p.m.	F 759		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when	F 761		12/23/18

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F 761	Continued From page 75 applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and facility document review, the facility staff failed to ensure drugs and biologicals were appropriately stored for two of two medications room in the facility, the medication room on the 200/300 hall and the medication room on the 400/500/600 hall. 1. The facility staff failed to ensure medication belonging to a discharged resident on the 400/500/600 hall medication room was removed from stock and returned to the pharmacy, to ensure the medication was not readily available for distribution. 2. The facility staff failed to ensure insulin was dated when opened on the 200/300 hall medication room.	F 761	The facility will return medications for residents that had been discharged on or before 11/30/2018. The facility Director of Nursing removed the undated open insulin on 200/300 hall and reordered the insulin. The new insulin supply was opened and dated upon arrival by the assigned hall nurse. The director of nursing will conduct an audit of all medication rooms and medications storage areas on or before 11/30/2018 and ensure that all discharged residents medications are removed and returned to pharmacy and that all insulins were dated when opened. 100% of all nurses will be educated on the	

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F 761	Continued From page 76 Findings include: 1. On 11/07/18 at approximately 9:40 a.m., an observation of a medication room with registered nurse (RN) #1, on the 400/500/600 hall was completed. The medication refrigerator was observed. A medication (Phenergan suppositories) was observed in the refrigerator for a resident no longer at the facility. The medication had a fill date of 08/25/18. The RN was asked when was the resident discharged from the facility. The RN stated that she was not sure, but would find out the discharge date. The RN was asked who is responsible to check the medication room/refrigerator and ensure that medications are returned to the pharmacy and/or disposed of if a resident is no longer at the facility, or if mediations are expired or discontinued. The RN stated that she did not think they had a policy, but would check and stated that she thought it was everyone's responsibility, but again stated that she would check to be positive. At approximately 10:00 a.m., the RN stated that the above resident was discharged from the facility on 10/03/18. The RN was asked when the resident is discharged from the facility what is supposed to happen to the medications. The RN stated that medications are typically returned to the pharmacy. The RN stated that they are normally put into the "return bin" and pharmacy picks them up. The RN stated that "maybe they [pharmacy] didn't pick this one up because it was in the refrigerator" and the return bin was outside of the refrigerator. The RN was again asked for a policy on medication returns. At approximately 11:45 a.m. a policy on "Disposal	F 761	process of return of medications to the pharmacy when a resident is discharged from the facility and that all insulin has to be dated when opened by the Director of Nursing by 12/23/18. The director of nursing will conduct audits weekly x 8 weeks then monthly x 1 month of both medication rooms/storage areas to ensure that any medications for residents that have been discharged are returned to the pharmacy and that all insulin is dated when opened utilizing a medications storage audit tool. The Director of nursing will retrain the nurse for any identified areas of concern. The Director of Nursing will forward the results of the Medication Storage Audit Tool to the Executive Quality Assurance (QA) Committee monthly x 3 months. The Executive QA committee will meet and review the Medication Storage Audit Tool and address any issues, concerns and\or trends and to make changes as needed, to include continued frequency of monitoring monthly x 3 months.	

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of Unused Medications" was presented and reviewed. The policy documented, "...Medication shall be returned to [name of pharmacy] for the following reasons: ...a medication is not released to the resident upon the resident's discharge from the facility...a medication is discontinued by the physician or by automatic stop order policy...a medication reaches its expiration date...complete the return of drugs form...providing all requested information, including quantity of medication being returned...place return of drugs form and medications to be returned in the medication delivery tote, to be returned with the courier on the next regular pick-up...the pink copy...placed in the...tote...the white copy...submitted to the Director of Nursing...tote shall then be released to courier...the pharmacist shall verify the contents of the tote...for accuracy."

A "memorandum" from (name of pharmacy) was presented along with the above policy, the memorandum dated 07/27/15 documented, "...return the discontinued medications to pharmacy for credit...nursing must complete the return of drugs form when returning medications to the pharmacy..."

