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E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 10/23/18 through 10/25/18. The facility was in compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities.	E 000		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 10/23/18 through 10/25/18. Corrections are required for compliance with the following 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. The census in this 225 certified bed facility was 163 at the time of the survey. The survey sample consisted of 42 current resident reviews (Residents #265, #55, #46, #101, #316, #54, #10, #8, #119, #113, #58, #73, #266, #128, #112, #117, #31, #95, #114, #60, #52, #74, #106, #108, #2, #133, #66, #77, #161, #158, #318, #5, #149, #110, #23, #68, #51, #48, #25, #64, #83 and #42) and four closed record reviews (Residents #317, #166, #115 and #167).	F 000		
F 558 SS=E	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review and clinical record review, it	F 558	1.Corrective Action	12/1/18

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

Electronically Signed | 11/16/2018

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F 558	Continued From page 1 was determined the facility staff failed to ensure a call bell was within reach for three of 46 residents, Resident #161, #54, #158 and failed to ensure resident's choices was honored for one of 46 residents in the survey sample, Resident #46. 1. The facility staff failed to ensure the call bell was within the resident's reach for Resident #161. 2. The facility staff failed to ensure Resident #54's call bell (a device with a button that can be pushed to alert staff when assistance is needed), was within the resident's reach. 3. The facility staff failed to ensure Resident #158's call bell was within the resident's reach. 4. The facility staff failed provide opportunities for Resident #46 to choose and listen to her preferred television programs. The findings include: 1. Resident #161 was admitted to the facility on 2/26/16 with diagnoses that included but were not limited to: depression, high blood pressure, hypothyroidism (1), chronic obstructive pulmonary disease (COPD) (2), anxiety disorder, and repeated falls. The most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 10/11/18, coded the resident as scoring a three of 15 on the BIMS (brief interview for mental status) score, indicating the resident was not capable of making daily cognitive decisions. The resident was coded as having the ability to understand and to make	F 558	The call bells for residents # 161, # 158 and #54 were observed on 10/24/18 located within reach of the resident. The volume for the television for resident #42 was repaired on 10/24/18 and is in working order. Both resident # 42 and # 46 are watching and listening to their own televisions. 2.Other Potential Residents All residents who rely on the use of call bells for assistance have the potential to be affected. A 100% audit of all call bells was completed on 10/24/18 to validate that the residents call bell was within reach. Any areas of non-compliance was immediately corrected and staff responsible were counseled. All residents who have televisions in their rooms have the potential to be affected. A 100% audit of all televisions was completed to validate that the television was working properly. All televisions were noted to be in working order. 3. Systemic Changes Nursing staff have been re-educated on the importance of making sure that the residents call bell is within reach prior to leaving the residents room. Facility staff have been re-educated on the process for reporting to maintenance when a residents television is not working properly	

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F 558	Continued From page 2 themselves understood. The resident was also coded as requiring extensive assistance for dressing and personal hygiene. The care plan dated 3/2/16, for Resident #161 documented, "Provide assistance to transfer and ambulate as needed." On 10/23/18 at approximately 1:09 p.m., an observation was made of Resident #161 sleeping in her bed; the call bell was approximately one foot away from the resident laying on the floor. On 10/23/18 at approximately 3:44 p.m., a second observation made of Resident #161 sleeping in her bed; the call bell was approximately one foot away from the resident laying on the floor. On 10/25/18 at approximately 10:16 a.m., an interview was conducted with CNA (certified nursing assistant) #2. When asked where Resident #161's call bell should be positioned, CNA #2 replied "Within reach at all times." When asked if Resident #161 was able to press the call bell, CNA #2 replied "Yes." On 10/25/18 at approximately 10:20 a.m., an interview was conducted with LPN (licensed practical nurse) #7. When asked how residents' get the attention of staff if they need help, LPN #7 replied, "Ring the call bell." When asked where a call bell should be placed, LPN #7 replied "On the bed or within their reach if they are not in the bed." When informed that Resident #161 call bell was observed not within reach, LPN #1 stated "It should be within her reach at all times." On 10/25/18 at approximately 12:45 p.m., ASM	F 558	Unit Managers will complete a 100% call bell audit 3 times a week for 3 months to validate that the residents call bell is within reach. Any areas of non-compliance will be immediately corrected and staff responsible will be counseled. Facility Maintenance staff will conduct weekly audits x 3 months, of all televisions to validate that all televisions are in working order. If any televisions are in need of repair the repair will be taken care of as soon as possible. 4.Monitoring The results of all audits will be forwarded to the QAPI Committee for review and recommendations. 5.Date of compliance 12/1/18	

