STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495220	A. BUILDING _____ B. WING _____	08/15/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SPRINGS NURSING CENTER	167 SPRING STREET HOT SPRINGS, VA 24445

(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 8/14/18 through 8/15/18. Corrections are required for compliance with CFR 483.73, the Federal requirements for Emergency Preparedness in Long Term Care facilities.	E 000		
E 007 SS=C	EP Program Patient Population CFR(s): 483.73(a)(3) [(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do the following:] (3) Address patient/client population, including, but not limited to, persons at-risk; the type of services the [facility] has the ability to provide in an emergency; and continuity of operations, including delegations of authority and succession plans.** *Note: ["Persons at risk" does not apply to: ASC, hospice, PACE, HHA, CORF, CMCH, RHC, FQHC, or ESRD facilities.] This REQUIREMENT is not met as evidenced by: Based on review of the facility's Emergency Preparedness Plan and staff interview, the facility failed to develop a plan to address the facility's patient population during an emergency event. Findings included: The facility's Emergency Preparedness Plan was reviewed on 08/15/18 at approximately 1:00 p.m. No documentation was located in the Emergency Preparedness binder regarding the facility's patient population, how their needs would be	E 007	Kissito Healthcare shares the state□s focus on the health, safety and well being of facility residents. Although the facility does not agree with some of the findings and conclusions of the surveyors, we have implemented a plan of correction to demonstrate our continuing effort to provide quality care to our residents. E007 The facility's Emergency Preparedness Plan addresses the patient population	9/13/18

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

Electronically Signed | 08/25/2018

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E 007	Continued From page 1 addressed during an emergency event, how the facility would continue to operate during the emergency or delegation of authority and succession plans. The Administrator, DON (director of nursing) and Maintenance were interviewed on 08/15/18 at approximately 4:30 p.m. The Administrator stated, "We have some work to do. I see what you mean now." No further information was received by the survey team prior to the exit conference on 08/15/18	E 007	during an emergency event. This component was added to the Emergency Preparedness Binder. Current residents in the facility have the potential to be affected. The facility staff will be educated by the CAO/designee on the facility's Emergency Preparedness Plan including the facility's patient population. The CAO/designee will update/revise the facility's Emergency Preparedness Plan periodically as needed and at least annually. The results will be reported to the monthly to the Quality Assurance Committee for review and discussion. Recommendations will be made by the Quality Assurance Committee on the updates and/or revisions. CAO/DON is responsible for implementation of the plan of correction.	
E 015 SS=C	Subsistence Needs for Staff and Patients CFR(s): 483.73(b)(1) [(b) Policies and procedures. [Facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually.] At a minimum, the policies and procedures must	E 015		9/13/18

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E 015	Continued From page 2	E 015		

address the following:

(1) The provision of subsistence needs for staff and patients whether they evacuate or shelter in place, include, but are not limited to the following:
(i) Food, water, medical and pharmaceutical supplies
(ii) Alternate sources of energy to maintain the following:
(A) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions.
(B) Emergency lighting.
(C) Fire detection, extinguishing, and alarm systems.
(D) Sewage and waste disposal.

*[For Inpatient Hospice at §418.113(b)(6)(iii):] Policies and procedures.
(6) The following are additional requirements for hospice-operated inpatient care facilities only. The policies and procedures must address the following:
(iii) The provision of subsistence needs for hospice employees and patients, whether they evacuate or shelter in place, include, but are not limited to the following:
(A) Food, water, medical, and pharmaceutical supplies.
(B) Alternate sources of energy to maintain the following:
(1) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions.
(2) Emergency lighting.
(3) Fire detection, extinguishing, and alarm systems.
(C) Sewage and waste disposal.

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E 015	Continued From page 3 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 subsistence needs, sewage and waste disposal, during an emergency event. Findings included: The facility's Emergency Preparedness Plan was reviewed on 08/15/18 at approximately 1:00 p.m. No documentation was located in the Emergency Preparedness binder regarding the facility's subsistence needs, sewage and waste disposal, during an emergency event. The Administrator, DON (director of nursing) and Maintenance were interviewed on 08/15/18 at approximately 4:30 p.m. The Administrator stated, "We have some work to do. I see what you mean now." No further information was received by the survey team prior to the exit conference on 08/15/18.	E 015	E015 The facility's Emergency Preparedness Plan addresses the facility's subsistence needs, sewage and waste disposal during an emergency event. This component was added to the Emergency Preparedness Binder. Current residents in the facility have the potential to be affected. The facility staff will be educated by the CAO/designee on the facility's Emergency Preparedness Plan including the facility's subsistence needs, sewage and waste disposal during an emergency event. The CAO/designee will update/revise the facility's Emergency Preparedness Plan periodically as needed and at least annually. The results will be reported to the monthly to the Quality Assurance Committee for review and discussion. Recommendations will be made by the Quality Assurance Committee on the updates and/or revisions. CAO/DON is responsible for implementation of the plan fo correction.	
E 023 SS=C	Policies/Procedures for Medical Documentation CFR(s): 483.73(b)(5) [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness	E 023		9/13/18

