STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495296	A. BUILDING ______ B. WING ______	C 11/08/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTLAND HEALTH & REHABILITATION CENTER	**23020 MAIN STREET** **COURTLAND, VA 23837**

(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 11/6/18 through 11/8/18. Corrections are required for compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities. No emergency preparedness complaints were investigated during the survey.	E 000		
E 036 SS=C	EP Training and Testing CFR(s): 483.73(d) (d) Training and testing. The [facility] must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least annually. *[For ICF/IIDs at §483.475(d):] Training and testing. The ICF/IID must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least annually. The ICF/IID must meet the requirements for evacuation drills and training at §483.470(h). *[For ESRD Facilities at §494.62(d):] Training, testing, and orientation. The dialysis facility must develop and maintain an emergency	E 036		12/18/18

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — Electronically Signed | TITLE | (X6) DATE 11/30/2018

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

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E 036	Continued From page 1 preparedness training, testing and patient orientation program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training, testing and orientation program must be reviewed and updated at least annually. This REQUIREMENT is not met as evidenced by: Based on staff interviews and review of the facility's Emergency Preparedness (EP) plan the facility staff failed to have an all inclusive training and testing program based on the facility's EP plan. The findings include: On 11/8/18 at 10:00 a.m., an interview was conducted with the Administrator, the Director of Maintenance and the Director of Environmental Services. They were unable to demonstrate that their EP training and testing program for the facility staff was all inclusive with the components of their plan and that the drills and exercises were in place to test the emergency plan in order to identify gaps and areas for improvement. They were not able to demonstrate that the current training and testing process included contractors and facility volunteers. The Administrator stated after the interview that she would update the current emergency preparedness training to broaden the training based on the additional required regulatory components. Interviews were conducted with the following eight facility staff: Registered Nurse (RN) #4 on 11/8/18 at 2:45 p.m., Housekeeper #4 on 11/8/18	E 036	The statements included are not an admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is completed in the compliance of state and federal regulations as outlined. To remain in compliance with all federal and state regulations the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the centers allegation of compliance. All alleged deficiencies cited have been or will be completed by the dates indicated. 1- The Emergency Preparedness Manual has been updated with a revised all-inclusive training and testing program. 2- The Administrator or Designee contacted Eastern Virginia Healthcare Coalition to obtain additional testing forms and training material to be included in the training and testing program. 3-The Administrator or designee conducted training to all staff, including contractors and facility volunteers on the revised program. 4- The Administrator or designee will conduct monthly interviews of staff to	

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E 036	Continued From page 2 at 3:00 p.m., Laundry staff #5 on 11/8/18 at 3:15 p.m., Licensed Practical Nurse (LPN) #1 on 11/8/18 at 3:30 p.m., RN #3 on 11/8/18 at 3:45 p.m., Certified Nursing Assistant (CNA) #3 on 11/8/18 at 4:00 p.m., CNA #4 on 11/8/18 at 4:10 p.m. and CNA #5 on 11/8/18 at 4:25 p.m. All eight staff members stated they received EP training that included fire drill procedures, missing residents and what to do if there were a bomb threat. They were not clear on the risks identified specific in their facility's risk assessment, that would close or cause evacuation, how they would communicate the facility closure to required individuals and agencies, nor testing and training on resident tracking systems to include transportation procedures for safely moving patients to other facilities.	E 036	validate their understanding of the Emergency Preparedness training program. Results of the audits will be presented to the quarterly Quality Assurance committee for review and recommendation. 5- Completion date 12/18/18.	
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 11/6/18 through 11/08/18. Corrections are required for compliance with the following 42 CFR Part 483 Federal Long Term Care requirements. Three complaints were investigated during the survey. The Life Safety Code survey/report will follow. The census in this 90 certified bed facility was 76 at the time of the survey. The survey sample consisted of 39 residents: 35 current resident reviews and and 4 closed record reviews.	F 000		
F 607 SS=E	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(3) §483.12(b) The facility must develop and implement written policies and procedures that:	F 607		12/18/18

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F 607	Continued From page 3 §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, This REQUIREMENT is not met as evidenced by: Based on clinical record review, staff interviews and facility documentation review, the facility staff failed to establish and implement policies and procedures that included immediately reporting all alleged violations of abuse to the Administrator, state agency, adult protective services and to all other required agencies within specified timeframes. Two out of 39 residents (Resident #30 and #10) in the survey sample were affected by the facility's failure to develop and implement policies to ensure alleged abuse reporting requirements were in compliance with regulatory requirements. 1. Resident #30 alleged his roommate had exhibited inappropriate sexual abuse behaviors towards him on 2/18/18 which was told to a Certified Nursing Assistant (CNA). The nursing staff failed to inform the Administrator within two hours after the allegation was made, as well as the State survey and certification agency. 2. An allegation of verbal abuse by a staff against Resident #10 occurred on 7/22/18 which was not reported to the State certification agency after the allegation was made. The findings include:	F 607	The statements included are not an admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is completed in the compliance of state and federal regulations as outlined. To remain in compliance with all federal and state regulations the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the centers allegation of compliance. All alleged deficiencies cited have been or will be completed by the dates indicated. 1-The Abuse Policy #704 was revised to include timely reporting of alleged violations of abuse to the Administrator and all other required agencies in the appropriate timeframe. Resident #30 was immediately separated from the alleged abuser. The alleged abuser no longer resides in the facility. Staff member involved in the incident with resident #10 was suspended upon notification of allegation and subsequently terminated. Resident #10 remains in the facility free from verbal abuse. 2-The DON or designee will review	

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F 607 Continued From page 4

1. Resident #30 was admitted to the nursing facility on 2/26/16 with diagnoses that included stroke and swallowing problems.

The most recent Minimal Data Set (MDS) assessment was a quarterly dated 9/5/18 and coded the resident on the Brief Interview for Mental Status (BIMS) with a score of 6 out of a possible score of 15 which indicated he was severely impaired in the necessary skills for daily decision making. The resident was not coded to have any mood or behavior problems. Resident #30 was coded to respond adequately to simple, direct communication and usually understood with clear speech. The resident was assessed to require extensive assistance from one staff for bed mobility, transfers and dressing. The resident was coded as totally dependent on one staff for locomotion on the unit via assistance from staff using a wheelchair, totally dependent on staff for eating, toilet use, personal hygiene and bathing.

The care plan created on 2/27/18 and revised as current on 9/25/18 indicated the resident had some Activities of Daily Living (ADL) self-care deficits. The goal set for the resident by the staff included they would address the resident's basic needs and ensure he would maintain his current level of function. The approaches the staff would implement to accomplish this goal included ensuring hearing aids were in place every morning, allow the resident to make decisions about treatment regime, to provide a sense of control, encourage as much participation/interaction by the resident as much as possible during care activities, give clear explanation of all care activities prior to and as they occur during each contact, when possible

F 607

current facility incidents to ensure that they were reported in the appropriate timeframe.
3-The DON or designee will educate all staff on the revised policy for timely reporting of allegations of abuse.
4-The DON or designee will review shift report and incidents on a daily basis to ensure that any alleged allegations or violations of abuse are reported in the appropriate timeframe. Results of the audits will be presented to the quarterly Quality Assurance committee for review and recommendation.
5-Completion date 12/18/18.

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F 607	Continued From page 5	F 607		

negotiate as time for ADLs so that the resident can participate in decision making and return at an agreed time.

A facility reported incident was forwarded to the State survey and certification agency on 2/19/18 that entailed the following information:
"During the rounds on the evening of 2/18/18, Certified Nursing Assistant (CNA) (name of CNA) noticed that (Resident #30's name) brief appeared to have been removed, he had a visible erection and he reported to her that someone touched him. (Resident #30's name) roommate has exhibited inappropriate sexual behaviors, such as public masturbation in the past. After confirming there were no visitors in their room the evening on 2/18/18, (Resident #30's name) was transferred to another room. A skin assessment was completed which did not show any impairments. An investigation is in progress. This alleged sexual assault was reported to state, responsible party, physician, law enforcement and the State survey and certification agency on 2/19/18".

On 11/8/18 at 2:00 p.m., an interview was conducted with the Administrator, the Interim Director of Nursing (DON) and the Corporate Clinical Nurse. They stated they thought reporting in two hours only referred to if serious bodily harm had to occurred. They stated there was concern about the failure of the CNA to report the alleged sexual assault incident to the charge nurse and the Administrator, thus causing the alleged incident to be reported late to State agencies. The Interim Director of Nursing (IDON) stated in response to the failure to report as mandated reporters, widespread abuse, neglect and reporting education was conducted. They

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F 607	Continued From page 6 stated they thought the facility's policy was revised to make clear the reporting mandates and requirements regarding abuse, but after review of the policy; it was determined the policy had not been revised to include the correct required timeframe for reporting alleged abuse. The Administrator confirmed that she was not informed of the incident on 2/18/18 until the following day 2/19/18 and that the CNA should have immediately informed the charge nurse at which time she would have been made aware and reporting to State agencies would have taken place. The previous Director of Nursing's written investigative statement undated titled "Notes from FRI (no date) on (Resident #30's name)" indicated Resident #30's roommate had a history of public masturbating and making inappropriate comments to female staff members. The Administrator stated although the outcome of the facility's investigation of the aforementioned did not confirm sexual abuse had occurred, Resident #30's roommate was transferred to another facility due to his repeated inappropriate behaviors. The education conducted on 2/21/18 and 2/28/18 was titled "Mandated Reporting of Abuse or Suspected Abuse", CNAs are to report allegations immediately to the charge nurse. Review of the education indicated the objectives of the in-service included verbalization of all types of abuse, verbalization of mandated reporting requirements, a discussion of the importance of immediately reporting allegations of abuse, verbalization of what immediate meant, identify who were mandated reporters in the facility and that the reporting was to be submitted within regulatory defined time frames. The timeframes were not specifically outlined in the education that	F 607		

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was presented to this surveyor. The education further indicated that failure to immediately report allegations of abuse may result in potential harm to residents and is a violation of the State and Federal Mandated Reporting regulations.

On 11/8/18 at 5:00 p.m., a debriefing was held with the Administrator, the Corporate Clinical Nurse and the Interim Director of Nursing. No further information was provided prior to survey exit.

The facility's policy was not revised to include reporting within 2 hours alleged abuse to the Administrator and other applicable State agencies.

The policy dated 11/4/16 titled Abuse/Neglect/Misappropriation/Crime Investigation and Follow Up reporting indicated serious bodily injury must be reported no later than two hours after forming the suspicion. Crimes not resulting in serious bodily injury to the patient must be reported no later than 24 hours after forming the suspicion. The Administrator will immediately (within 2 or 24 hours of knowledge of the allegation), notify the State licensure and certification agency.

2. An allegation of verbal abuse by a staff against Resident #10 occurred on 7/22/18 which was not reported to the State certification agency after the allegation was made.

Resident #10 was re-admitted to the nursing facility on 9/4/18 with diagnoses that included history of falls, diabetes and high blood pressure.