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(administrative staff member) #2, Assistant Administrator and ASM #5, the Director of Nursing were made aware of the findings.

The facility policy entitled "Answering the Call Light" documented, "5. When the resident is in bed or confined to a chair be sure the call light is within easy reach of the resident."

No further information was provided prior to exit.

1. Not enough thyroid hormone to meet your body's needs. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/hypothyroidism.html.
2. Disease that makes it difficult to breath that can lead to shortness of breath). The two main types are chronic bronchitis and emphysema. The main cause of COPD is long-term exposure to substances that irritate and damage the lungs. This is usually cigarette smoke. Air pollution, chemical fumes, or dust can also cause it. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/copd.html.
2. The facility staff failed to ensure Resident #54's call bell (a device with a button that can be pushed to alert staff when assistance is needed), was within the resident's reach.

Resident # 54 was admitted to the facility on 09/07/13 with diagnoses that included but were not limited to: dysphagia (1), hemiplegia (2), cerebral infarction (3) and hypertension (4).

Resident # 54's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 08/02/18, coded Resident # 54 as scoring a 15 on the brief

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interview for mental status (BIMS) of a score of 0 - 15, 15 - being cognitively intact for making daily decisions. Resident # 54 was coded as requiring extensive assistance of one staff member for locomotion, dressing and toilet use and being totally dependent with the assistance of one staff member for personal hygiene and bathing.

On 10/23/18 at 11:56 a.m., an observation of Resident # 54 revealed he was lying in his bed. During the interview with Resident # 54, he was asked to activate his call bell Resident # 54 was unable to locate it. Observation of the call bell revealed it was lying on the floor on the right side of the resident's bed.

On 10/23/18 at 4:35 p.m., an observation of Resident # 54 revealed he was in bed watching television. Resident # 54 was asked to activate his call bell. Resident # 54 was unable to locate it. Observation of the call bell revealed it was lying on the floor on the right side of the resident's bed.

On 10/24/18 at 2:50 p.m., an interview was conducted with LPN (licensed practical nurse) # 8 in presence of Resident # 54 while he was lying in bed. When Resident # 54 was asked if recalled this surveyor asking about his call bell on 10/23/18 during the interview, Resident # 54 stated "Yes." Resident # 54 further stated, "I couldn't find it." LPN # 8 was then informed that the call bell was lying on the floor under Resident # 54's bed. When asked how often the placement of the call bell should be checked, LPN # 8 stated, "It should checked during rounds and prn (as needed)." Resident # 54 was asked how it made him feel not having the call bell to call for assistance. Resident # 54 stated, "It's

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terrible."

On 10/24/18 at approximately 5:40 p.m., ASM (administrative staff member) # 2, the administrator and ASM # 2, assistant administrator, ASM # 4 assistant administrator, ASM # 5 director of nursing and ASM # 6, medical director were made aware of the findings.

No further information was provided prior to exit.

References:
(1) A swallowing disorder. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/swallowingdisorders.html.

(2) Also called: Hemiplegia, Palsy, Paraplegia, Quadriplegia. Paralysis is the loss of muscle function in part of your body. It happens when something goes wrong with the way messages pass between your brain and muscles. Paralysis can be complete or partial. It can occur on one or both sides of your body. It can also occur in just one area, or it can be widespread This information was obtained from the website: https://medlineplus.gov/paralysis.html.