On 11/07/18 at approximately 6:00 p.m., the DON (director of nursing) and the administrator were made aware of the above information in a meeting with the survey team. The DON was again asked for information regarding the procedures of nurses to ensure medications for discharged residents are not readily available for administration.

On 11/08/18 at approximately 7:20 a.m., the administrator stated that our policy does not specify who is specifically responsible to return

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meds to the pharmacy and ensure there are no expired medications.

At approximately 12:30 p.m., the administrator and DON were again informed of the above. The DON stated that the expectation would be that when a resident is discharged, that nurse will make sure that the resident's medications are taken out of stock and returned to the pharmacy.

No further information and/or documentation was presented prior to the exit conference on 11/08/18 at 1:45 p.m.

2. On 11/07/2018 at 8:30 a.m. the medication room on the 200 hall was inspected. Observed in the refrigerator was a plastic container that had multiple brown medication bottles containing insulin vials. Each bottle was labeled with a resident's name and the insulin information. One bottle of Humalog 100 units/ml was observed opened inside of the brown medication bottle.

LPN (licensed practical nurse) #2 was in the medication room and asked what the policy was when opening insulin. She stated, "We date it with the date that we open it and throw it way if we haven't used it all within 30 days." She pointed to a sticker on the insulin vial that had a typed date of 11/03/2018. She stated, "That's the date it was filled, whoever opened it probably just forgot to date it."

A copy of the facility policy for insulin storage was requested from the administrator and received. Per the facility policy, "Insulin storage": Recommendations: Vials and pens should be dated upon opening and unused portions discarded within the timeframe recommended by the manufacturer."

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F 761	Continued From page 79 The above information was discussed with the DON (director of nursing) and the administrator during and end of the day meeting on 11/07/2018. No further information was obtained prior to the exit conference on 11/08/2018.	F 761		
F 806 SS=D	Resident Allergies, Preferences, Substitutes CFR(s): 483.60(d)(4)(5) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(4) Food that accommodates resident allergies, intolerances, and preferences; §483.60(d)(5) Appealing options of similar nutritive value to residents who choose not to eat food that is initially served or who request a different meal choice; This REQUIREMENT is not met as evidenced by: Based on observations, clinical record review, resident interview, and staff interview, the facility staff failed, for two of 21 residents in the survey sample (Residents # 5 and 69), to accomodate resident food preferences. The findings were: Resident # 5 was admitted to the facility on 10/2/09, and most recently readmitted on 5/8/17 with diagnoses that included hypertension, peripheral vascular disease, cerebrovascular accident, Non-Alzheimer's dementia, hemiplegia, depression, bipolar disorder, psychotic disorder, generalized muscle weakness, and personality disorder. According to the most recent Minimum	F 806	The dietary manager will met with resident #69 and resident #5 to review meal preferences and update their dietary tickets to reflect their preferences on or before 12/15/18. All residents have been interviewed by the dietary manager regarding dietary preferences and meal tickets were updated accordingly on or before 12/15/2018. All staff will be educated on or before 12/23/2018 by the Director of Nursing regarding accommodation of resident food preferences to include not allowing	12/23/18