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E 023	Continued From page 4 policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. At a minimum, the policies and procedures must address the following:] (5) A system of medical documentation that preserves patient information, protects confidentiality of patient information, and secures and maintains availability of records. [(5) or (3),(4),(6)] A system of medical documentation that preserves patient information, protects confidentiality of patient information, and secures and maintains availability of records. *[For RNHCIs at §403.748(b):] Policies and procedures. (5) A system of care documentation that does the following: (i) Preserves patient information. (ii) Protects confidentiality of patient information. (iii) Secures and maintains the availability of records. *[For OPOs at §486.360(b):] Policies and procedures. (2) A system of medical documentation that preserves potential and actual donor information, protects confidentiality of potential and actual donor information, and secures and maintains the availability of records. This REQUIREMENT is not met as evidenced by: Based on review of the facility's Emergency Preparedness Plan and staff interview, the facility failed to develop a plan to address how the facility preserves patient information, protects confidentiality, and secures and maintains	E 023	E023 The facility's Emergency Preparedness Plan addresses how the facility preserves patient information, potects confidentiality and secures and maintains availability of	

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E 023	Continued From page 5 availability of patient records during an emergency event. Findings included: The facility's Emergency Preparedness Plan was reviewed on 08/15/18 at approximately 1:00 p.m. No documentation was located in the Emergency Preparedness binder on how the facility preserves patient information, protects confidentiality, and secures and maintains availability of patient records during an emergency event. The Administrator, DON (director of nursing) and Maintenance were interviewed on 08/15/18 at approximately 4:30 p.m. The Administrator stated, "We have some work to do. I see what you mean now." No further information was received by the survey team prior to the exit conference on 08/15/18	E 023	patient records during an emergency event. This component was added to the Emergency Preparedness Binder. Current residents in the facility have the potential to be affected. The facility staff will be educated by the CAO/designee on the facility's Emergency Preparedness Plan including how the facility preserves patient information, protects confidentiality and secures and maintains availability of patient records during an emergency event. The CAO/designee will update/revise the facility's Emergency Preparedness Plan periodically as needed and at least annually. The results will be reported to the monthly to the Quality Assurance Committee for review and discussion. Recommendations will be made by the Quality Assurance Committee on the updates and/or revisions. CAO/DON is responsible for implementation of the plan fo correction.	
E 024 SS=C	Policies/Procedures-Volunteers and Staffing CFR(s): 483.73(b)(6) [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of	E 024		9/13/18

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E 024	Continued From page 6 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 08/15/18 at approximately 1:00 p.m. No documentation was located in the Emergency Preparedness binder on the use of volunteers	E 024	E024 The facility's Emergency Preparedness Plan addresses the use of volunteers and other staffing strategies during an emergency event. This component was added to the Emergency Preparedness Binder. Current residents in the facility have the potential to be affected. The facility staff will be educated by the	

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E 024	Continued From page 7 and other staffing strategies during an emergency event. The Administrator, DON (director of nursing) and Maintenance were interviewed on 08/15/18 at approximately 4:30 p.m. The Administrator stated, "We have some work to do. I see what you mean now." No further information was received by the survey team prior to the exit conference on 08/15/18.	E 024	CAO/designee on the facility's Emergency Preparedness Plan including the use of volunteers and other staffing strategies during an emergency event. The CAO/designee will update/revise the facility's Emergency Preparedness Plan periodically as needed and at least annually. The results will be reported to the monthly to the Quality Assurance Committee for review and discussion. Recommendations will be made by the Quality Assurance Committee on the updates and/or revisions. CAO/DON is responsible for implementation of the plan fo correction.	
E 026 SS=C	Roles Under a Waiver Declared by Secretary CFR(s): 483.73(b)(8) [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. At a minimum, the policies and procedures must address the following:] (8) [(6), (6)(C)(iv), (7), or (9)] The role of the [facility] under a waiver declared by the Secretary, in accordance with section 1135 of the Act, in the provision of care and treatment at an alternate care site identified by emergency management	E 026		9/13/18