The most recent Minimum Data Set (MDS) was a

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quarterly dated 9/2/18 and coded the resident with short term memory problems and moderately impaired in the skills needed for daily decision making.

A facility reported incident was forwarded to the State survey and certification agency on 7/23/18 at 3:15 p.m. that entailed the following information:
"Visitor approached nurse (supervisor) on 7/22/18 stating he witnessed a Certified Nursing Assistant (CNA) yelling at a resident and pointing her finger at her face. The nurse identified the CNA as (CNA's name). The CNA was suspended pending an investigation". The follow up report to the State survey and certification agency dated 7/27/18 indicated after reviewing and obtaining statements from the staff that was on duty, it was validated from other witnesses that the CNA implicated in the verbal abuse toward Resident #10 yelled and aggressively pushed her down the hallway in her wheelchair. The CNA was terminated based on the aforementioned findings from the abuse investigation. This alleged verbal abuse was reported to the responsible party and the State survey and certification agency on 7/23/18.

On 11/8/18 at 2:00 p.m., an interview was conducted with the Administrator, the Interim Director of Nursing (DON) and the Corporate Clinical Nurse. They stated they thought reporting in two hours only referred to if serious bodily harm had to occurred. The Administrator stated the alleged verbal abuse occurred on a Sunday and was reported to the nursing supervisor by a visitor on 7/22/18 and she was made aware of the incident on Monday 7/23/18. They stated they thought the facility's policy was

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F 607	Continued From page 9 revised to make clear the reporting mandates and requirements regarding abuse, but after review of the policy; it was determined the policy had not been revised to include the correct required timeframe for reporting alleged abuse. The facility's policy was not revised to include reporting within 2 hours alleged abuse to the Administrator and other applicable State agencies. On 11/8/18 at 5:00 p.m., a debriefing was held with the Administrator, the Corporate Clinical Nurse and the Interim Director of Nursing. No further information was provided prior to survey exit.	F 607		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures.	F 609		12/18/18

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§483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.
This REQUIREMENT is not met as evidenced by:
Based on clinical record review, staff interviews and facility documentation review, the facility staff failed to report an allegation of abuse immediately to the Administrator, as well as the State survey and certification agency for 2 of 39 residents (Resident #30 and #10) in the survey sample.

1. Resident #30 alleged his roommate had exhibited inappropriate sexual abuse behaviors towards him on 2/18/18 which was told to a Certified Nursing Assistant (CNA). The nursing staff failed to inform the Administrator within two hours after the allegation was made, as well as the State survey and certification agency.

2. An allegation of verbal abuse by a staff against Resident #10 occurred on 7/22/18 which was not reported to the State certification agency after the allegation was made.

The findings include:

1. Resident #30 was admitted to the nursing facility on 2/26/16 with diagnoses that included stroke and swallowing problems.

The most recent Minimal Data Set (MDS) assessment was a quarterly dated 9/5/18 and coded the resident on the Brief Interview for

1-. The facility has not had any reportable incidents since 11/9/18. Resident #30 was immediately separated from the alleged abuser. The alleged abuser no longer resides in the facility. Staff member involved in the incident with resident #10 was suspended upon notification of allegation and subsequently terminated. Resident #10 remains in the facility free from verbal abuse.
2-The DON or designee will review current facility incidents to ensure that they were reported in the appropriate timeframe to the Administrator and other required agencies.
3-The DON or designee will educate all staff on the reporting requirements of allegations of abuse.
4-The DON or designee will review shift report and incidents on a daily basis to ensure that any alleged allegations or violations of abuse are reported in the appropriate timeframe. Results of the audits will be presented to the quarterly Quality Assurance committee for review and recommendation.
5-Completion date 12/18/18.

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F 609	Continued From page 11 Mental Status (BIMS) with a score of 6 out of a possible score of 15 which indicated he was severely impaired in the necessary skills for daily decision making. The resident was not coded to have any mood or behavior problems. Resident #30 was coded to respond adequately to simple, direct communication and usually understood with clear speech. The resident was assessed to require extensive assistance from one staff for bed mobility, transfers and dressing. The resident was coded as totally dependent on one staff for locomotion on the unit via assistance from staff using a wheelchair, totally dependent on staff for eating, toilet use, personal hygiene and bathing. The care plan created on 2/27/18 and revised as current on 9/25/18 indicated the resident had some Activities of Daily Living (ADL) self-care deficits. The goal set for the resident by the staff included they would address the resident's basic needs and ensure he would maintain his current level of function. The approaches the staff would implement to accomplish this goal included ensuring hearing aids were in place every morning, allow the resident to make decisions about treatment regime, to provide a sense of control, encourage as much participation/interaction by the resident as much as possible during care activities, give clear explanation of all care activities prior to and as they occur during each contact, when possible negotiate as time for ADLs so that the resident can participate in decision making and return at an agreed time. A facility reported incident was forwarded to the State survey and certification agency on 2/19/18 that entailed the following information: "During the rounds on the evening of 2/18/18,	F 609		

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F 609	Continued From page 12 Certified Nursing Assistant (CNA) (name of CNA) noticed that (Resident #30's name) brief appeared to have been removed, he had a visible erection and he reported to her that someone touched him. (Resident #30's name) roommate has exhibited inappropriate sexual behaviors, such as public masturbation in the past. After confirming there were no visitors in their room the evening on 2/18/18, (Resident #30's name) was transferred to another room. A skin assessment was completed which did not show any impairments. An investigation is in progress. This alleged sexual assault was reported to state, responsible party, physician, law enforcement and the State survey and certification agency on 2/19/18". On 11/8/18 at 2:00 p.m., an interview was conducted with the Administrator, the Interim Director of Nursing (DON) and the Corporate Clinical Nurse. They stated they thought reporting in two hours only referred to if serious bodily harm had to occurred. They stated there was concern about the failure of the CNA to report the alleged sexual assault incident to the charge nurse and the Administrator, thus causing the alleged incident to be reported late to State agencies. The Interim Director of Nursing (IDON) stated in response to the failure to report as mandated reporters, widespread abuse, neglect and reporting education was conducted. They stated they thought the facility's policy was revised to make clear the reporting mandates and requirements regarding abuse, but after review of the policy; it was determined the policy had not been revised to include the correct required timeframe for reporting alleged abuse. The Administrator confirmed that she was not informed of the incident on 2/18/18 until the	F 609		

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following day 2/19/18 and that the CNA should have immediately informed the charge nurse at which time she would have been made aware and reporting to State agencies would have taken place. The previous Director of Nursing's written investigative statement undated titled "Notes from FRI (no date) on (Resident #30's name)" indicated Resident #30's roommate had a history of public masturbating and making inappropriate comments to female staff members. The Administrator stated although the outcome of the facility's investigation of the aforementioned did not confirm sexual abuse had occurred, Resident #30's roommate was transferred to another facility due to his repeated inappropriate behaviors.

The education conducted on 2/21/18 and 2/28/18 was titled "Mandated Reporting of Abuse or Suspected Abuse", CNAs are to report allegations immediately to the charge nurse. Review of the education indicated the objectives of the in-service included verbalization of all types of abuse, verbalization of mandated reporting requirements, a discussion of the importance of immediately reporting allegations of abuse, verbalization of what immediate meant, identify who were mandated reporters in the facility and that the reporting was to be submitted within regulatory defined time frames. The timeframes were not specifically outlined in the education that was presented to this surveyor. The education further indicated that failure to immediately report allegations of abuse may result in potential harm to residents and is a violation of the State and Federal Mandated Reporting regulations.

On 11/8/18 at 5:00 p.m., a debriefing was held with the Administrator, the Corporate Clinical

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Nurse and the Interim Director of Nursing. No further information was provided prior to survey exit.

The facility's policy was not revised to include reporting within 2 hours alleged abuse to the Administrator and other applicable State agencies.

The policy dated 11/4/16 titled Abuse/Neglect/Misappropriation/Crime Investigation and Follow Up reporting indicated serious bodily injury must be reported no later than two hours after forming the suspicion. Crimes not resulting in serious bodily injury to the patient must be reported no later than 24 hours after forming the suspicion. The Administrator will immediately (within 2 or 24 hours of knowledge of the allegation), notify the State licensure and certification agency.

2. An allegation of verbal abuse by a staff against Resident #10 occurred on 7/22/18 which was not reported to the State certification agency after the allegation was made.

Resident #10 was re-admitted to the nursing facility on 9/4/18 with diagnoses that included history of falls, diabetes and high blood pressure.

The most recent Minimum Data Set (MDS) was a quarterly dated 9/2/18 and coded the resident with short term memory problems and moderately impaired in the skills needed for daily decision making.

A facility reported incident was forwarded to the State survey and certification agency on 7/23/18 at 3:15 p.m. that entailed the following

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information:
"Visitor approached nurse (supervisor) on 7/22/18 stating he witnessed a Certified Nursing Assistant (CNA) yelling at a resident and pointing her finger at her face. The nurse identified the CNA as (CNA's name). The CNA was suspended pending an investigation". The follow up report to the State survey and certification agency dated 7/27/18 indicated after reviewing and obtaining statements from the staff that was on duty, it was validated from other witnesses that the CNA implicated in the verbal abuse toward Resident #10 yelled and aggressively pushed her down the hallway in her wheelchair. The CNA was terminated based on the aforementioned findings from the abuse investigation. This alleged verbal abuse was reported to the responsible party and the State survey and certification agency on 7/23/18.