(3) A stroke. When blood flow to a part of the brain stops. A stroke is sometimes called a "brain attack." If blood flow is cut off for longer than a few seconds, the brain cannot get nutrients and oxygen. Brain cells can die, causing lasting damage. This information was obtained from the website: https://medlineplus.gov/ency/article/000726.htm .

(4) High blood pressure. This information was

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

3. The facility staff failed to ensure Resident #158's call bell was within the resident's reach.

Resident # 158 was admitted to the facility on 06/26/17 with diagnoses that included but were not limited to: heart failure (1), depressive disorder (2), anemia (3) and chronic obstructive pulmonary disease (4).

Resident # 158's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 10/11/18, coded Resident # 158 as scoring a 13 on the brief interview for mental status (BIMS) of a score of 0 - 15, 13 - being cognitively intact for making daily decisions. Resident # 158 was coded as requiring extensive assistance of one staff member for all activities of daily living.

On 10/24/18 at 9:37 a.m., an observation of Resident # 158 revealed she was sitting up in bed. During an interview, Resident # 158 was asked to locate and activate the call bell. Resident # 158 was unable to locate it. Observation of the call bell revealed it was under the resident's pillow at the level of her neck.

On 10/24/18 at 2:50 p.m., an interview was conducted with LPN (licensed practical nurse) # 8. When asked how often the placement of the call bell should be checked LPN # 8 stated, "It should checked during rounds and prn (as needed)." When informed of the observation of Resident # 158 not being able to locate and activate her call bell LPN # 8 stated it should have

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been placed where she could access it.

On 10/25/18 at approximately 12:45 p.m., ASM (administrative staff member) # 2, the administrator and ASM # 2, assistant administrator, ASM # 4 assistant administrator, ASM # 5 director of nursing and ASM # 6, medical director were made aware of the findings.

No further information was provided prior to exit.

References:
(1) A condition in which the heart is no longer able to pump oxygen-rich blood to the rest of the body efficiently. This causes symptoms to occur throughout the body. This information was obtained from the website: https://medlineplus.gov/ency/article/000158.htm.

(2) Depression may be described as feeling sad, blue, unhappy, miserable, or down in the dumps. Most of us feel this way at one time or another for short periods. Clinical depression is a mood disorder in which feelings of sadness, loss, anger, or frustration interfere with everyday life for weeks or more. This information was obtained from the website: https://medlineplus.gov/ency/article/003213.htm.

(3) Low iron. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/anemia.html .

(4) Disease that makes it difficult to breath that can lead to shortness of breath. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/copd.html.

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4. The facility staff failed provide opportunities for Resident # 46 to choose and listen to her preferred television programs.

Resident # 46 was admitted to the facility on 10/31/16 with diagnoses that included but were not limited to: dementia (1), dysphagia (2), anemia (3) and spinal stenosis (4).

Resident # 46's most recent MDS (minimum data set), an annual assessment with an ARD (assessment reference date) of 08/30/18, coded Resident # 46 as scoring a 5 (five) on the brief interview for mental status (BIMS) of a score of 0 - 15, 5 (five) - being severely impaired of cognition for making daily decisions. Resident # 46 was coded as requiring extensive assistance of one staff member for locomotion, dressing, toilet use and bed mobility and being totally dependent of one staff member for transfers, eating, personal hygiene and bathing. Section F "Preferences for Customary Routine and Activities" coded Resident # 42 as 1 (one) - "Very important" under "D. how important is it to you to keep up on the news?"