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E 026	Continued From page 8 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 08/15/18 at approximately 1:00 p.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 event. The Administrator, DON (director of nursing) and Maintenance were interviewed on 08/15/18 at approximately 4:30 p.m. The Administrator stated, "We have some work to do. I see what you mean now." No further information was received by the survey team prior to the exit conference on 08/15/18.	E 026	E026 The facility's Emergency Preparedness Plan addresses the facility's role in providing care and treatment at alternate care sites during an emergency event. This component was added to the Emergency Preparedness Binder. Current residents in the facility have the potential to be affected. The facility staff will be educated by the CAO/designee on the facility's Emergency Preparedness Plan including the facility's role in providing care and treatment at alternate care sites during an emergency event. The CAO/designee will update/revise the facility's Emergency Preparedness Plan periodically as needed and at least annually. The results will be reported to the monthly to the Quality Assurance Committee for review and discussion. Recommendations will be made by the Quality Assurance Committee on the updates and/or revisions.	

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E 026	Continued From page 9	E 026	CAO/DON is responsible for implementation of the plan of correction.	
E 033 SS=C	Methods for Sharing Information CFR(s): 483.73(c)(4)-(6) [(c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least annually.] The communication plan must include all of the following: (4) A method for sharing information and medical documentation for patients under the [facility's] care, as necessary, with other health providers to maintain the continuity of care. (5) A means, in the event of an evacuation, to release patient information as permitted under 45 CFR 164.510(b)(1)(ii). [This provision is not required for HHAs under §484.102(c), CORFs under §485.68(c), and RHCs/FQHCs under §491.12(c).] (6) [(4) or (5)]A means of providing information about the general condition and location of patients under the [facility's] care as permitted under 45 CFR 164.510(b)(4). *[For RNHCIs at §403.748(c):] (4) A method for sharing information and care documentation for patients under the RNHCI's care, as necessary, with care providers to maintain the continuity of care, based on the written election statement made by the patient or his or her legal representative.	E 033		9/13/18

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E 033	Continued From page 10 *[For RHCs/FQHCs at §491.12(c):] (4) A means of providing information about the general condition and location of patients under the facility's care as permitted under 45 CFR 164.510(b)(4). This REQUIREMENT is not met as evidenced by: Based on review of the facility's Emergency Preparedness Plan and staff interview, the facility failed to develop a plan to address the means the facility will use to release patient information to include general condition and location of patients, by reviewing the communication plan, during an emergency event. Findings included: The facility's Emergency Preparedness Plan was reviewed on 08/15/18 at approximately 1:00 p.m. No documentation was located in the Emergency Preparedness binder on the means the facility will use to release patient information to include general condition and location of patients, by reviewing the communication plan, during an emergency event. The Administrator, DON (director of nursing) and Maintenance were interviewed on 08/15/18 at approximately 4:30 p.m. The Administrator stated, "We have some work to do. I see what you mean now." No further information was received by the survey team prior to the exit conference on 08/15/18.	E 033	E033 The facility's Emergency Preparedness Plan addresses the means in which the facility will use to release patient information to include general condition and location of patients during an emergency event. This component was added to the Emergency Preparedness Binder. Current residents in the facility have the potential to be affected. The facility staff will be educated by the CAO/designee on the facility's Emergency Preparedness Plan including the means in which the facility will use to release patient information to include general condition and location of patients during an emergency event. The CAO/designee will update/revise the facility's Emergency Preparedness Plan periodically as needed and at least annually. The results will be reported to the monthly to the Quality Assurance Committee for review and discussion. Recommendations will be made by the Quality Assurance Committee on the updates and/or revisions.	

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E 033	Continued From page 11	E 033	CAO/DON is responsible for implementation of the plan of correction.	
E 034 SS=C	Information on Occupancy/Needs CFR(s): 483.73(c)(7) [(c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least annually.] The communication plan must include all of the following: (7) [(5) or (6)] A means of providing information about the [facility's] occupancy, needs, and its ability to provide assistance, to the authority having jurisdiction, the Incident Command Center, or designee. *[For ASCs at 416.54(c)]: (7) A means of providing information about the ASC's needs, and its ability to provide assistance, to the authority having jurisdiction, the Incident Command Center, or designee. *[For Inpatient Hospice at §418.113:] (7) A means of providing information about the hospice's inpatient occupancy, needs, and its ability to provide assistance, to the authority having jurisdiction, the Incident Command Center, or designee. This REQUIREMENT is not met as evidenced by: Based on review of the facility's Emergency Preparedness Plan and staff interview, the facility failed to develop a plan to address the communication plan to include a means of providing information about the facility's needs,	E 034	E034 The facility's Emergency Preparedness Plan addresses the means the facility will use to provide information about the facility's needs and its ability to provide	9/13/18