On 11/8/18 at 2:00 p.m., an interview was conducted with the Administrator, the Interim Director of Nursing (DON) and the Corporate Clinical Nurse. They stated they thought reporting in two hours only referred to if serious bodily harm had to occurred. The Administrator stated the alleged verbal abuse occurred on a Sunday and was reported to the nursing supervisor by a visitor on 7/22/18 and she was made aware of the incident on Monday 7/23/18. They stated they thought the facility's policy was revised to make clear the reporting mandates and requirements regarding abuse, but after review of the policy; it was determined the policy had not been revised to include the correct required timeframe for reporting alleged abuse. The facility's policy was not revised to include reporting within 2 hours alleged abuse to the Administrator and other applicable State

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F 609	Continued From page 16 agencies. On 11/8/18 at 5:00 p.m., a debriefing was held with the Administrator, the Corporate Clinical Nurse and the Interim Director of Nursing. No further information was provided prior to survey exit.	F 609		
F 622 SS=E	Transfer and Discharge Requirements CFR(s): 483.15(c)(1)(i)(ii)(2)(i)-(iii) §483.15(c) Transfer and discharge- §483.15(c)(1) Facility requirements- (i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless- (A) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility; (B) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility; (C) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident; (D) The health of individuals in the facility would otherwise be endangered; (E) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid;	F 622		12/18/18

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F 622	Continued From page 17 or (F) The facility ceases to operate. (ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose. §483.15(c)(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider. (i) Documentation in the resident's medical record must include: (A) The basis for the transfer per paragraph (c)(1)(i) of this section. (B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s). (ii) The documentation required by paragraph (c)(2)(i) of this section must be made by- (A) The resident's physician when transfer or discharge is necessary under paragraph (c) (1)(A) or (B) of this section; and (B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of	F 622		

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F 622	Continued From page 18 this section. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care. This REQUIREMENT is not met as evidenced by: Based on medical record review, facility document review and staff interviews the facility staff failed to convey the Individual Plan Of Care upon transfer/discharge to the hospital for 6 of 39 Residents in the survey sample, Resident #60, #18, #10, #26, #122 and #7. 1. The facility staff failed to convey the Individual Plan Of Care upon transfer/discharge on 8/1/18 for Resident #60. 2. The facility staff failed to convey the Individual Plan Of Care upon transfer/discharge on 8/11/18 for Resident #18 3. The facility staff failed to convey the Individual Plan Of Care upon transfer/discharge on 9/2/18 for Resident #10 4. The facility staff failed to convey the Individual Plan Of Care upon transfer/discharge on 5/7/18	F 622	1-The Individual Plan of Care is now being sent with the resident upon transfer/discharge to the hospital. 2-Residents being transferred or discharged to the hospital will be sent with a copy of the Plan of Care. 3- The DON or designee will educate Licensed Nursing staff on the requirement to send the Individual Plan of Care with the resident upon transfer/discharge to the hospital and to provide documentation that the Plan of Care was sent in the resident□s medical record. 4-The DON or designee will review any residents transferred or discharged to the hospital on a weekly basis to ensure that the Plan of Care was sent with the resident at the time of the transfer as evidenced by the documentation in the resident□s medical record. Results of the audits will be presented to the quarterly	

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for Resident #26

5. The facility staff failed to convey the Individual Plan Of Care upon transfer/discharge on 3/7/18 for Resident #122

6. The facility staff failed to convey the Individual Plan Of Care upon transfer/discharge on 2/17/18 for Resident #7.

The findings included:

1. Resident #60 is a 72 year old admitted to the facility on 1/8/99 and readmitted on 8/5/18 with diagnoses to include Hypertension and Diabetes Mellitus.

The most recent Minimum Data Set (MDS) was a Significant Change with an Assessment Reference Date (ARD) of 7/13/18. The Brief Interview for Mental Status was coded as 0, not attempted because the resident is rarely/never understood. Under Section C Cognitive Patterns Resident #60 was coded to have long and short term memory deficits and was severely impaired in cognition for daily decision making. While reviewing Resident #60's MDS's a Discharge Assessment-return anticipated with an ARD date of 8/1/18 was identified.

Resident #60's Progress Notes were reviewed and are documented in part, as follows:

8/1/18 22:39 (10:39) P.M. Health Status Note: Resident admitted to Hospital for sepsis and ARF (acute renal failure). MD (Medical Doctor) notified.

Resident #60's Hospital Discharge Summary was

Provider's plan of correction (F 622):

Quality Assurance committee for review and recommendation.
5-Completion date 12/18/18.

F 622 Continued From page 20 F 622

reviewed and is documented in part, as follows:

Date of Admission: Aug-01-2018
Date of Discharge: Aug-05-2018

On 11/7/18 at approximately 11:45 A.M. the facility was asked for documentation to show that Resident #60's Comprehensive Plan of Care was sent with her on 8/1/18 when transferred/discharged to the hospital. The Corporate Clinical Nurse stated, "We do not have any documentation to support the care plan was sent with the resident when discharged. The nurses are able to state that they send the POC (plan of care) with the resident at the time of transfer, however there is no evidence that this was done. We need to develop a system for this to occur forward."

The facility policy titled "Patient Transfer Form" effective date 11/28/17 was reviewed and is documented in part, as follows:

POLICY: A Patient Transfer Form (eINTERACT) must be sent with the patient when transporting to a hospital or acute care setting. This process will provide a format of all pertinent information regarding the patient's medical status when the patient requires additional hospital care and treatment.

PROCEDURE:
3. Place a copy of the Patient Transfer Form (eInteract), copies of the current face sheet, current MAR (medication administration record), current TAR(treatment medication record), Nurses Notes for 24 hour care plan, and Physician Progress notes in the designated INTERACT envelope and send with the patient to

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F 622	Continued From page 21 the acute care center or hospital. On 11/8/18 at 5:00 P.M. a pre-exit conference was conducted with the Administrator, the Director of Nursing, the Corporate Clinical Nurse where the above information was shared. Prior to exit no further information was shared by the facility. 2. Resident #18 is a 82 year old admitted to the facility on 7/21/2016 and readmitted on 8/13/18 with diagnoses to include Hypertension and Anemia. The most recent Minimum Data Set (MDS) was an Annual Assessment with an Assessment Reference Date (ARD) of 10/16/18. The Brief Interview for Mental Status was coded as a 15 out of a possible 15 indicating Resident #18 was cognitively intact and capable of daily decision making. While reviewing Resident #18's MDS's a Discharge Assessment-return anticipated with an ARD date of 8/11/18 was identified. Resident #18's Progress Notes were reviewed and are documented in part, as follows: 8/12/18 at 11:01 A.M.: Resident was sent to ER (emergency room) and was admitted 8/11/18. On 11/7/18 at approximately 11:45 A.M. the facility was asked for documentation to show that Resident #18's Comprehensive Plan of Care was sent with her on 8/11/18 when transferred/discharged the he hospital. The Corporate Clinical Nurse stated, "We do not have any documentation to support the care plan was sent with the resident when discharged. The	F 622		

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nurses are able to state that they send the POC (plan of care) with the resident at the time of transfer, however there is no evidence that this was done. We need to develop a system for this to occur forward."

The facility policy titled "Patient Transfer Form" effective date 11/28/17 was reviewed and is documented in part, as follows:

POLICY: A Patient Transfer Form (eINTERACT) must be sent with the patient when transporting to a hospital or acute care setting. This process will provide a format of all pertinent information regarding the patient's medical status when the patient requires additional hospital care and treatment.

PROCEDURE:
3. Place a copy of the Patient Transfer Form (eInteract), copies of the current face sheet, current MAR (medication administration record), current TAR(treatment medication record), Nurses Notes for 24 hour care plan, and Physician Progress notes in the designated INTERACT envelope and send with the patient to the acute care center or hospital.

On 11/8/18 at 5:00 P.M. a pre-exit conference was conducted with the Administrator, the Director of Nursing, the Corporate Clinical Nurse where the above information was shared. Prior to exit no further information was shared by the facility.

3. Resident #10 was admitted to the facility on 3/28/18 and readmitted on 9/4/18 with diagnoses to include Diabetes Mellitus and Hypertension.

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The most recent Minimum Data Set (MDS) was a Quarterly with an Assessment Reference Date (ARD) of 8/14/18. The Brief Interview for Mental Status was coded as a 10 out of a possible 15 indicating Resident #10 was cognitively intact and capable of daily decision making. While reviewing Resident #10's MDS' a Discharge Assessment-return anticipated with an ARD date of 9/02/18 was identified.

Resident #10's Progress Notes were reviewed and are documented in part, as follows:

9/2/18 22:03 (10:03) P.M.: Resident vomited 4 times in 30 minutes. Doctor notifies and advised to send to ER (emergency room) for evaluation.
9/2/18 22:32 (10:32) P.M.: Resident admitted with hyponatremia to hospital ruling out concussion from earlier fall.

Resident #10's Hospital Discharge Summary was reviewed and is documented in part, as follows:

Date of Admission: Sep-02-2018
Date of Discharge: Sep-04-2018

On 11/7/18 at approximately 11:45 A.M. the facility was asked for documentation to show that Resident #10's Comprehensive Plan of Care was sent with her on 9/2/18 when transferred/discharged the he hospital. The Corporate Clinical Nurse stated, "We do not have any documentation to support the care plan was sent with the resident when discharged. The nurses are able to state that they send the POC(plan of care) with the resident at the time of transfer, however there is no evidence that this was done. We need to develop a system for this to occur forward."

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The facility policy titled "Patient Transfer Form" effective date 11/28/17 was reviewed and is documented in part, as follows:

POLICY: A Patient Transfer Form (eINTERACT) must be sent with the patient when transporting to a hospital or acute care setting. This process will provide a format of all pertinent information regarding the patient's medical status when the patient requires additional hospital care and treatment.

PROCEDURE:
3. Place a copy of the Patient Transfer Form (eInteract), copies of the current face sheet, current MAR (medication administration record), current TAR(treatment medication record), Nurses Notes for 24 hour care plan, and Physician Progress notes in the designated INTERACT envelope and send with the patient to the acute care center or hospital.

On 11/8/18 at 5:00 P.M. a pre-exit conference was conducted with the Administrator, the Director of Nursing, the Corporate Clinical Nurse where the above information was shared. Prior to exit no further information was shared by the facility.

4. Resident #26 is a 76 year old admitted to the facility on 9/19/16 and readmitted on 5/21/18 with diagnoses to include Congestive Heart Failure and Hypertension.

The most recent Minimum Data Set (MDS) was a Quarterly with an Assessment Reference Date (ARD) of 8/28/18. The Brief Interview for Mental Status was coded as a 15 out of a possible 15

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indicating Resident #26 was cognitively intact and capable of daily decision making. While reviewing Resident #26's MDS' a Discharge Assessment-return anticipated with an ARD date of 5/07/18 was identified.

Resident #26's Progress Notes were reviewed and are documented in part, as follows:

5/7/18 at 15:58 (1:58) P.M.: Resident was sent to ER via stretcher with transportation drivers.
5/7/18 at 22:44 (10:44) P.M.: Per ER, resident has been admitted to hospital with Sepsis diagnosis.

Resident #26's Hospital Discharge Summary was reviewed and is documented in part, as follows:

Admit Date: 5/7/2018
Discharge Date: 5/21/2018

On 11/7/18 at approximately 11:45 A.M. the facility was asked for documentation to show that Resident #26's Comprehensive Plan of Care was sent with her on 5/7/18 when transferred/discharged the he hospital. The Corporate Clinical Nurse stated, "We do not have any documentation to support the care plan was sent with the resident when discharged. The nurses are able to state that they send the POC(plan of care) with the resident at the time of transfer, however there is no evidence that this was done. We need to develop a system for this to occur forward."

The facility policy titled "Patient Transfer Form" effective date 11/28/17 was reviewed and is documented in part, as follows:

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F 622 Continued From page 26 F 622

POLICY: A Patient Transfer Form (eINTERACT) must be sent with the patient when transporting to a hospital or acute care setting. This process will provide a format of all pertinent information regarding the patient's medical status when the patient requires additional hospital care and treatment.

PROCEDURE:
3. Place a copy of the Patient Transfer Form (eInteract), copies of the current face sheet, current MAR (medication administration record), current TAR(treatment medication record), Nurses Notes for 24 hour care plan, and Physician Progress notes in the designated INTERACT envelope and send with the patient to the acute care center or hospital.