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F 806	Continued From page 80 Data Set (MDS), a Quarterly Review with an Assessment Reference Date (ARD) of 7/30/18, the resident was assessed under Section C (Cognitive Patterns) as being cognitively intact, with a Summary Score of 15 out of 15. Under Section G (Functional Status), the resident was assessed as needing supervision with set-up help for eating. Resident # 69 was admitted to the facility on 8/22/14, and most recently readmitted on 10/7/16 with diagnoses that included hypertension, obstructive uropathy, hyperlipidemia, Non-Alzheimer's dementia, edema, muscle wasting and atrophy, and benign prostatic hyperplasia. According to the most recent MDS, a Quarterly Review with an ARD of 10/1/18, the resident was assessed under Section C (Cognitive Patterns) as being cognitively intact, with a Summary Score of 15 out of 15. Under Section G (Functional Status), the resident was assessed as needing supervision with set-up help for eating. At approximately 12:10 p.m. on 11/6/18, during observation of the noon meal, Resident # 69, who was seated in a wheelchair, was at a table eating lunch. Resident # 69 backed his wheelchair away from the table where he was seated and wheeled himself to the next table where Resident # 5, who was also in a wheelchair, was seated. Resident # 69 took a bowl of chicken noodle soup from Resident # 5's meal tray and wheeled himself back to his table. Before he could begin eating the soup, an unidentified staff member took the bowl of soup from him, but returned it to	F 806	residents to give other residents food items off of their trays and intervening if this is observed; if the resident request an item with meals, staff are to check with the kitchen and if they are permitted to have it to procure the items from the kitchen for the resident. The dietary manager will observe 3 meals to include breakfast, lunch, and dinner weekly x 8 weeks then monthly x 1 month to ensure resident preferences are being upheld and any requested items are obtained from the kitchen and not from other resident□s trays utilizing a meal observation audit tool. Staff will be retrained by the dietary manager for any identified areas of concern. The Administrator will forward the results of the Meal Observation Audit Tool to the Executive Quality Assurance (QA) Committee monthly x 3 months. The Executive QA committee will meet and review the Meal Observation Audit Tool and address any issues, concerns and\or trends and to make changes as needed, to include continued frequency of monitoring monthly x 3 months.	

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him seconds later. As he was eating the soup, the surveyor asked him if he was supposed to have the soup. Resident # 69 replied, "He don't need it, he don't eat it anyway. Around here you take what you can get. It's all free."

Resident # 5 was asked about the soup and he replied, "My name is (name). I don't eat soup."

According to the meal ticket for Resident # 5, chicken noodle soup was included as a menu item for lunch on 11/6/18. The meal ticket for Resident # 69 did not include any soup as a menu item.

Resident # 5's care plan, dated 7/27/15, and revised on 2/16/16, included the following problem, "State of nourishment; less than body requirement characterized by weight loss, decrease intake, decreased appetite related to: refuses some meals at times (fluctuating weights)." The goal for the problem was, "Will maintain or increase weight thru next review; Will not experience significant weight loss thru next review."

Included as an intervention to the stated problem was, "Assess for/provide food preferences (spaghetti, toss salad with French or Italian dressing, bologna sandwich, gravy biscuits, pancakes, bacon, sausage, grits, mashed potatoes and gravy, fried chicken thigh or leg, fried pork chop, tomato soup, chicken noodle soup, ice cream)."

Regarding the resident's weight, review of the Weight/Vital Signs section of his Electronic Health Record indicated he has a weight gain of approximately 20 pounds over the last six

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months.

Resident # 69's care plan, dated 4/22/18, included the following problem, "Mr. (name of resident) is at risk for further decline in ADL's (Activities of Daily Living) d/t (due to) decreased mobility and cognitive impairment. Resident has dx (diagnoses) of muscle wasting atrophy, weakness, benign prostatic hyperplasia, retention of urine, obstructive and reflux uropathy, hypertension, and anemia." The goal for the problem was, "Will receive physical assist daily and as needed thru next review."

Included as an intervention to the stated problem was, "EATING: Provide supervision with minimal set up or assistance i.e., cut food for resident."

At 2:50 p.m. on 11/6/18, the facility's Certified Dietary Manager (CDM) was interviewed regarding Resident # 69 taking and eating Resident # 5's soup. "Mr. (Resident # 69) will eat soup sometimes, usually vegetable. What should have happened is, he is to ask a nurse or CNA (Certified Nursing Assistant) for soup. They would then come to the Kitchen and get a bowl of soup for him." Asked if the chicken noodle soup was consistent with Resident # 69's diet needs, the CDM said that it was. The CDM went on to say that this was the first she heard of Resident # 69 taking Resident # 5's soup.