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E 034	Continued From page 12 and its ability to provide assistance, to the authority having jurisdiction, the Incident Command Center, or designee, and also that the communication plan includes a means of providing information about their occupancy, during an emergency event. Findings included: The facility's Emergency Preparedness Plan was reviewed on 08/15/18 at approximately 1:00 p.m. No documentation was located in the Emergency Preparedness binder on the communication plan to include a means of providing information about the facility's needs, and its ability to provide assistance, to the authority having jurisdiction, the Incident Command Center, or designee, and also that the communication plan includes a means of providing information about their occupancy, during an emergency event. The Administrator, DON (director of nursing) and Maintenance were interviewed on 08/15/18 at approximately 4:30 p.m. The Administrator stated, "We have some work to do. I see what you mean now." No further information was received by the survey team prior to the exit conference on 08/15/18.	E 034	assistance to the authority having jurisdiction, the Incident Command Center/designee. The communication plan includes the means in which the facility will provide information about their occupancy during an emergency event. This component was added to the Emergency Preparedness Binder. Current residents in the facility have the potential to be affected. The facility staff will be educated by the CAO/designee on the facility's Emergency Preparedness Plan including the means the facility will use to provide information about the facility's needs and its ability to provide assistance to the authority having jurisdiction, the Incident Command Center/designee. Education will also include the communication plan and the means in which the facility will provide information about their occupancy during an emergency event. The CAO/designee will update/revise the facility's Emergency Preparedness Plan periodically as needed and at least annually. The results will be reported to the monthly to the Quality Assurance Committee for review and discussion. Recommendations will be made by the Quality Assurance Committee on the updates and/or revisions. CAO/DON is responsible for implementation of the plan of correction.	

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E 035 SS=C	LTC and ICF/IID Sharing Plan with Patients CFR(s): 483.73(c)(8) [(c) The [LTC facility and ICF/IID] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least annually.] The communication plan must include all of the following: (8) A method for sharing information from the emergency plan, that the facility has determined is appropriate, with residents [or clients] and their families or representatives. This REQUIREMENT is not met as evidenced by: Based on review of the facility's Emergency Preparedness Plan and staff interview, the facility failed to develop a plan that the communication plan includes a method for sharing information from the emergency plan, and that the facility has determined it is appropriate with residents or clients and their families or representatives, during an emergency event. Findings included: The facility's Emergency Preparedness Plan was reviewed on 08/15/18 at approximately 1:00 p.m. No documentation was located in the Emergency Preparedness binder that the communication plan includes a method for sharing information from the emergency plan, and that the facility has determined it is appropriate with residents or clients and their families or representatives, during an emergency event. The Administrator, DON (director of nursing) and Maintenance were interviewed on 08/15/18 at approximately 4:30 p.m. The Administrator	E 035	E035 The Facility's Emergency Preparedness Plan addresses the method for sharing information from the emergency plan and that it is appropriate with residents and their families/representatives during am emergency event. This component was added to the Emergency Preparedness Binder. Current residents in the facility have the potential to be affected. The facility staff will be educated by the CAO/designee on the facility's Emergency Preparedness Plan including the method for sharing information from the emergency plan and that it is appropriate with residents and their families/representatives during an emengency event. The CAO/designee will update/revise the	9/13/18

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E 035	Continued From page 14 stated, "We have some work to do. I see what you mean now." No further information was received by the survey team prior to the exit conference on 08/15/18.	E 035	facility's Emergency Preparedness Plan periodically as needed and at least annually. The results will be reported to the monthly to the Quality Assurance Committee for review and discussion. Recommendations will be made by the Quality Assurance Committee on the updates and/or revisions. CAO/DON is responsible for implementation of the plan of correction.	
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 8/14/18 through 8/15/18. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. No complaints were investigated during the survey. The Life Safety Code survey/report will follow. The census in this 60 certified bed facility was 51 at the time of the survey. The survey sample consisted of 18 current Resident reviews and 3 closed record reviews.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident	F 550		9/13/18

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F 550	Continued From page 15 with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility staff failed to ensure a dignified dining experience during breakfast in the main dining room on 08/14/2018. During breakfast observation on 08/14/2018, staff	F 550	Kissito Healthcare shares the state's focus on the health, safety and well being of facility residents. Although the facility does not agree with some of the findings and conclusions of the surveyors, we have implemented a plan of correction to	