On 11/8/18 at 5:00 P.M. a pre-exit conference was conducted with the Administrator, the Director of Nursing, the Corporate Clinical Nurse where the above information was shared. Prior to exit no further information was shared by the facility.

5. Resident #122 is a 83 year old admitted to the facility on 11/20/17 with diagnoses to include Diabetes Mellitus and Schizophrenia.

The most recent Minimum Data Set (MDS) was a Quarterly with an Assessment Reference Date (ARD) of 2/27/18. The Brief Interview for Mental Status was coded as 0, not attempted because the resident is rarely/never understood. Under Section C Cognitive Patterns Resident #122 was coded to have long and short term memory deficits and was moderately impaired in cognition for daily decision making. While reviewing Resident #122's MDS' a Discharge

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F 622	Continued From page 27	F 622		

Assessment-return not anticipated with an ARD date of 3/7/18 was identified.

Resident #122's Progress Notes were reviewed and are documented in part, as follows:

3/7/2048 10:24 A.M.: Sent to ER via EMS (emergency medical services) to be evaluated.

Resident #122's Hospital Discharge Summary was reviewed and is documented in part, as follows:

Date of Admission: Mar-07-2018
Date of Discharge: Mar-12-2018

On 11/7/18 at approximately 11:45 P.M. the facility was asked for documentation to show that Resident #122's Comprehensive Plan of Care was sent with her on 3/7/18 when transferred/discharged the he hospital. The Corporate Clinical Nurse stated, "We do not have any documentation to support the care plan was sent with the resident when discharged. The nurses are able to state that they send the POC (plan of care) with the resident at the time of transfer, however there is no evidence that this was done. We need to develop a system for this to occur forward."

The facility policy titled "Patient Transfer Form" effective date 11/28/17 was reviewed and is documented in part, as follows:

POLICY: A Patient Transfer Form (eINTERACT) must be sent with the patient when transporting to a hospital or acute care setting. This process will provide a format of all pertinent information regarding the patient's medical status when the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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Continued From page 28
patient requires additional hospital care and treatment.

PROCEDURE:
3. Place a copy of the Patient Transfer Form (eInteract), copies of the current face sheet, current MAR (medication administration record), current TAR(treatment medication record), Nurses Notes for 24 hour care plan, and Physician Progress notes in the designated INTERACT envelope and send with the patient to the acute care center or hospital.

On 11/8/18 at 5:00 P.M. a pre-exit conference was conducted with the Administrator, the Director of Nursing, the Corporate Clinical Nurse where the above information was shared. Prior to exit no further information was shared by the facility.

6. Resident #7 was originally admitted to the facility 10/12/16 and was last readmitted to the facility after a hospital admission 2/21/18. The current diagnoses included; protein energy malnutrition, cardiomegaly and dementia.

The significant change Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 8/1/18 coded the resident as not having the ability to complete the Brief Interview for Mental Status (BIMS). The staff interview was coded for long and short term memory problems as well as moderately impaired abilities for daily decision making.

In section "G" (Physical functioning) the resident was coded as requiring limited assistance of 1 person with walking, extensive assistance of 2 people with bed mobility, extensive assistance of

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F 622	Continued From page 29 1 person with transfers dressing, eating, toileting, personal hygiene and total care with bathing. Review of the discharge MDS assessment dated 2/17/18, revealed Resident #7 was discharged-return anticipated. Review of the clinical record revealed a Nursing Home to Hospital Transfer Form dated 2/17/18, which stated Resident #7 had a fall and was with pain at a level 5. Included on the Hospital Transfer Form was the following information; Contact information of the practitioner who was responsible for the care of the resident, Resident representative information, including contact information, Advance directive information, Treatments and devices (oxygen, implants, IVs, tubes/catheters), Precautions such as isolation or contact, Special risks such as risk for falls, elopement, bleeding, or pressure injury and/or aspiration precautions, Resident status, including baseline and current mental, behavioral, and functional status, reason for transfer, recent vital signs, some recent immunizations, and allergies. No documentation was included which stated the facility staff conveyed to the receiving providers the resident's comprehensive care plan goals at the time of discharge or as soon as possible to the actual time of transfer. On 11/8/18 at approximately 5:00 p.m., the above findings were shared with the Administrator, Director of Nursing and two Corporate Consultants. Corporate Consultant #1 stated she thinks the care plan was sent with the resident to the hospital but she has no way of proving it was	F 622		

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F 622	Continued From page 30 sent.	F 622		
F 625 SS=E	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on medical record review, facility document review and staff interviews the facility staff failed to issue a written notice of Bed-Hold upon transfer/discharge to the hospital for 6 of 39	F 625	1-Resident #60, 18, 10, 26 and 7 have returned to the facility. Resident #122 was discharged and did not return to the facility.	12/18/18

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Residents in the survey sample, Resident #60, #18, #10, #26, #122 and #7.

1. The facility staff failed to issue a written notice of Bed-Hold upon transfer/discharge on 8/1/18 for Resident #60.

2. The facility staff failed to issue a written notice of Bed-Hold upon transfer/discharge on 8/11/18 for Resident #18

3. The facility staff failed to issue a written notice of Bed-Hold upon transfer/discharge on 9/2/18 for Resident #10

4. The facility staff failed to issue a written notice of Bed-Hold upon transfer/discharge on 5/7/18 for Resident #26

5. The facility staff failed to issue a written notice of Bed-Hold upon transfer/discharge on 3/7/18 for Resident #122

6. The facility staff failed to issue a written notice of Bed-Hold upon transfer/discharge on 2/17/18 for Resident #7.

The findings included:

1. Resident #60 was a 72 year old admitted to the facility on 1/8/99 and readmitted on 8/5/18 with diagnoses to include Hypertension and Diabetes Mellitus.

The most recent Minimum Data Set (MDS) was a Significant Change with an Assessment Reference Date (ARD) of 7/13/18. The Brief Interview for Mental Status was coded as 0, not attempted because the resident is rarely/never

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2- Residents being transferred or discharged to the hospital will receive the bed-hold notice upon transfer or discharge.
3-The Administrator educated the Admissions Department staff and the Discharge Planner on the requirements for providing the bed-hold notice to residents being transferred to the hospital. The DON or designee will provide education to the Licensed Nursing staff on providing each resident the written notice of the Bed-hold upon transfer/discharge from the facility and to include documentation that the notice was provided.
4-The DON or designee will review any residents transferred to the hospital on a weekly basis to ensure that the bed-hold written notice was sent with the resident at the time of transfer. Results of the audits will be presented to the quarterly Quality Assurance committee for review and recommendation.
5-Completion date 12/18/18.

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understood. Under Section C Cognitive Patterns Resident #60 was coded to have long and short term memory deficits and was severely impaired in cognition for daily decision making. While reviewing Resident #60's MDS's a Discharge Assessment-return anticipated with an ARD date of 8/1/18 was identified.

Resident #60's Progress Notes were reviewed and are documented in part, as follows:

8/1/18 22:39 (10:39) P.M. Health Status Note: Resident admitted to Hospital for sepsis and ARF (acute renal failure). MD (Medical Doctor) notified.

Resident #60's Hospital Discharge Summary was reviewed and is documented in part, as follows:

Date of Admission: Aug-01-2018
Date of Discharge: Aug-05-2018

On 11/7/18 at approximately 11:55 A.M. the facility was asked for documentation to show that a Bed-Hold Notice was provided prior to Resident #60 being transferred to the hospital on 8/1/18. The Corporate Clinical Nurse stated, "The evidence that the Bed-Hold policy was provided for the resident or responsible party is not in place for the resident."

The facility policy titled "Documentation-Bed Hold" effective date 2/5/15 was reviewed and is documented in part, as follows:

POLICY: The Admissions Director will ensure all proper documents are executed whenever a patient returns to the Health and Rehabilitation Center from a bed hold retention arrangement

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PROCEDURE:
1. Readmitted from Bed Retention-Patients who have reserved a bed while hospitalized by way of a Voluntary Bed Retention Agreement must complete the appropriate Medicare documentation resubmission requirements.

On 11/8/18 at 5:00 P.M. a pre-exit conference was conducted with the Administrator, the Director of Nursing, and the Corporate Clinical Nurse where the above information was shared. Prior to exit no further information was shared by the facility staff.

2. Resident #18 was a 82 year old admitted to the facility on 7/21/2016 and readmitted on 8/13/18 with diagnoses to include Hypertension and Anemia.

The most recent Minimum Data Set (MDS) was an Annual Assessment with an Assessment Reference Date (ARD) of 10/16/18. The Brief Interview for Mental Status was coded as a 15 out of a possible 15 indicating Resident #18 was cognitively intact and capable of daily decision making.

While reviewing Resident #18's MDS' a Discharge Assessment-return anticipated with an ARD date of 8/11/18 was identified.

Resident #18's Progress Notes were reviewed and are documented in part, as follows:

8/12/18 at 11:01 A.M.: Resident was sent to ER (emergency room) and was admitted 8/11/18.

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On 11/7/18 at approximately 11:55 A.M. the facility was asked for documentation to show that a Bed-Hold Notice was provided prior to Resident #18 being transferred to the hospital on 8/11/18. The Corporate Clinical Nurse stated, "The evidence that the Bed-Hold policy was provided for the resident or responsible party is not in place for the resident."

The facility policy titled "Documentation-Bed Hold" effective date 2/5/15 was reviewed and is documented in part, as follows:

POLICY: The Admissions Director will ensure all proper documents are executed whenever a patient returns to the Health and Rehabilitation Center from a bed hold retention arrangement

PROCEDURE:
1. Readmitted from Bed Retention-Patients who have reserved a bed while hospitalized by way of a Voluntary Bed Retention Agreement must complete the appropriate Medicare documentation resubmission requirements.

On 11/8/18 at 5:00 P.M. a pre-exit conference was conducted with the Administrator, the Director of Nursing, the Corporate Clinical Nurse where the above information was shared. Prior to exit no further information was shared by the facility staff.

3. Resident #10 was admitted to the facility on 3/28/18 and readmitted on 9/4/18 with diagnoses to include Diabetes Mellitus and Hypertension.

The most recent Minimum Data Set (MDS) was a Quarterly with an Assessment Reference Date (ARD) of 8/14/18. The Brief Interview for Mental

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Status was coded as a 10 out of a possible 15 whic indicated Resident #10 was cognitively intact and capable of daily decision making. While reviewing Resident #10's MDS' a Discharge Assessment-return anticipated with an ARD date of 9/02/18 was identified.

Resident #10's Progress Notes were reviewed and are documented in part, as follows:

9/2/18 22:03 (10:03) P.M.: Resident vomited 4 times in 30 minutes. Doctor notifies and advised to send to ER (emergency room) for evaluation.
9/2/18 22:32 (10:32) P.M.: Resident admitted with hyponatremia to hospital ruling out concussion from earlier fall.