During an end of day meeting at 5:45 p.m. on 11/7/18, that included the Administrator, the Director of Nursing, and the survey team, the surveyor recounted the observation of Resident # 69 taking and eating Resident # 5's soup, and the lack of staff intervention when he took the soup.

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BERRY HILL NURSING HOME	621 BERRY HILL ROAD SOUTH BOSTON, VA 24592

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 812	Continued From page 83	F 812		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, facility staff failed to procure, store, prepare and serve food in a sanitary manner in the main kitchen. Facility staff failed to remove expired milk products from the refrigerator and failed to ensure a clean can opener and area behind the ovens and stove. Findings included: The initial tour of the kitchen was conducted 11/06/18 at 11:30 a.m. along with the Dietary Manager (DM). While in the walk-in refrigerator six cartons of 1% milk were observed with an	F 812	The dietary manager removed the expired milk, cleaned the can opener and cleaned the area behind the ovens and stove on 11/6/2018. The administrator and Dietary Manager will conduct a thorough audit of the kitchen, equipment and surfaces on or before 12/15/2018 to identify any sanitation issues and all identified issues were corrected. The dietary staff have been educated to check dates on items daily, clean the can opener after each use and to monitor the	12/23/18

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F 812	Continued From page 84 expiration date of 11/4/18 and three quarts of butter milk with an expiration date of 11/5/18. The Dietary Manager immediately removed the expired milk from the shelf and placed them in a separate area to return to the delivery person. The DM stated, "Milk is delivered on Mondays and Thursdays. The delivery person rotates the milk with each delivery. I haven't had time to do my rounds this morning or I would have caught that." Also observed during the tour was the backs of the ovens and stove. These areas were noted with rust, dust and dried debris. Lights attached to the back of the hood, over the cooking area were observed with dust and cobwebs. The DM was interviewed regarding a cleaning schedule for the kitchen and equipment. The DM stated, "There is a schedule for daily cleaning that the employees are supposed to complete, as well as, cleaning the area where they are working for the day. The hood gets cleaned every six months by maintenance. It is due on 11/18/18." The can opener was observed with black, sticky, debris. This was shown to the DM. She stated, "Yes, that definitely needs to be cleaned." The Administrator and DON (director of nursing) were informed of the above findings during an end of the day meeting with the survey team on 11/07/18. No further information was received by the survey team prior to the exit conference on 11/08/18.	F 812	cleanliness of the kitchen equipment and surfaces daily on 11/7/18 by Administrator and Dietary manager. The administrator and dietary manager will conduct rounds of the kitchen, coolers and all equipment weekly x 8 weeks then monthly x 1 month to ensure sanitation is maintained utilizing a Kitchen Audit Tool. Dietary staff will be retrained by the administrator or dietary manager for any identified areas of concern. The Administrator will forward the results of the Kitchen Audit Tool to the Executive Quality Assurance (QA) Committee monthly x 3 months. The Executive QA committee will meet and review the Kitchen Audit Tool and address any issues, concerns and\or trends and to make changes as needed, to include continued frequency of monitoring monthly x 3 months.	
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control	F 880		12/23/18

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F 880	Continued From page 85	F 880		

The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.

§483.80(a) Infection prevention and control program.
The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:

§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism

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F 880	Continued From page 86 involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and facility document review, the facility staff failed to develop and implement a water management program to identify where Legionella and other opportunistic waterborne bacteria could grow and spread in the facility water system. The facility staff also failed to ensure proper handwashing during a medication pass and pour observation. Findings include: 1. On 11/7/18 at 7:45 a.m., the maintenance director, OS (other staff) # 6 was asked about the	F 880	The Administrator will develop a water management program to identify where Legionella and other opportunistic waterborne bacteria could grow and spread in the facility water system on or before 12/23/2018. LPN nurse #2 and LPN nurse #3 have been educated on proper hand washing during medication pass on or before 12/23/2018. The Corporate Clinical Consultant will	