On 10/24/18 at 5:50 p.m., observation of Resident # 46 revealed she was lying in bed awake looking/watching the television on her side of the room. Observation of her wall-mounted television revealed it was on and tuned into a television program. Further observation of the television revealed that there was no sound coming from the television. Observation of the room revealed Resident # 46's roommate, she was lying in bed with her eyes closed and head phones on her head and over her ears. When asked what Resident # 46's roommate was

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listening to, CNA (certified nursing assistant) # 4 stated, "The T.V." Observation of the television for Resident # 46's roommate, which was mounted on the wall at the foot of the bed, revealed that there was no picture and the television was off. When asked what television Resident # 46's roommate was listening to, CNA # 4 pointed to Resident # 46's television, which was mounted on the wall on the A-side of the room. CNA # 4 stated, "She's listening to that one." CNA # 4 stated, "(Resident # 42) listens to her roommate's (resident # 46) T.V." When asked if Resident # 46's roommate listens to Resident # 46's television while Resident # 46 looks at her own television without any sound, CNA # 4 verbally confirmed the arrangement. When asked if she thought that this arrangement was okay, CNA # 4 didn't have a response.

On 10/25/18 at 8:55 a.m., observation of Resident # 46 revealed she was lying in bed awake looking/watching the television on her side of the room. Observation of her wall-mounted television revealed it was on and tuned into a television program. Further observation of the television revealed that there was no sound coming from the television. Observation of the room revealed Resident # 46's roommate revealed she was sitting up in bed with her eyes closed and the headphones on her head and over her ears and being assisted by a staff member with breakfast. When asked what Resident # 46's roommate was listening to, CNA # 3 stated, "The T.V." Observation of the television for Resident # 46's roommate, which was mounted on the wall at the foot of the bed, revealed that there was no picture and the television was off. When asked what television Resident # 46's roommate was listening to, CNA # 3 pointed to

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Resident # 46's television, which was mounted on the wall on the A-side of the room and stated, "She's listening to that one." CNA # 3 stated, "(Resident # 42) listens to her roommate's (Resident # 46) T.V." When asked if Resident # 46's roommate listens to Resident # 46's television while Resident # 46 looks at her own television without any sound CNA # 3 verbally confirmed the arrangement. When asked if she thought that this arrangement was okay, CNA # 3 didn't have a response.

On 10/25/18 at 9:14 a.m., an observation of Resident # 46 revealed she was in bed looking at her television. Observation of the television revealed it was on and there was no sound coming from it. When asked if she could hear the television Resident # 46 stated, "No." When asked if she wanted to hear her television Resident # 46 stated, "Yes but not loud."

The "Activity Evaluation" for Resident # 46 dated 10/17/2016 documented, "C. 11. TV Program Viewing/Radio" Current interest."

The comprehensive care plan with a revision date of 08/30/2018 for Resident # 46 documented, "Focus: Enjoys activities such as music, pets/animals, group activities, outdoors in appropriate weather, religious/spiritual, exercise, games and socials." Under "Goals" it documented, "Will participate in independent leisure activities of choice such as watching t.v., visitors."

On 10/25/18 at 9:43 a.m., an interview was conducted with LPN (licensed practical nurse) # 9, unit manager. After LPN #9 was informed of the observations of Resident # 46 not being able

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to listen to her television or being given the choice to select preferred television programming, LPN # 9 agreed Resident # 46's choices or preferences were not honored. LPN # 9 further stated, "I was not aware of this until yesterday."

On 10/25/18 at 10:02 a.m., an interview was conducted with ASM # 4, assistant administrator. When informed of the observation of Resident # 46 not being able to hear or watch what she wanted on her television, ASM # 4 stated, "I agree that Resident # 46 was not being accommodated for their television preferences."

The facility's policy "Resident Rights" documented, "6. To self-determination resident choice including: a. To choose activities and schedulers."

On 10/25/18 at approximately 12:45 p.m., ASM (administrative staff member) # 2, the administrator and ASM # 2, assistant administrator, ASM # 4 assistant administrator, ASM # 5 director of nursing and ASM # 6, medical director were made aware of the findings.

No further information was provided prior to exit.

References:
(1) A loss of brain function that occurs with certain diseases. It affects memory, thinking, language, judgment, and behavior. This information was obtained from the website: https://medlineplus.gov/ency/article/000739.htm.