Resident #10's Hospital Discharge Summary was reviewed and is documented in part, as follows:

Date of Admission: Sep-02-2018
Date of Discharge: Sep-04-2018

On 11/7/18 at approximately 11:55 A.M. the facility was asked for documentation to show that a Bed-Hold Notice was provided prior to Resident #10 being transferred to the hospital on 9/2/18. The Corporate Clinical Nurse stated, "The evidence that the Bed-Hold policy was provided for the resident or responsible party is not in place for the resident."

The facility policy titled "Documentation-Bed Hold" effective date 2/5/15 was reviewed and is documented in part, as follows:

POLICY: The Admissions Director will ensure all proper documents are executed whenever a patient returns to the Health and Rehabilitation

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Center from a bed hold retention arrangement

PROCEDURE:
1. Readmitted from Bed Retention- Patients who have reserved a bed while hospitalized by way of a Voluntary Bed Retention Agreement must complete the appropriate Medicare documentation resubmission requirements.

On 11/8/18 at 5:00 P.M. a pre-exit conference was conducted with the Administrator, the Director of Nursing, the Corporate Clinical Nurse where the above information was shared. Prior to exit no further information was shared by the facility staff.

4. Resident #26 was a 76 year old admitted to the facility on 9/19/16 and readmitted on 5/21/18 with diagnoses to include Congestive Heart Failure and Hypertension.

The most recent Minimum Data Set (MDS) was a Quarterly with an Assessment Reference Date (ARD) of 8/28/18. The Brief Interview for Mental Status was coded as a 15 out of a possible 15 indicating Resident #26 was cognitively intact and capable of daily decision making. While reviewing Resident #26's MDS' a Discharge Assessment-return anticipated with an ARD date of 5/07/18 was identified.

Resident #26's Progress Notes were reviewed and are documented in part, as follows:

5/7/18 at 15:58 (1:58) P.M.: Resident was sent to ER via stretcher with transportation drivers.
5/7/18 at 22:44 (10:44) P.M.: Per ER, resident has been admitted to hospital with Sepsis diagnosis.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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Resident #26's Hospital Discharge Summary was reviewed and is documented in part, as follows:

Admit Date: 5/7/2018
Discharge Date: 5/21/2018

On 11/7/18 at approximately 11:55 A.M. the facility was asked for documentation to show that a Bed-Hold Notice was provided prior to Resident #26 being transferred to the hospital on 5/7/18. The Corporate Clinical Nurse stated, "The evidence that the Bed-Hold policy was provided for the resident or responsible party is not in place for the resident."

The facility policy titled "Documentation-Bed Hold" effective date 2/5/15 was reviewed and is documented in part, as follows:

POLICY: The Admissions Director will ensure all proper documents are executed whenever a patient returns to the Health and Rehabilitation Center from a bed hold retention arrangement

PROCEDURE:
1. Readmitted from Bed Retention- Patients who have reserved a bed while hospitalized by way of a Voluntary Bed Retention Agreement must complete the appropriate Medicare documentation resubmission requirements.

On 11/8/18 at 5:00 P.M. a pre-exit conference was conducted with the Administrator, the Director of Nursing, the Corporate Clinical Nurse where the above information was shared. Prior to exit no further information was shared by the facility staff.

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5. Resident #122 was a 83 year old admitted to the facility on 11/20/17 with diagnoses to include Diabetes Mellitus and Schizophrenia.

The most recent Minimum Data Set (MDS) was a Quarterly with an Assessment Reference Date (ARD) of 2/27/18. The Brief Interview for Mental Status was coded as 0, not attempted because the resident is rarely/never understood. Under Section C Cognitive Patterns Resident #122 was coded to have long and short term memory deficits and was moderately impaired in cognition for daily decision making. While reviewing Resident #122's MDS' a Discharge Assessment-return not anticipated with an ARD date of 3/7/18 was identified.

Resident #122's Progress Notes were reviewed and documented in part, as follows:

3/7/2048 10:24 A.M.: Sent to ER via EMS (emergency medical services) to be evaluated.

Resident #122's Hospital Discharge Summary was reviewed and is documented in part, as follows:

Date of Admission: Mar-07-2018
Date of Discharge: Mar-12-2018

On 11/7/18 at approximately 11:55 A.M. the facility was asked for documentation to show that a Bed-Hold Notice was provided prior to Resident #122 being transferred to the hospital on 3/7/18. The Corporate Clinical Nurse stated, "The evidence that the Bed-Hold policy was provided for the resident or responsible party is not in place for the resident."

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COURTLAND HEALTH & REHABILITATION CENTER	23020 MAIN STREET COURTLAND, VA 23837

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The facility policy titled "Documentation-Bed Hold" effective date 2/5/15 was reviewed and is documented in part, as follows:

POLICY: The Admissions Director will ensure all proper documents are executed whenever a patient returns to the Health and Rehabilitation Center from a bed hold retention arrangement

PROCEDURE:
1. Readmitted from Bed Retention-Patients who have reserved a bed while hospitalized by way of a Voluntary Bed Retention Agreement must complete the appropriate Medicare documentation resubmission requirements.

On 11/8/18 at 5:00 P.M. a pre-exit conference was conducted with the Administrator, the Director of Nursing, the Corporate Clinical Nurse where the above information was shared. Prior to exit no further information was shared by the facility.

6. Resident #7 was originally admitted to the facility 10/12/16 and was last readmitted to the facility after a hospital admission 2/21/18. The current diagnoses included; protein energy malnutrition, cardiomegaly and dementia.

The significant change Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 8/1/18 coded the resident as not having the ability to complete the Brief Interview for Mental Status (BIMS). The staff interview was coded for long and short term memory problems as well as moderately impaired abilities for daily decision making. In section "G" (Physical functioning) the resident was coded as requiring

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limited assistance of 1 person with walking, extensive assistance of 2 people with bed mobility, extensive assistance of 1 person with transfers dressing, eating, toileting, personal hygiene and total care with bathing.

Review of the discharge MDS assessment dated 2/17/18, revealed Resident #7 was discharged-return anticipated.

Review of the clinical record revealed a Nursing Home to Hospital Transfer Form dated 2/17/18, which stated Resident #7 had a fall and was with pain at a level 5.

An interview was attempted with Resident #7 on 11/8/18, at approximately 12:05 p.m. The resident wasn't capable of providing information regarding the 2/17/18 discharge to the hospital

The primary care physician's readmission history and physical dated 2/22/18, revealed Resident #7 had been transferred to the local acute care hospital after an unwitnessed fall resulting in a frontal hematoma and laceration but; the resident was admitted to the hospital 2/17/18, for urosepsis and a low potassium level.

On 11/8/18 at approximately at 3:00 p.m., an interview was conducted with the Admission's Director. The Admission's Director stated Resident #7 wasn't offered or provided information on the facility's bed hold policy at the time of her discharge.

On 11/8/18 at approximately 5:00 p.m., the above findings were shared with the Administrator, Director of Nursing and two Corporate Consultants. An opportunity was given for the

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F 625	Continued From page 41 facility to present additional information but none was provided.	F 625		
F 636 SS=D	Comprehensive Assessments & Timing CFR(s): 483.20(b)(1)(2)(i)(iii) §483.20 Resident Assessment The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. §483.20(b) Comprehensive Assessments §483.20(b)(1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following: (i) Identification and demographic information (ii) Customary routine. (iii) Cognitive patterns. (iv) Communication. (v) Vision. (vi) Mood and behavior patterns. (vii) Psychological well-being. (viii) Physical functioning and structural problems. (ix) Continence. (x) Disease diagnosis and health conditions. (xi) Dental and nutritional status. (xii) Skin Conditions. (xiii) Activity pursuit. (xiv) Medications. (xv) Special treatments and procedures. (xvi) Discharge planning. (xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of	F 636		12/18/18

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F 636	Continued From page 42 the Minimum Data Set (MDS). (xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts. §483.20(b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs. (i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or therapeutic leave.) (iii)Not less than once every 12 months. This REQUIREMENT is not met as evidenced by: Based on clinical record review and staff interviews the facility staff failed to complete a comprehensive assessment as required for 1 of 39 residents (Resident #172), in the survey sample. The facility's staff failed to complete Resident #172's admission Minimum Data Set (MDS) assessment within 14 calendar days after admission to the facility. The findings included:	F 636	1-1-A modification for Resident #172 was completed on Thursday, 11/8/18. A copy was given to the surveyor. Validation report, Batch# 1190 is attached showing the assessment was accepted on 11/8/18. The MDSC was terminated as the result of the audit completed on 11/13/18-results were sent to the corporate compliance committee. 2An audit was completed by the Regional Data Analyst & Verification Specialist on 11/13/18 to review all comprehensive assessments completed & accepted from	

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F 636	Continued From page 43 Resident #172 was originally admitted to the facility 10/19/18 and has never been discharged from the facility. The current diagnoses included; heart failure, kidney disease and high blood pressure. The uncompleted admission MDS assessment with an assessment reference date (ARD) of 10/31/18 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 11 out of a possible 15. This indicated Resident #172's cognitive abilities for daily decision making were moderately impaired. In section "G" (Physical functioning) the resident was coded as requiring supervision after set-up with eating, limited assistance of 1 person with bed mobility, transfers, walking, locomotion, dressing, toileting, and personal hygiene. An admission MDS assessment dated 10/19/18 was observed in the facility's computer system for Resident #172 and it was signed at Z0500B as completed 11/1/18. A copy was requested on 11/6/18 at 2:55 p.m., but the facility staff provided the entry MDS; the admission MDS was requested again on 11/6/18 at approximately 5:00 p.m. Upon receiving the admission MDS assessment it was completed but; sections (A, B, E, G, some of O, P, Q and S) were dated as completed on 11/2/18 instead of 11/1/18. On 11/8/18, at approximately 5:00 p.m., the above findings were shared with the Administrator, Interim Director of Nursing and two Corporate Consultants. Corporate Consultant #1 stated she would have the MDS Coordinator provide information on Resident #172's MDS.	F 636	8/1/18 thru 11/13/18 for late completion dates.3-Assessments were modified on 11/13/18 to correct completion dates. All assessments were accepted into the QIES ASAP system. 3-The Regional Data Analyst and Verification Specialist educated the MDSC on accuracy of signing section Z and V according to the RAI manual. This was completed during facility site visit on 11/13 & 11/15/2018. 4-The Regional Data Analyst and Verification Specialist or designee will complete a random monthly audit of comprehensive assessments for late completion dates. Results of the audits will be presented to the quarterly Quality Assurance committee for review and recommendation. 5-Completion Date 12/18/18	

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The MDS Coordinator stated on 11/8/18 at approximately 6:45 p.m., that the admission MDS was completed late for they didn't finish it until 11/2/18. At approximately 7:30 p.m. the MDS Coordinator presented a new admission MDS assessment for Resident #172 with a completion date of 11/2/18.

The facility's policy titled Resident Assessment and Care Planning dated 7/3/18 read at Procedure 2; the MDS will be completed within 14 days of each ARD or within 14 days of admission.