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F 550	Continued From page 16 were observed feeding more than one resident at the same time and standing over residents while feeding them. Findings were: A dining observation was conducted during breakfast on 08/14/2018 beginning at approximately 8:00 a.m. Residents were observed seated at various tables around the dining room. CNA [certified nursing assistant] #1 was observed seated between two residents. She was observed feeding both residents at the same time. She alternated between the two, giving one resident a few bites and then feeding the other. This continued for the entire meal. Neither of the residents being fed made any effort to feed themselves. CNA #2 was observed at another table, also feeding two residents at the same time in the same manner as above. Neither of the residents made any attempt to feed themselves. Neither CNA #1 or CNA #2 were conversing with the residents being fed. Other staff members were observed walking around the dining room, stopping at tables and assisting various residents with breakfast, including but not limited to standing over residents and offering them bites of food. On 08/14/2018 at 11:07 AM, CNA #2 was interviewed regarding the breakfast observation. She was asked why both residents were being fed at the same time. She stated that she feeds	F 550	demonstrate our continuing effort to provide quality care to our residents. F 550 Employees participating in dining room activity during 8/14/18 and 8/15/18 were educated on providing a dignified dining experience for residents by engaging with the resident during assistance with meals and assisting residents while seated beside of resident and not standing. Current residents in the facility have the potential of being affected. Clinical staff will be educated by the Director of Nursing/designee on providing a dignified dining experience for residents requiring assistance with their meals. The Director of Nursing/designee will monitor dining room service meals three times weekly to ensure the dining experience is dignified for those residents requiring assistance with their meals. The results will be reported to the monthly to the Quality Assurance Committee for review and discussion. Once the Quality Assurance Committee determines the problem no longer exists, audits will be conducted on a random basis. CAO/DON is responsible for implementation of the plan of correction.	

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F 550	Continued From page 17 them at the same time everyday. CNA #1 was interviewed after breakfast at approximately 11:26 a.m. She was asked about the feeding of the two residents at breakfast. She stated, "I don't like them to have cold food." She was asked if she normally fed more than one resident at a time. She stated, "Yes." The DON (director of nursing), the regional nurse consultant and the administrator were notified of the above information during an end of the day meeting on 08/15/2018 at approximately 3:15 p.m. The DON was asked what the expectation was regarding feeding assistance. She stated that everywhere I have ever worked we feed more than one resident at a time. The corporate nurse consultant stated if they are engaing the resident it's "Okay." She was told that neither CNA was observed talking with the resident's individually during the meal. The administrator stated, "We have so many [residents] that need assistance with feeding or need to be fed that we have to feed more than one at a time or the food will get cold." No further information was obtained prior to the exit conference on 08/15/2018.	F 550		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's	F 656		9/13/18

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F 656	Continued From page 18 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 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 staff interview, and clinical record review, the facility staff failed to develop a care plan for one of 21 residents, Resident #7.	F 656	F656 Resident #7's care plan was updated immediately to reflect hydration needs.	

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F 656	Continued From page 19 Resident #7 did not have a care plan to address hydration. The Findings Include: Resident #7 was admitted to the facility on 7/21/15. Diagnoses for Resident #7 included: Edema, acute respiratory failure, and acute congestive heart failure. The most current MDS (minimum data set) was a quarterly with an ARD (assessment reference date) of 5/25/18. Resident #7 was assessed with a cognitive score of 15, indicating cognitively intact. On 8/15/18 Resident #7's record was reviewed. A hospital discharge summary, dated 7/27/2018, documented that Resident #7 was sent to the hospital due to shortness of breath and was diagnosed with acute respiratory failure and acute congestive heart failure. Review of the physician orders documented an order dated 8/10/18, for fluid restriction of less than 1200 milliliters of fluids a day. Resident #7's care plan was then reviewed and did not evidence that a care plan was in place for hydration/dehydration versus fluid overload. On 08/15/18 10:17 AM the MDS coordinator was interviewed (registered nurse, RN #2) regarding a care plan for hydration relating to fluid restriction. RN #2 reviewed the physician's order along with the hospital diagnoses and agreed, verbalizing that a care plan should be put in place to reflect hydration/dehydration. On 8/15/18 at 3:17 AM, the above information was presented to the director of nursing (DON)	F 656	A care plan audit was conducted on current residents in the center to ensure the residents physical and psychosocial needs are care planned including hydration needs. MDS staff was educated by the Director of Nursing/designee on ensuring the residents physical and psychosocial needs are care planned including hydration needs. The Director of Nursing/designee will monitor 5 care plans weekly to ensure the care plan addresses the physical and psychosocial needs of the resident including hydration needs. The results will be reported to the monthly to the Quality Assurance Committee for review and discussion. Once the Quality Assurance Committee determines the problem no longer exists, audits will be conducted on a random basis.	