(2) A swallowing disorder. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/swallowingdi

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WESTPORT REHABILITATION AND NURSING CENTER	7300 FOREST AVE RICHMOND, VA 23226

(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 558	Continued From page 12 sorders.html. (3) Low iron. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/anemia.html . (4) A narrowing of the spinal column that causes pressure on the spinal cord, or narrowing of the openings (called neural foramina) where spinal nerves leave the spinal column. This information was obtained from the website: https://medlineplus.gov/ency/article/000441.htm.	F 558		
F 577 SS=C	Right to Survey Results/Advocate Agency Info CFR(s): 483.10(g)(10)(11) §483.10(g)(10) The resident has the right to- (i) Examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility; and (ii) Receive information from agencies acting as client advocates, and be afforded the opportunity to contact these agencies. §483.10(g)(11) The facility must-- (i) Post in a place readily accessible to residents, and family members and legal representatives of residents, the results of the most recent survey of the facility. (ii) Have reports with respect to any surveys, certifications, and complaint investigations made respecting the facility during the 3 preceding years, and any plan of correction in effect with respect to the facility, available for any individual to review upon request; and (iii) Post notice of the availability of such reports in areas of the facility that are prominent and	F 577		12/1/18

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F 577	Continued From page 13 accessible to the public. (iv) The facility shall not make available identifying information about complainants or residents. This REQUIREMENT is not met as evidenced by: Based on observation, resident group interview, and staff interview, it was determined that the facility staff failed to properly display notice that prior Survey results were available for review. There was no notice displayed alerting residents, families, legal representatives and visitors that the previous 3 years of survey results were available for review. The Findings included: During the course of the annual certification survey, a meeting was conducted with the Resident Group on 10/23/18 at 2:00 p.m. eight current cognitively intact residents attended. During the course of the Group meeting, when asked if they were aware of how to review previous years' survey results. The Group all responded that they did not. On 10/25/18 at 2:59 p.m., this surveyor inspected the facility's posting of prior survey results. A small binder was found in the main lobby hanging from a hook on the wall, within easy reach of wheelchair height. The binder was found to contain the most recent Survey results report. However, the book contained only the most recent survey results. There was no notice in the binder or anywhere nearby that the previous 3 years of survey results and the plans of corrections were available for review. This surveyor took the Survey Results binder to	F 577	1. Corrective Action The notice has been re-posted at the receptionist desk and in the survey book that identifies the location of the surveys for the past 3 years. 2.Other Potential Residents All residents have the potential to be affected.A notice has been posted at the receptionist desk and in the survey book that identifies the location of the surveys for the past 3 years. A meeting was held with the resident council on 11/8/18 and the residents in the group were shown the location of the survey results for the previous 3 years. 3.Systemic Changes An audit will be completed weekly x3 months to validate that the notice of location of survey results is present. 4. Monitoring The results of all audits will be forwarded to the QAPI Committee for review and recommendations. 5.Date of compliance	

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F 577	Continued From page 14 the office of Administrative Staff Member (ASM) #1, the Senior Administrator, and asked where the 3-year look back of survey results were kept. ASM #1 contacted ASM #4, the Assistant Administrator, who stated that the 3 years of survey results were kept in a binder at the reception desk. When asked how a person would know to ask the reception desk for the 3-year survey results binder, ASM #4 stated "well, we can add a notice to that book" (the survey results binder displayed on the wall). The Administrator and Director of Nursing were informed of the findings at the end of day meeting on 10/25/18. No further documentation was provided.	F 577	12/1/18	
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft.	F 584		12/1/18

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F 584	Continued From page 15 §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review and clinical record review, it was determined that the facility staff failed to maintain a homelike environment in one of two dining areas and maintain a resident's room in a homelike environment for one of 46 residents in the survey sample, Resident #42. 1. The facility staff failed to serve resident's meal in a homelike manner in the first floor dining area. 2. The facility staff failed to maintain Resident # 42's television in working order. The findings include: 1. The facility staff failed to serve resident's meal	F 584	1. Corrective Action The staff serving the meals were re-educated on 10/24/18 how to serve meals to promote a homelike atmosphere The television for resident # 42 was repaired on 10/24/18. 2.Other Potential Residents Residents that are served meals in the first floor dining have the potential to be affected. Nursing staff have been re-educated on how to serve meals to promote a homelike atmosphere.	