The CMS guidelines for Comprehensive Assessments are as follows:
OBRA-required comprehensive assessments include the completion of both the MDS and the Care Area Assessments (CAA) process, as well as care planning. Comprehensive assessments are completed upon admission, annually, and when a significant change in a resident's status has occurred or a significant correction to a prior comprehensive assessment is required. They consist of: Admission Assessment, Annual Assessment, and Significant Change in Status Assessment, and Significant Correction to Prior Comprehensive Assessment. The ARD (Item A2300) is the last day of the observation/look back period, and day 1 for purposes of counting back to determine the beginning of observation/look back periods. For example, if the ARD is set for day 14 of a resident's admission, then the beginning of the observation period for MDS items requiring a 7-day observation period would be day 8 of admission (ARD + 6 previous calendar days), while the beginning of the observation period for MDS items requiring a 14-day observation period would

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F 636	Continued From page 45 be day 1 of admission (ARD + 13 previous calendar days). (CMS' RAI Version 3.0 Manual, October 2018 Page 2-19).	F 636		
F 645 SS=D	PASARR Screening for MD & ID CFR(s): 483.20(k)(1)-(3) §483.20(k) Preadmission Screening for individuals with a mental disorder and individuals with intellectual disability. §483.20(k)(1) A nursing facility must not admit, on or after January 1, 1989, any new residents with: (i) Mental disorder as defined in paragraph (k)(3)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission, (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services; or (ii) Intellectual disability, as defined in paragraph (k)(3)(ii) of this section, unless the State intellectual disability or developmental disability authority has determined prior to admission- (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services for intellectual disability. §483.20(k)(2) Exceptions. For purposes of this	F 645		12/18/18

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F 645	Continued From page 46 section- (i)The preadmission screening program under paragraph(k)(1) of this section need not provide for determinations in the case of the readmission to a nursing facility of an individual who, after being admitted to the nursing facility, was transferred for care in a hospital. (ii) The State may choose not to apply the preadmission screening program under paragraph (k)(1) of this section to the admission to a nursing facility of an individual- (A) Who is admitted to the facility directly from a hospital after receiving acute inpatient care at the hospital, (B) Who requires nursing facility services for the condition for which the individual received care in the hospital, and (C) Whose attending physician has certified, before admission to the facility that the individual is likely to require less than 30 days of nursing facility services. §483.20(k)(3) Definition. For purposes of this section- (i) An individual is considered to have a mental disorder if the individual has a serious mental disorder defined in 483.102(b)(1). (ii) An individual is considered to have an intellectual disability if the individual has an intellectual disability as defined in §483.102(b)(3) or is a person with a related condition as described in 435.1010 of this chapter. This REQUIREMENT is not met as evidenced by: Based on medical record review, facility document review and staff interviews the facility staff failed to ensure a Level I PASARR (Preadmission Screening and Resident Review; a pre-admission screening for a mental disorder	F 645	1-The Discharge Planner has contacted DMAS to obtain assistance in completing the Level 1 PASARR for resident #10 and Resident #24. 2-The Discharge Planner will review	

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F 645	Continued From page 47 (MD) or intellectual disability) was completed prior to admission for 2 of 39 Residents in the survey sample, Resident #10 and #24. 1. The facility staff failed to ensure a Level I PASARR was completed prior to admission for Resident #10. 2. The facility staff failed to ensure a Level I PASARR was completed prior to admission for Resident #24 The findings included: 1. Resident #10 was admitted to the facility on 3/28/18 and readmitted on 9/4/18 with diagnoses to include Anxiety Disorder and Major Depressive Disorder. The most recent Minimum Data Set (MDS) was a Quarterly with an Assessment Reference Date (ARD) of 8/14/18. The Brief Interview for Mental Status was coded as a 10 out of a possible 15 indicating Resident #10 was cognitively intact and capable of daily decision making. On 11/08/18 at approximately 10:53 AM the facility was asked for for Resident #10's PASARR that was completed prior to admission of 3/28/18 or within 30 days of admission. The Corporate Clinical Nurse stated, "We can not locate any documentation to show that a level 1 PASARR was completed on the resident prior to admission or a screening was performed within 30 days of admission in the facility." The facility policy titled "Level I PASARR" effective date 4/25/18 was reviewed and is documented in part, as follows:	F 645	current residents to ensure that a PASARR Screening is in place and will address any issues noted. 3-The Administrator or designee will educate the Admissions Director and Discharge Planner on the requirement of obtaining PASARR Screenings upon admission. 4- 4-The Admissions Director or designee will review residents prior to admission to the facility to ensure that the PASARR screening is in place and if not will take appropriate measures to obtain the PASARR screening. Results of the audits will be presented to the quarterly Quality Assurance committee for review and recommendation. 5-Completion date 12/18/18.	

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F 645	Continued From page 48	F 645		

POLICY: Prior to the arrival of a planned admission the Discharge Planner will collaborate with the Admission Director to preview the transferring hospital's Level I PASARR (Preadmission Screening and Resident Review).

On 11/8/18 at 5:00 PM a pre-exit conference was conducted with the Administrator, the Director of Nursing, the Corporate Clinical Nurse where the above information was shared. Prior to exit no further information was shared by the facility.

2. Resident #24 was a 87 year old admitted to the facility originally on 1/31/16 and readmitted on 1/17/18 with diagnoses to include Major Depressive Disorder and Bipolar Disorder.

The most recent Minimum Data Set (MDS) was a Quarterly with an Assessment Reference Date (ARD) of 4/26/18. The Brief Interview for Mental Status was coded as a 15 out of a possible 15 indicating Resident #24 was cognitively intact and capable of daily decision making.

On 11/08/18 at approximately 10:53 AM the facility was asked for for Resident #24's PASARR that was completed prior to admission of 1/31/16 or within 30 days of admission. The Corporate Clinical Nurse stated, "We can not locate any documentation to show that a level 1 PASARR was completed on the resident prior to admission or a screening was performed within 30 days of admission in the facility."

The facility policy titled "Level I PASARR" effective date 4/25/18 was reviewed and is documented in part, as follows:

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F 645	Continued From page 49 POLICY: Prior to the arrival of a planned admission the Discharge Planner will collaborate with the Admission Director to preview the transferring hospital's Level I PASARR (Preadmission Screening and Resident Review). On 11/8/18 at 5:00 PM a pre-exit conference was conducted with the Administrator, the Director of Nursing, the Corporate Clinical Nurse where the above information was shared. Prior to exit no further information was shared by the facility.	F 645		
F 687 SS=D	Foot Care CFR(s): 483.25(b)(2)(i)(ii) §483.25(b)(2) Foot care. To ensure that residents receive proper treatment and care to maintain mobility and good foot health, the facility must: (i) Provide foot care and treatment, in accordance with professional standards of practice, including to prevent complications from the resident's medical condition(s) and (ii) If necessary, assist the resident in making appointments with a qualified person, and arranging for transportation to and from such appointments. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview and a review of clinical records, the facility staff failed to ensure foot care was received for 1 of 39 residents (Resident # 44), in the survey sample. The facility staff failed to provide podiatry services for Resident # 44. The findings included:	F 687	1-Resident #44 received foot care by the Podiatrist on 11/9/18. 2-The Unit Manager will review current residents to ensure that they have received foot care and have been seen by a Podiatrist as necessary. 3-The DON will educate all Licensed Nursing staff and Nursing Assistants on proper foot care and notifying the Physician for Podiatry care as necessary.	12/18/18

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Resident # 44 was originally admitted to the facility on 09/12/16 and readmitted on 07/23/17. The current diagnoses included; Unspecified Dementia, and Type 2 Diabetes Mellitus.

The admission Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 09/13/18 was reviewed. The staff assessment for mental status coded Resident #44 as unable to complete the interview due to short term and long term memory problems. The assessment for mental status coded the Resident's cognitive skills for daily decision making as moderately impaired decisions, poor, cues/supervision required.

In section "G" (Physical functioning) the resident was coded as requiring extensive assistance, one person physical assistance. Staff requiring weight bearing support with eating requiring one person physical assistance. Total dependence with locomotion requiring physical assistance. Total dependence with dressing, personal hygiene and bathing requiring one person physical assistance. Total dependence with bed mobility requiring two person physical assist requiring a two personal physical assistance Total assistance with transfers, and toileting requiring two person physical assistance. In section "H" Bladder and Bowel, the resident was coded as always incontinent of bowel and bladder.

11/07/18 11:40 AM Resident states he requires assistance with ADLs.

On 11/07/18 at 12:00 PM while Resident #44 was resting in bed, CNA #1 (Certified Nursing Assistant) and CNA # 2, assessed Resident's

F 687

4-The Unit Manager or designee will check resident□s feet on a random monthly basis to ensure that the residents receive proper foot care and that the resident is seen by the Podiatrist as necessary. Results of the audits will be presented to the quarterly Quality Assurance committee for review and recommendation.
5-Completion date 12/18/18.

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F 687	Continued From page 51	F 687		

skin and lower extremities. Resident# 44's toenails were untrimmed, long, thick and sharp on both feet.

On 11/07/18 at 4:30 PM Corporate Clinical Coordinator # 1 was approached concerning podiatry appointments for Resident # 44. She stated that she couldn't find any record of podiatry appointments for Resident # 44.

On 11/08/18 at 10:45 AM a previous appointment letter was received from Corporate Clinical Coordinator # 1. The letter included that the last podiatry appointment was on 12/26/17. The SOAP note from the podiatrist office read that Resident # 44 has diagnoses for Peripheral Vascular disease, Nail dystrophy and type 2 diabetes mellitus with peripheral angiopathy without gangrene.

On 11/08/18 at 11:00 AM LPN # 2 (Licensed Practical Nurse) was asked to do an ADL assessment on Resident # 44. His toenails on both feet were long, thick, sharp and untrimmed. LPN # 2 said that she thinks the podiatrist should trim Resident # 44 toenails. She stated that she will put his name on the podiatry list today. She was asked for the podiatry list at the nurse's station. LPN # 2 stated that the list hasn't been made yet.

On 11/08/18 at 5:01 PM The Charge Nurse, LPN# 3 (Licensed Practical Nurse) was asked how do they determine who receives foot care/podiatry services. She states that "If a nurse or CNA see that a resident need toenail care that they will trim the toenails or if a Resident is a diabetic, they will put them on the podiatry list". The Podiatry list was shown to the surveyor at

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F 687	Continued From page 52 5:05 PM. The current care plan revised on 07/23/17, included that the resident has an ADL self-care deficit performance relating to Disease Process Rheumatoid Arthritis. The Care Plan Goal read: The resident will improve his current level of function in all ADLs through the review date. The Care Plan interventions read: The resident's preferred dressing/grooming routine is dressing in the AM. Bathing/Showering : Provide sponge bath when a full bath or shower cannot be tolerated. The facility Administrator was asked for a policy on Podiatry care/services and or a diabetic Foot Care Policy. The corporate Quality Assurance Nurse # 2, stated that there were no policies. On 11/08/18, at approximately 5:00 p.m. a pre-exit interview was conducted. The above findings were shared with the Administrator, Director of Nursing, Corporate Clinical Coordinator and Quality Assurance nurse. There were no comments made by the administrative staff.	F 687		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by:	F 689		12/18/18

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Based on observations, clinical record review, staff interviews, and review of the facility's policy, the facility staff failed to ensure a resident's assistance device to prevent accidents was in place for 1 of 39 residents (Resident #7), in the survey sample.