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F 656	Continued From page 20 and administrator. No other information was provided prior to exit conference on 8/15/18.	F 656		
F 693 SS=D	Tube Feeding Mgmt/Restore Eating Skills CFR(s): 483.25(g)(4)(5) §483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, clinical record review and facility document review, facility staff failed to follow physician orders for bolus tube feedings for one of 21 residents in the survey sample, Resident #35.	F 693	F693 Resident #35 physician orders are being followed for the elevation of the head of bed during and after bolus feedings via peg tube.	9/13/18

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F 693	Continued From page 21 LPN #4 (licensed practical nurse) failed to check residual volume for Resident #35 prior to administering bolus tube feeding. Resident #35's HOB (head of bed) was not maintained at 45 degrees per physician order. Findings included: Resident #35 was originally admitted to the facility on 11/01/17 and readmitted 11/20/17 with diagnoses including, but not limited to: Chronic Respiratory Failure, Cardiomyopathy, Dyskinesia of Esophagus, and Gastrostomy Tube (G-tube). The most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 07/17/18. Resident #35 was assessed as moderately impaired in her cognitive status with a total cognitive score of 12 out of 15. The clinical record was reviewed and included in Resident #35's August physician order sheet was: "...Check residual before each feeding and hold feeding if residual is 100 ml's (milliliters) or greater...HOB elevated 45 degrees @ (at) all times due aspiration risk (sic)..." Resident #35 was observed on 08/14/18 at 8:11 a.m. and at 1:31 p.m. lying in bed with her eyes closed. The HOB was elevated approximately 10-15 degrees. Resident #35 was again observed on 08/15/18 at 8:10 a.m., 10:47 a.m. and at 11:45 a.m. with the HOB elevated at approximately 20 degrees. LPN #4 was observed on 08/15/18 at approximately 11:50 a.m. administering a bolus tube feeding to Resident #35 via her G-tube. Prior to administering Resident #35's tube	F 693	LPN #4 was immediately educated in regards to following physician orders for checking residual prior to tube feedings. Current residents with feeding tubes have the potential to be affected. Licensed nurses/designee will be educated by Director of Nursing/designee on checking residue prior to administering tube feedings and following physical orders for elevation of the head of bed during and after bolus tube feedings. The Director of Nursing/designee will observe residents with tube feedings three times per week to ensure residues are checked prior to administering bolus tube feeding and ensure the head of the bed is elevated per physician orders. The results will be reported to the monthly to the Quality Assurance Committee for review and discussion. Once the Quality Assurance Committee determines the problem no longer exists, audits will be conducted on a random basis. CAO/DON is responsible for implementation of the plan of correction.	

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F 693	Continued From page 22 feeding LPN #4 failed to aspirate any residual volume from Resident #35's G-tube. LPN #4 was interviewed regarding not checking residual volume prior to the tube feeding. LPN #4 stated, "Yes, I normally do check. I should have. I guess I was just nervous. I checked this morning with her water flush and it went right through." Resident #35 was interviewed during her tube feeding regarding the HOB placement. Her head was at 45 degrees during the bolus feeding. Resident #35 stated, "I don't like my head up this far. It is uncomfortable. I like it up just a little bit." The facility tube feeding policy was requested and received. Included in the policy, "Enteral Feeding Guidelines Purpose: To provide guidelines for the safe administration of tube feedings. Key Procedural Points...8. Residuals: Bolus/Gravity Feedings - Check for residual prior to feeding and/or medication administration...Procedure Guidelines: Feeding Administration: 1. Bolus Feedings...g) Check for residual..." During a meeting with the survey team on 08/15/18 at approximately 3:15 p.m., the Administrator, DON (director of nursing), and Regional Nurse Consultant-Registered Nurse (RN #1) were informed of the above. RN #1 stated, "We will need to get her order clarified for the HOB placement." No further information was received by the survey team prior to the exit conference on 08/15/18.	F 693		
F 759 SS=D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1)	F 759		9/13/18