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F 584	Continued From page 16 in a homelike manner in the first floor dining area. A dining observation was conducted on 10/23/18 at 12:30 p.m., in the first floor dining area (activity room). An observation of the room revealed sixteen residents seated at tables for lunch. For fifteen residents in the dining area, staff members were observed serving residents' their meal. Observation of the serving revealed staff members taking the resident's cups, dessert dishes, utensils and dinner plates from the trays and placing the items in front of each resident. Observations of the dinner plates revealed that they were left on the warming bases when placed in front of the resident while they ate. Further observation of the dining revealed one resident received their meal on the serving tray. The staff member was observed placing the tray containing the resident's cups, dessert dishes, utensils and dinner plate in front of the resident and then assisting the resident with eating their meal. On 10/24/18 at 3:50 p.m., an interview was conducted with CNA (certified nursing assistant) # 5. When asked what the facility means to the residents, CNA # 5 stated, "It's their home." When asked how the resident's should have been served their lunch on 10/23/18, CNA # 5 stated, "In the first floor dining area I was suppose to take everything off the tray. Their plates were left on the warmer plates. In the main dining room the plates are placed on the table." When asked if she thought it was homelike to leave the plates on the tray or on the warmer plates, CNA # 5 stated, "We've always done it that way." On 10/25/18 at 11:02 a.m., an interview was conducted with OSM (other staff member) # 5, dietary manager. When asked about the	F 584	All residents who have televisions in their rooms have the potential to be affected. Facility staff have been re-educated on the process for reporting to maintenance when a residents television is not working properly A 100% audit of all televisions was completed on 10/24/18 to validate that the television was working properly. All televisions were noted to be in working order. 3.Systemic Changes A audit will be completed weekly x 3 months to validate that residents that are served meals in the first floor dining are being served meals in a homelike environment. Any areas of non-compliance will be immediately corrected and staff responsible will be counseled. Facility Maintenance staff will conduct weekly audits x 3 months, of all televisions to validate that all televisions are in working order. If any televisions are in need of repair the repair will be taken care of as soon as possible. 4.Monitoring The results of all audits will be forwarded to the QAPI Committee for review and recommendations. 5.Date of compliance 12/1/18	

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resident's meals being served on the warming plates and the serving tray, OSM # 5 stated, "For a homelike atmosphere you wouldn't keep the plate on the base or the tray." When informed of the observation of lunch being served on the first floor dining area, OSM # 5 stated, "It's not homelike."

The facility's policy "Dining Room Audits" documented, "Policy Statement: Our facility audits the food and nutrition services department to ensure that residents needs are met and that dining is a safe and pleasant experience for residents." Under "Policy Interpretation and Implementation" it documented, "g. Whether all food and beverages are removed from resident's trays and placed on the table in a homelike setting (Notes: When this is not feasible for a resident, the exceptions must be noted in the resident's care plan)."

On 10/24/18 at approximately 5:40 p.m., ASM (administrative staff member) # 2, the administrator and ASM # 2, assistant administrator, ASM # 4 assistant administrator, ASM # 5 director of nursing and ASM # 6, medical director were made aware of the findings.

No further information was provided prior to exit.

2. The facility staff failed to maintain Resident # 42's television in working order.

Resident # 42 was admitted to the facility on 11/03/15 with diagnoses that included but were not limited to: vision loss, both eyes, hearing loss, heart failure (1), dysphagia (2), hemiplegia (3) and cerebrovascular disease (4).