The facility staff failed to ensure Resident #7's wander guard assistive device was on the resident on 11/7/18 and 11/8/18, as ordered and care planned to aid in preventing falls.

The findings included:

Resident #7 was originally admitted to the facility 10/12/16 and was last readmitted to the facility after a hospital admission 2/21/18. The current diagnoses included; protein energy malnutrition, cardiomegaly and dementia.

The significant change Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 8/1/18 coded the resident as not having the ability to complete the Brief Interview for Mental Status (BIMS). The staff interview was coded for long and short term memory problems as well as moderately impaired abilities for daily decision making.

In section "G" (Physical functioning) the resident was coded as requiring limited assistance of 1 person with walking, extensive assistance of 2 people with bed mobility, extensive assistance of 1 person with transfers dressing, eating, toileting, personal hygiene and total care with bathing.

The clinical record revealed Resident #7 had a fall 9/1/18, while repositioning, no injuries were

F 689

1- Resident #7 was re-assessed and determined that the wander guard assistive device is no longer necessary and was discontinued on 11/16/18.
2-The Unit Manager or designee will review current residents with wander guard assistive devices to ensure that the device is in place for the resident as ordered and as indicated per the care plan.
3-The DON will educate all Licensed Nursing staff on the requirements for ensuring that wander guard devices are in place for the resident as ordered and as indicated on the care plan.
4-The Unit Manager or designee will complete audits on a weekly basis of residents with wander guard assistive devices to ensure that they are in place for the resident as ordered and as indicated on the care plan. Results of the audits will be presented to the quarterly Quality Assurance committee for review and recommendation.
5-Completion date 12/18/18.

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documented. Another fall was documented 9/8/18, while the resident was in bed, again no injuries were document.

In section "J1900" (number of falls since prior assessment) of the 8/1/18, MDS assessment Resident #7 was coded for 2 falls without injury. The 7/12/18 significant change MDS assessment was coded the resident experienced 2 falls without injury and the 2/17/18 discharge MDS assessment revealed the resident had one fall resulting in injury. The unwitnessed fall occurred 2/17/18, and resulted in a frontal hematoma and laceration.

The Physician's order summary revealed the following assistive devices were ordered to aid in fall prevention; check wander guard function every week, every day shift, every Wednesday, dated 6/30/18. Check wander prevention patient band every shift dated 10/25/18. Devices; assist bars to bed, concave mattress to bed, low bed, mats to floor, wedge use and bed against the wall.

The person centered care plan dated 10/12/16 had a problem which read; The resident is at risk for falls related to dementia and blindness of the right eye. The goal read; the resident will be free of falls through the next review date 1/30/19. The interventions included; anticipate and meet the resident's needs. Encourage the resident to participate in activities that promote exercise, physical activity for strengthening and improved mobility such as all group activities. Devices; assist bars, wedges, wander guard, concave mattress, low bed, floor mats and bed against the wall,

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F 689	Continued From page 55 Observation of Resident #7 room revealed the concave mattress and the assist bars to the bed, a wedge was observed in a chair, the bed was low to the floor, a floor mat was observed propped against the wall and the bed was against the wall as ordered and care planned but the wander guard bracelet was not in place when the Resident was observed 11/7/18 and 11/8/18. Resident #7 was observed in the day room on unit "A" on 11/7/18 at approximately 2:40 p.m., a wander guard bracelet wasn't observed on the resident. Resident #7 was observed in the dining room 11/8/18 at approximately 12:05 p.m., again a wander guard bracelet was not observed on the resident or the wheel chair. Two Certified Nursing Assistants (CNAs) present in the dining room were asked if they observed a wander guard on Resident #7. Both observed the resident and touched her ankles and wrist to determine if the wander guard was present, neither located a wander guard on the resident. An interview was conducted on 11/8/18, at approximately 12:10 p.m., with CNA #2. CNA #2 stated she understood the wander guard was discontinued and it was not attached to the resident during am care and when she got her up. An interview was also conducted on 11/8/18, with Licensed Practical Nurse (LPN) #2. LPN #2 stated she needed to review the resident's order before she could stated what was ordered. LPN #2 stated at approximately 1:00 p.m., the resident was supposed to have a wander guard on and she had applied it. Resident #7 was observed at approximately 2:40 p.m., with the wander guard on.	F 689		

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The facility's policy titled Fall Management Program dated 2/1/15 read "The Center considers all patients to be at risk for falls and provides an environment as safe as practical for all patients. The center utilizes a systems approach to a Falls Management Program that conducts multi-faceted, interdisciplinary assessments with evidence based interventions to develop individual care strategies. Fall Occurrence Immediate Responsibilities: Do not move or reposition patient until a licensed nurse has completed a physical and mental assessment. A licensed nurse will: assess, intervene, and promptly provide the necessary interventions for any patient experiencing a fall. Notify the physician, responsible party, and/or EMS (emergency medical services, as well as the Supervisor/Administrative personnel as appropriate

Evaluate, monitor, and document patient response for the first 24 hours (3 consecutive shifts) post fall, include a neurological assessment if the fall was unwitnessed and/or the patient hit his/her head. For the next 48 hours a comprehensive assessment will be documented daily.

A licensed nurse will review, revise, and implement interventions to the care plan based on: Post Fall Assessment findings. Review of Device Assessment. Review of Fall Risk Assessment".

Follow-Up Responsibilities: The Unit Manager will review the Incident Report and post fall follow-up and communicate any necessary fall management interventions to direct caregivers. The DON will analyze and present an electronic

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F 689	Continued From page 57 fall tracking data findings during the QA (Quality Assurance) meeting at least quarterly. On 11/8/18 at approximately 5:00 p.m., the above findings were shared with the Administrator, Director of Nursing and two Corporate Consultants. Corporate Consultant #1 stated she was aware if the resident required use of a wander guard but if it was ordered and care planned for use, it should have been in place.	F 689		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident	F 842		12/18/18

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representative where permitted by applicable law;
(ii) Required by Law;
(iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;
(iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.

§483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.

§483.70(i)(4) Medical records must be retained for-
(i) The period of time required by State law; or
(ii) Five years from the date of discharge when there is no requirement in State law; or
(iii) For a minor, 3 years after a resident reaches legal age under State law.

§483.70(i)(5) The medical record must contain-
(i) Sufficient information to identify the resident;
(ii) A record of the resident's assessments;
(iii) The comprehensive plan of care and services provided;
(iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State;
(v) Physician's, nurse's, and other licensed professional's progress notes; and
(vi) Laboratory, radiology and other diagnostic services reports as required under §483.50.

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F 842	Continued From page 59 This REQUIREMENT is not met as evidenced by: Based on clinical record review, staff interviews, review of the facility's policy, and during a complaint investigation, the facility staff failed to ensure accurate documentation of a pressure ulcer wound for 1 of 39 residents (Resident #171), in the survey sample. The facility staff failed to identify the location of Resident #171's pressure ulcer on the 7/26/18, 8/1/18, 8/8/18, and 8/15/18 weekly pressure ulcer assessments. The findings included: Resident #171 was originally admitted to the facility 7/26/18 and was discharged to a local hospital 8/23/18 for an acute problem. The diagnoses at the time of the discharge included; benign prostate hypertrophy with urinary retention requiring a chronic indwelling catheter, elevated prostate-specific antigen, a urinary tract infection and a sacral pressure ulcer. The admission Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 8/2/18 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 4 out of a possible 15. This indicated Resident #171's cognitive abilities for daily decision making were severely impaired. In section "D" (Mood) the resident was coded with no mood problems, in section "E" (Behavior) the resident was coded with no behavior problems, in section "G" (Physical functioning) the resident was coded as requiring total care of 1 with bathing and locomotion, extensive assistance of 2	F 842	1-Resident #171 was discharged from the facility on 8/23/18. 2-The DON will review current residents with pressure ulcers to ensure that the wound records are completed accurately per the assessment of the pressure ulcer. 3-The DON will educate Licensed Nursing staff on proper documentation of pressure ulcers on the wound records to include correct location of the pressure ulcers. 4-The DON or designee will complete weekly audits of the wound records of residents with pressure ulcers to ensure that the documentation is accurate on the wound record. Results of the audits will be presented to the Quarterly Assurance Committee for review and recommendation. 5-Completion date 12/18/18.	

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people with bed mobility, transfers, and toileting, extensive assistance of 1 person with personal hygiene, dressing, and eating, in section "M" (Skin Condition) the resident was coded as having a stage 2 pressure ulcer on admission.

The current care plan dated 7/28/18 and revised 8/23/18 had a problem which read; Actual skin impairment to sacrum and penis. The goal read; Resident will have no evidence of skin impairment through next review, 10/30/18 and Resident's wound will heal without complications by review date, 10/30/18. The interventions included; keep skin clean and dry. Lotion to dry skin. Moisture barrier cream as needed for protection of skin. Pericare with incontinence episodes. Pressure reduction mattress. Pressure reduction surface to wheel chair. Routine wound care and assessment. Weekly skin assessment.

The facility's weekly pressure ulcer assessments revealed on 7/26/18, a stage 2 pressure injury (site not identified), measuring; length 2.3 centimeters by width, 1.8 centimeters by 0 depth and 100% epithelial tissue. Light serosanguineous drainage and no odor after cleansing.

The Physician's order summary had an order dated 7/28/18, which read; Wound 1: stage 2 to sacrum (present on admission). Cleanse with normal saline (NS) and cover with Allevyn daily every day shift.

The facility's weekly pressure ulcer assessments revealed on 8/1/18, a stage 2 pressure injury, (site not identified), measuring; length 1.8 centimeters by width, 1.5 centimeters by 0 depth and 100% epithelial tissue. No drainage and no

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odor after cleansing.

The Physician's order summary revealed an order dated 8/6/18, which read; Start 8/7/18, *Santyl Ointment 250 unit/gram; Collangenase Apply to sacrum topically every day shift for pressure ulcer: sacrum. Apply to wound bed.

The facility's weekly pressure ulcer assessments revealed on 8/8/18, a stage 2 pressure ulcer, (site not identified), measuring; length 3.1 centimeters by width, 1.6 centimeters by 0 depth and 100% slough (dead) tissue. No drainage and faint odor after cleansing. (A stage 2 pressure ulcers by definition have partial thickness loss of the dermis. Granulation tissue, slough, and eschar are not present in Stage 2 pressure ulcers.) per RAI manual 3.0, October 2018 Chapter 3 page M-14.