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F 759	Continued From page 23 §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 medication administration observation, resident interview, staff interview and clinical record review, facility staff failed to ensure a medication error rate of less than five percent in the facility. There were three medication administration errors out of 33 opportunities total, resulting in an overall medication error rate of 9.09%. 1. LPN #3 (licensed practical nurse) administered Resident #8's insulin after breakfast, which was completed and one hour and seven minutes after the dose was scheduled. 2. Resident #30 was given 500 mg of Oyster Shell Calcium. He was ordered to receive 600 mg of Calcium Carbonate. 3. Resident # 198's finger stick blood sugar, ordered before meals and at bedtime, was not obtained until after breakfast. Findings included: 1. Resident #8 was originally admitted to the facility on 10/08/15 and readmitted on 06/23/16 with diagnoses including, but not limited to: Cerebral Infarction with left-sided paralysis, Convulsions, Diabetes and Depression. The most recent MDS (minimum data set) was a	F 759	F759 LPN #3 and LPN #2 were educated on the 5 R(s) of medication administration including timeliness of medication administration and blood sugar monitoring. Resident #8 is receiving insulin as per physician orders and within the time requirement. Resident #30 is receiving medications as per physician orders. Resident #198 is receiving blood sugar monitoring as per physician orders. Current residents in the center have the potential of being affected. Licensed nurses will be educated by the Director of Nursing/designee on the 5 R(s) of medication administration including timeliness of medication administration and blood sugar monitoring. The DON/designee will observe 2 nurses weekly across both shifts during medication pass to ensure the 5 R(s) of medication administration is being	

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F 759	Continued From page 24 quarterly assessment with an ARD (assessment reference date) of 05/31/18. Resident #8 was assessed as cognitively intact with a total cognitive score of 15 out of 15. During the medication administration observation on 08/14/18 at 9:07 a.m., LPN #3 administered Resident #8's insulin into her right arm. Following this observation Resident #8's clinical record was reviewed for reconciliation of the medication pass with the physician orders. Resident #8's August POS (physician order sheet) included the following: "...Novolog FlexPen Solution Pen-Injector 100 UNIT/ML (milliliter) (Insulin Aspart) Inject 5 unit subcutaneously with meals..." The scheduled administration time for the morning insulin was 8:00 a.m. on the MAR (medication administration sheet). This dose of insulin was given at 9:07 a.m. Breakfast had already been served to Resident #8 and her tray picked up. LPN #3 was interviewed at 9:30 a.m. regarding Resident #8's insulin order and administration time. LPN #3 stated, "Well, I don't know about that because there are people on the 100 hall that have scheduled meds before her." During a meeting with the survey team on 08/15/18 at 3:15 p.m., RN #1 (registered nurse), Regional Nurse Consultant stated, "Our practice is to administer medications within one hour before or after the scheduled time." No further information was received by the survey team prior to the exit conference on 08/15/18. 2. A medication pass and pour observation was conducted on 08/14/2018 beginning at	F 759	completed, including timeliness of medications. In addition, during the clinical meeting the Director of Nursing/designee will review the missed documentation report in EMAR to ensure medications and blood sugar monitoring is signed off as completed. The results will be reported to the monthly to the Quality Assurance Committee for review and discussion. Once the Quality Assurance Committee determines the problem no longer exists, audits will be conducted on a random basis. CAO/DON is responsible for implementation of the plan of correction.	

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approximately 8:00 a.m., with LPN (licensed practical nurse) #1 and LPN # 2. The two LPNs were working together, and LPN #2 was identified as being on orientation. The two LPNs agreed that LPN #2 would prepare the medications. Resident #30 was the first resident she administered medications to.

Resident #30 was recently readmitted to the facility on 07/16/2018 with the following diagnoses, but not limited to: chronic obstructive pulmonary disease, hypertension, bipolar disorder, Alzheimer's, osteoporosis, and obesity.

A quarterly MDS (minimum data set) with an ARD (assessment reference date) of 07/06/2018, assessed Resident #30 as being moderately impaired in his cognitive status with a summary score of "09".

Medications were prepared for Resident #30. A stock medication was pulled from the medication cart. LPN #2 stated, "He gets 600 mg of Calcium." She placed one pill from the bottle in the medication cup. The bottle was handed to this surveyor and the label was observed, "Oyster Shell Calcium 500 mg".

After the medications were administered, LPN #2 was asked about the Calcium administered to Resident #30. LPN #2 and LPN #1 opened the medication cart. A bottle of Calcium Carbonate was in the drawer beside the Oyster Shell Calcium. LPN #2 stated, "This is the one I should have given", as she pointed to the Calcium Carbonate.

The medications were reconciled with the current POS (physician order sheet). Orders were

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observed for "Calcium Carbonate tablet 600 mg Give 1 tablet by mouth one time a day related to AGE-RELATED OSTEOPOROSIS WITHOUT CURRENT PATHOLOGICAL FRACTURE."