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Resident # 42's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 08/23/18, coded Resident # 42 as scoring a 5 (five) on the brief interview for mental status (BIMS) of a score of 0 - 15, 5 (five) - being severely impaired of cognition for making daily decisions. Resident # 42 was coded as requiring extensive assistance of one staff member for locomotion, eating, toilet use and bed mobility and being totally dependent of one staff member for dressing, personal hygiene and bathing. Section F "Preferences for Customary Routine and Activities" coded Resident # 42 as 1 (one) - "Very important" under "D. how important is it to you to keep up on the news?"

On 10/24/18 at 5:50 p.m., observation of Resident # 42 revealed she was lying in bed with headphones on. CNA (certified nursing assistant) # 4 entered the room and closed the door to provide personal care to Resident # 42. At 6:00 p.m., an interview was conducted with CNA # 4 when she finished providing care. When asked if Resident # 42 was blind, CNA # 4 stated, "Yes." When asked about Resident # 42's headphones CNA stated, "She uses the head phones to listen to T.V. (television)." When asked what Resident # 42 was listening to CNA # 4 stated, "The T.V." Observation of Resident # 42's television, which was mounted on the wall at the foot of the bed, revealed that there was no picture and was off. When asked what television Resident # 42 was listening to CNA # 4 pointed to the television for Resident # 42's roommate, which was mounted on the wall on the A-side of the room. CNA #4 stated, "She's listening to that one." Observation of the roommate's television revealed it was on

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and showing a picture however there was no audible sound. CNA # 4 stated, "(Resident # 42) listens to her roommate's T.V." When asked why Resident # 42 was listening to her roommate's television, CNA # 4 stated she didn't know.

On 10/25/18 at 8:55 a.m., Resident # 42 was observed being assisted by a staff member with breakfast. Observation revealed Resident # 42 was sitting up in bed with headphones on listening to her roommate's television. Further observation revealed Resident # 42's television was not on.

The "Activity Evaluation" for Resident # 42 dated 11/06/2015 documented, "C. 11. TV Program Viewing/Radio" Current interest."

The comprehensive care plan with a target date of 11/21/2018 for Resident # 42 documented, "Focus: Prefers not to attend group activities due to being blind, does not like to be around groups of people and prefers to stay in room." Under "Interventions" it documented, "Provide 1:1 (one-to-one) activity visits of potential interest (i.e. discussions of weather, every day activities/rec (recreation) living, family) 2 (two) times per week but visit resident daily."

On 10/25/18 at 9:43 a.m., an interview was conducted with LPN (licensed practical nurse) # 9, unit manager. After LPN #9 was informed of the observations of Resident # 42 listening to her roommate's television, LPN # 9 stated, "I was not aware of this until yesterday."

On 10/25/18 at 9:46 a.m., an observation revealed OSM (other staff member) # 10, director of maintenance and OSM # 11, maintenance

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worker coming out of Resident # 42's room. When asked what they were doing in Resident # 42's room, OSM # 10 stated they were checking Resident # 42's television. When asked when he was informed about the television, OSM # 10 stated, "I was verbally informed this morning by my colleague (OSM # 11- maintenance worker). We are in the process of fixing it now." When asked if there was a work order for the repair, OSM # 10 stated yes. This surveyor then requested a copy of the work order from OSM # 10.

On 10/25/18 at 9:53 a.m., this surveyor received a copy of the facility's "Daily Maintenance Request Log" from OSM # 10. When asked who completed the work order for Resident # 42's television OSM # 10 stated, "(ASM [administrative staff member] # 4, assistant administrator."

The facility's "Daily Maintenance Request Log" documented, "Location (room number). Request Description: (Resident # 42's) t.v. has no sound; sound is connected to (Resident # 46's) t.v. Requested Time/ Date: 9:42 a.m., 10-25-18. Requested by: Nursing."

On 10/25/18 at 10:02 a.m., an interview was conducted with ASM # 4, assistant administrator. When asked if she had the work order, filled out for the repair on Resident # 42's television, ASM # 4 stated yes. When asked how she knew about the repair needed for the television in Resident # 42's room, ASM # 4 stated, "One of the administrative nurses told me. I did not know about it until this morning."