The facility's weekly pressure ulcer assessments revealed on 8/15/18, a stage 2 pressure ulcer, (site not identified), measuring; length 2.7 centimeters by width, 2.1 centimeters by 0 depth. The wound bed tissue type was not identified. Light purulent drainage, with faint odor after cleansing. A note was documented on page 6, "wound showing no deterioration, but also no improvement. Dressing changed to; cleanse with normal saline, apply Aquacel Ag, and cover with Allevyn every Monday, Wednesday and Friday".

Also on 8/15/18, an order was received to discontinue the following order. Santyl Ointment 250 unit/gram; Collangenase Apply to sacrum topically every day shift for pressure ulcer: sacrum. Apply to wound bed. The Physician's order summary also revealed an order dated 8/15/18, which read; start 8/17/18, wound 1.

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stage 2 to sacrum (present on admission) dressing change to cleanse with normal saline, Apply Aquacel Ag and cover with Allevyn every day shift, Monday, Wednesday and Friday. (a 2 day delay in institution of the new treatment)

The facility's weekly pressure ulcer assessments revealed on 8/22/18, an unstageable pressure injury to the sacrum, measuring; length 5.0 centimeters by width, 2.8 centimeters by 0 depth and 60% slough tissue with light serosanguineous drainage and a moderate odor after cleansing. The Physician's order summary revealed another order dated 8/22/18, which read; start 8/23/18, Dakins (1/2 strength) solution 0.2-0.25%, Apply to sacrum topically every day shift for wound, clean sacral wound. Apply Santyl, cover with a dry dressing daily, every day shift for pressure ulcer.

The facility's policy titled Pressure Ulcer Monitoring dated 2/1/15 read; All pressure ulcers will be monitored. The procedure; A licensed nurse will assess patients for the presence of pressure ulcers; if a pressure ulcer is present, the nurse will evaluate for complications. Provide pain management prior to pressure ulcer treatment as indicated. The Wound Record will be competed weekly by a licensed nurse for any patient with pressure ulcers. There will be a Wound Record for each site.

On 11/8/18 at approximately 5:00 p.m., the above findings were shared with the Administrator, Director of Nursing and two Corporate Consultants.

*Santyl Topical Ointment: 1g, 250U is for the treatment of decubitus ulcer, diabetic foot ulcer,

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F 842	Continued From page 63 or varicose ulcer that requires debridement. Collagenase should only be used on wounds that have necrotic material. (https://www.pdr.net/drug-summary/Collagenase-Santyl-collagenase-250).	F 842		
F 849 SS=D	Hospice Services CFR(s): 483.70(o)(1)-(4) §483.70(o) Hospice services. §483.70(o)(1) A long-term care (LTC) facility may do either of the following: (i) Arrange for the provision of hospice services through an agreement with one or more Medicare-certified hospices. (ii) Not arrange for the provision of hospice services at the facility through an agreement with a Medicare-certified hospice and assist the resident in transferring to a facility that will arrange for the provision of hospice services when a resident requests a transfer. §483.70(o)(2) If hospice care is furnished in an LTC facility through an agreement as specified in paragraph (o)(1)(i) of this section with a hospice, the LTC facility must meet the following requirements: (i) Ensure that the hospice services meet professional standards and principles that apply to individuals providing services in the facility, and to the timeliness of the services. (ii) Have a written agreement with the hospice that is signed by an authorized representative of the hospice and an authorized representative of the LTC facility before hospice care is furnished to any resident. The written agreement must set out at least the following: (A) The services the hospice will provide. (B) The hospice's responsibilities for determining	F 849		12/18/18

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 849	Continued From page 64 the appropriate hospice plan of care as specified in §418.112 (d) of this chapter. (C) The services the LTC facility will continue to provide based on each resident's plan of care. (D) A communication process, including how the communication will be documented between the LTC facility and the hospice provider, to ensure that the needs of the resident are addressed and met 24 hours per day. (E) A provision that the LTC facility immediately notifies the hospice about the following: (1) A significant change in the resident's physical, mental, social, or emotional status. (2) Clinical complications that suggest a need to alter the plan of care. (3) A need to transfer the resident from the facility for any condition. (4) The resident's death. (F) A provision stating that the hospice assumes responsibility for determining the appropriate course of hospice care, including the determination to change the level of services provided. (G) An agreement that it is the LTC facility's responsibility to furnish 24-hour room and board care, meet the resident's personal care and nursing needs in coordination with the hospice representative, and ensure that the level of care provided is appropriately based on the individual resident's needs. (H) A delineation of the hospice's responsibilities, including but not limited to, providing medical direction and management of the patient; nursing; counseling (including spiritual, dietary, and bereavement); social work; providing medical supplies, durable medical equipment, and drugs necessary for the palliation of pain and symptoms associated with the terminal illness and related	F 849		

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	495296	A. BUILDING ______ B. WING ______	C 11/08/2018

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conditions; and all other hospice services that are necessary for the care of the resident's terminal illness and related conditions.
(I) A provision that when the LTC facility personnel are responsible for the administration of prescribed therapies, including those therapies determined appropriate by the hospice and delineated in the hospice plan of care, the LTC facility personnel may administer the therapies where permitted by State law and as specified by the LTC facility.
(J) A provision stating that the LTC facility must report all alleged violations involving mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown source, and misappropriation of patient property by hospice personnel, to the hospice administrator immediately when the LTC facility becomes aware of the alleged violation.
(K) A delineation of the responsibilities of the hospice and the LTC facility to provide bereavement services to LTC facility staff.

§483.70(o)(3) Each LTC facility arranging for the provision of hospice care under a written agreement must designate a member of the facility's interdisciplinary team who is responsible for working with hospice representatives to coordinate care to the resident provided by the LTC facility staff and hospice staff. The interdisciplinary team member must have a clinical background, function within their State scope of practice act, and have the ability to assess the resident or have access to someone that has the skills and capabilities to assess the resident.
The designated interdisciplinary team member is responsible for the following:

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F 849	Continued From page 66 (i) Collaborating with hospice representatives and coordinating LTC facility staff participation in the hospice care planning process for those residents receiving these services. (ii) Communicating with hospice representatives and other healthcare providers participating in the provision of care for the terminal illness, related conditions, and other conditions, to ensure quality of care for the patient and family. (iii) Ensuring that the LTC facility communicates with the hospice medical director, the patient's attending physician, and other practitioners participating in the provision of care to the patient as needed to coordinate the hospice care with the medical care provided by other physicians. (iv) Obtaining the following information from the hospice: (A) The most recent hospice plan of care specific to each patient. (B) Hospice election form. (C) Physician certification and recertification of the terminal illness specific to each patient. (D) Names and contact information for hospice personnel involved in hospice care of each patient. (E) Instructions on how to access the hospice's 24-hour on-call system. (F) Hospice medication information specific to each patient. (G) Hospice physician and attending physician (if any) orders specific to each patient. (v) Ensuring that the LTC facility staff provides orientation in the policies and procedures of the facility, including patient rights, appropriate forms, and record keeping requirements, to hospice staff furnishing care to LTC residents. §483.70(o)(4) Each LTC facility providing hospice	F 849		

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F 849	Continued From page 67 care under a written agreement must ensure that each resident's written plan of care includes both the most recent hospice plan of care and a description of the services furnished by the LTC facility to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, as required at §483.24. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review, and review of the Hospice policy; the facility staff failed to ensure the Hospice Agency provided resident specific information describing the provision of services for 1 of 39 residents (Resident #7), in the survey sample. The facility staff failed to ensure the Hospice Agency provided the facility staff with the Hospice recertification of the terminal illness and the most recent coordinated plan of care for Resident #7. The findings included: Resident #7 was originally admitted to the facility 10/12/16 and was last readmitted to the facility after a hospitalization on 2/21/18. The current diagnoses included; protein energy malnutrition, cardiomegaly and dementia. The significant change Minimum Data Set (MDS) assessment with an Assessment Reference Date (ARD) of 8/1/18 coded the resident as not having the ability to complete the Brief Interview for Mental Status (BIMS). The staff interview was coded for long and short term memory problems as well as moderately impaired abilities for daily decision making. In section "O0100K2" the resident was coded for	F 849	-The Hospice Agency provided the facility a current recertification and most recent plan of care for Resident #7. 2-The DON will review residents receiving Hospice care to ensure that a current recertification is in place for each resident and any issues noted will be addressed with the Hospice Agency. 3-The DON will educate the Interdisciplinary team on reviewing the medical record for residents receiving Hospice to ensure that a current recertification and plan of care provided by the Hospice Agency is in place. 4-The DON or designee will review residents receiving Hospice care on a monthly basis to ensure that a current recertification and plan of care provided by the Hospice Agency is in place on the medical record. 5-Completion date 12/18/18.	

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Hospice care. In section "D" the resident was coded for sleep problems, tiredness and a poor appetite 7-11 days out of 14 days. In section "G" (Physical functioning) the resident was coded as requiring limited assistance of 1 person with walking, extensive assistance of 2 people with bed mobility, extensive assistance of 1 person with transfers dressing, eating, toileting, personal hygiene and total care with bathing.

Review of the physician's order summary revealed an order dated 7/25/18 which read; Admit to Hospice Care with (name of the hospice agency).

Review of the person centered care plan dated 7/26/18 was a problem which read; the resident is under hospice care related to dementia and functional decline. The goals included; the resident will be free of depression and anxiety through 1/30/19. The resident's comfort will be maintained through the review date, 1/30/19. The resident's dignity and autonomy will be maintained at the highest level through the review date, 1/30/19. The interventions included; work cooperatively with the hospice team as ordered to ensure the resident's spiritual, emotional, intellectual, physical and social needs are met. Hospice nurse and aide will visit at least weekly. Spiritual Care Coordinator will visit monthly and as needed. Notify physician and hospice agency of any changes in condition.

Review of the clinical record revealed an initial hospice certification and care plan for 7/24/18 through 10/21/18.

On 11/8/18 at approximately 12:15 p.m., the Administrator was asked if the hospice

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recertification beginning 10/22/18, and the associated care plan was available for review. The Administrator stated she would follow-up on it. The Administrator returned at approximately 4:00 p.m., with a copy of the hospice recertification covering 10/22/18 through 1/19/19. It had been faxed to the facility on 11/8/18 at 3:50 p.m.; and attached was a review of the care plan dated 11/8/18 at 11:30 a.m. and a note that read all of the care plan was reviewed and there were no new problems.

The facility's Hospice Services policy read at 4.13.3; they will provide the facility with the following information specific to each Hospice patient residing at the facility; (i) the most recent plan of care, (ii) the hospice election form and any advanced directives, (iii) the physician's certification and recertification of the terminal illness, (iv) the names and contact information for hospice staff involved in the care of the patient, (v) instructions on how to access hospice's 24 hour on-call system, (vi) hospice medication information, and (vii) hospice physician and attending physician orders.

On 11/8/18 at approximately 5:00 p.m., the above findings were shared with the Administrator, Director of Nursing and two Corporate Consultants. An opportunity was given for the facility to present additional information but none was provided.