The above information was discussed with the DON (director of nursing) and the administrator during an end of the day meeting on 08/15/2018.

No further information was obtained prior to the exit conference on 08/15/2018.

3. A medication pass and pour observation was conducted on 08/14/2018 beginning at approximately 8:00 a.m., with LPN (licensed practical nurse) #1 and LPN #2. The two LPNs were working together, and LPN #2 was identified as being on orientation. The two LPNs agreed that LPN #2 would prepare the medications.

Resident # 198 was recently readmitted to the facility on 08/07/2018 with the following diagnoses, but not limited to: Dementia, Type II Diabetes Mellitus, conduct disorder, peripheral vascular disease, and dysphagia.

A quarterly MDS with an ARD of 07/04/2018 assessed Resident #198 as moderately impaired in his cognitive status, with a summary score of "12".

Resident #198 was observed self-propelling in his wheelchair down the 400 hallway. He stopped at the medication cart. Medications were prepared for him by LPN #2. During the preparation of his medications LPN #1 stated, "We need to get his blood sugar...it doesn't look like they got it this morning." LPN #2 did a finger stick blood sugar on Resident #198 with a reading of 324. LPN #1

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F 759	Continued From page 27 and LPN #2 were asked when the blood sugar had been ordered to be obtained. LPN #1 stated, "Before breakfast...they should have gotten it at 6:30 this morning...but he's not on any insulin or anything for his diabetes...we are just monitoring him." LPN #1 was asked if there were any notations as to why the blood sugar had not been obtained as ordered. She stated, "No, I don't know why they didn't get it." The medications were reconciled with the current POS (physician order sheet). Orders were observed for "Blood Sugar Checks at AC [before meals] and HS [bedtime] X [times] 7 days four times a day related to TYPE 2 DIABETES MELLITUS WITH HYPERGLYCEMIA". The above information was discussed with the DON (director of nursing) and the administrator during an end of the day meeting on 08/15/2018. No further information was obtained prior to the exit conference on 08/15/2018.	F 759		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control 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	F 880		9/13/18

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F 880	Continued From page 28 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 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.	F 880		

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F 880	Continued From page 29 §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 medication administration observation, staff interview, and facility document review, facility staff failed to ensure infection control practices during the medication pass and pour observation for Resident #8. LPN #3 (licensed practical nurse) was observed punching three of 16 pills for Resident #8, out of the pill cards, into her bare hand and then placing them into the medication cup. Findings included: Resident #8 was originally admitted to the facility on 10/08/15 and readmitted on 06/23/16 with diagnoses including, but not limited to: Cerebral Infarction with left-sided paralysis, Convulsions, Diabetes and Depression. The most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 05/31/18. Resident #8 was assessed as cognitively intact with a total cognitive score of 15 out of 15.	F 880	F880 LPN #3 was educated immediately on appropriate procedure regarding the 5 R(s) of medication administration and infection control practices during a medication pass. Current residents in the facility have the potential to be affected. Licensed nurses will be educated by the Director of Nursing/designee on the 5 R(s) of medication administration including timeliness of medication administration and blood sugar monitoring. In addition, the education will also include the facility policy on infection control practices during medication administration. The DON/designee will observe 2 nurses weekly across both shifts during medication pass to ensure the 5 R(s) of medication administration is being	

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F 880	Continued From page 30 During the medication pass and pour observation on 08/14/18 at approximately 9:00 a.m. LPN #3 was observed touching three pills out of 16 with her bare hands before placing the pills into the medication cup for administration. LPN #3 punched three pills out of the pill cards into her bare hand and then placed them into the medication cup. LPN #3 then administered these medications to Resident #8. LPN #3 was interviewed at approximately 9:15 a.m. regarding touching some of the medications with her bare hands. LPN #3 stated, "Normally, I do not. I guess I was just nervous." A copy of the facility medication administration policy was requested and received. The policy "General Dose Preparation and Medication Administration" included "...3.4 Facility staff should not touch the medication when opening a bottle or unit dose package..." During a meeting with survey team on 08/15/18 at approximately 3:15 p.m., the Administrator, DON (director of nursing) and Regional Nurse Consultant-Registered Nurse (RN #1) were informed of the above observation. RN #1 stated, "Oh, that is not good." No further information was received by the survey team prior to the exit conference on 08/15/18.	F 880	completed. In addition, the observation will include infection control practices and to ensure there is no breech during medication administration. The results will be reported to the monthly to the Quality Assurance Committee for review and discussion. Once the Quality Assurance Committee determines the problem no longer exists, audits will be conducted on a random basis. CAO/DON is responsible for implementation of the plan of correction.	