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F 880	Continued From page 87 water management program for identification of Legionella. He stated he would get with the administrator and get that information. The maintenance director returned a few minutes later and stated "No, I don't have what you are talking about as far as describing the water flow, and where water is held...I'm going to check with public works to see if they have done any testing for Legionella when they come in..." On 11/7/18 at 9:20 a.m. the administrator stated "I don't have any further information about the Legionella water management program; we went to a training, but no one from corporate came here to assist [name of OS # 6] in using the toolkit to develop a program for that. The administrator also verbalized there were no policies/procedures for a water management program to address/identify Legionella. On 11/7/18 at 10:45 a.m. OS # 6 presented a signed copy from the county water authority of a routine water sample which was negative for coliform bacteria and E. Coli. OS # 6 was advised that while that test result was good news, it did not cover the specific testing/protocols needed for a Legionella program. The administrator and DON (director of nursing) were informed of the above findings during a meeting with facility staff 11/7/18 beginning at 5:45 p.m. No further information was provided prior to the exit conference. 2. A medication pass and pour observation was completed on 11/07/18 with LPN (Licensed Practical Nurse) #3. On 11/07/18 at approximately 8:50 a.m., LPN #2 had prepared	F 880	review the facility's water management program to ensure it had been developed and implemented by 12/23/18. 100% of nurses will be observed utilizing the resident care audit hand washing tool to ensure nurses are washing hands by the Director of Nursing by 12/23/18. All maintenance staff will be educated on the water management program and the implementation, monitoring of such program by the administrator on or before 12/23/2018. All nurses have been educated on proper hand washing during medication pass by the Director of Nursing on or before 12/23/2018. The Administrator will monitor the water management program weekly x 8 weeks then monthly x 1 month to ensure the water management program is implemented and testing is being conducted as per the program utilizing a Water Management audit tool. The Maintenance Director will be reeducated for any identified areas of concern during the audit by the administrator. The Director of Nursing will conduct hand washing audits during med pass weekly x 8 weeks then monthly x 1 month to ensure the nurses are demonstrating proper hand washing during medication administration utilizing a medication pass audit tool. The nurse will be reeducated for any identified areas of concern during the audit by Director of Nursing. The Administrator will forward the results	

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F 880	Continued From page 88 and administered medications for Resident #70. The LPN then donned gloves to administer a nasal spray to the resident. The LPN administered Flonase 50 mcg nasal spray to the resident, dispensing one spray into each nostril. The LPN then left the resident's bedside, taking off the gloves at the door, exited the room and went to the medication cart. The LPN then walked back into the room to Resident #70 and applied a mask for a breathing treatment for the resident. The LPN then exited the room and began pushing the medication cart up the hall. The LPN stated that she was finished with Resident #70 and proceeded down the hall to the next resident without washing her hands or using any type of hand sanitizer. On 11/07/18 at approximately 6:00 p.m., the DON (director of nursing) and the administrator were made aware of the above in a meeting with the survey team. Policies and procedures were requested for handwashing practices. On 11/08/18 policies were presented for review. A policy on "administration of oral (po) medication" documented, "...wash hands..." A policy on "handwashing procedure" was presented and documented, "...you should was your hands: ...before and after contact with residents..." The DON (director of nursing) and the administrator were again made aware of the above observations in a meeting with the survey team on 11/08/18 at approximately 12:00 noon. No further information and/or documentation was	F 880	of the Water management and medication pass Audit Tools to the Executive Quality Assurance (QA) Committee monthly x 3 months. The Executive QA committee will meet and review the Water management and medication pass Audit Tools and address any issues, concerns and\or trends and to make changes as needed, to include continued frequency of monitoring monthly x 3 months.	

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F 880	Continued From page 89 presented prior to the exit conference on 11/08/18 at 1:45 p.m.	F 880		