On 10/25/18 at approximately 12:45 p.m., ASM (administrative staff member) # 2, the

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administrator and ASM # 2, assistant administrator, ASM # 4 assistant administrator, ASM # 5 director of nursing and ASM # 6, medical director were made aware of the findings.

No further information was provided prior to exit.

References:
(1) A condition in which the heart is no longer able to pump oxygen-rich blood to the rest of the body efficiently. This causes symptoms to occur throughout the body. This information was obtained from the website: https://medlineplus.gov/ency/article/000158.htm.

(2) A swallowing disorder. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/swallowingdisorders.html.

(3) Also called: Hemiplegia, Palsy, Paraplegia, Quadriplegia. Paralysis is the loss of muscle function in part of your body. It happens when something goes wrong with the way messages pass between your brain and muscles. Paralysis can be complete or partial. It can occur on one or both sides of your body. It can also occur in just one area, or it can be widespread This information was obtained from the website: https://medlineplus.gov/paralysis.html.

(4) A stroke. When blood flow to a part of the brain stops. A stroke is sometimes called a "brain attack." If blood flow is cut off for longer than a few seconds, the brain cannot get nutrients and oxygen. Brain cells can die, causing lasting damage. This information was obtained from the website:

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F 584	Continued From page 22 https://medlineplus.gov/ency/article/000726.htm.	F 584		
F 607 SS=D	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(3) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview, facility document review, and clinical record review, it was determined that the facility staff failed to implement abuse policies and report an allegation of abuse to the appropriate agencies for one of 46 residents in the survey sample, Resident #23. The facility staff failed to implement abuse policies and report an allegation of abuse made by Resident #23 to this writer and reported to the administrator on 10/23/18. The findings include: Resident #23 was admitted to the facility on 6/24/16 with diagnoses that included but were not limited to Parkinson's Disease, contractors of the muscles, difficulty swallowing, unspecified dementia, high blood pressure, major depressive	F 607	1. Corrective Action The Facility Reported Incident on resident # 23's allegation of abuse was faxed to the Office of Licensure and Certification on 11/16/18. 2. Other Potential Residents Any resident that has an allegation of abuse, neglect, exploitation or mistreatment has the potential to be affected. The facility's Assistant Administrator of Clinical Services was re-educated on 11/15/18 by the Administrator on requirements of reporting and the facility's abuse policy. 3. Systemic Changes	12/1/18

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F 607	Continued From page 23 disorder, and type two diabetes. Resident #23's most recent MDS (minimum data set) assessment was quarterly assessment with an ARD (assessment reference date of 8/16/18. Resident #23 was coded as severely impaired in cognitive function scoring 05 out of 15 on the BIMS (Brief Interview for Mental Status) exam. Resident #23 was coded as requiring total dependence on one staff member with dressing, personal hygiene, and bathing; and extensive assistance with two or more staff members with bed mobility, and transfers. Resident #23 was coded in Section B (Hearing, Speech, and Vision), as sometimes understanding others and sometimes being understood by others for communication. On 10/23/18 at 3:30 p.m., an interview was conducted with Resident #23. During the interview, Resident #23 alleged that a woman had hit her with a stick. Resident #23 identified the woman as "the woman who runs this place." Resident #23 could not recall her name. Resident #23 then stated that the woman had then gone back to bed afterwards. When asked if this woman was her roommate, Resident #23 stated, "No." When asked what kind of stick was used, Resident #23 stated that is was the end of a broom handle. Resident #23 stated that it happened at 2 a.m. that morning. Resident #23 stated she had not reported this to anyone and that it probably "should be looked at." Resident #23 stated she still felt safe at the facility. On 10/23/18 at 3:46 p.m., this allegation was reported to ASM (administrative staff member) #2, the administrator. ASM #2 stated that she would take care of the situation.	F 607	Any allegations of abuse, neglect, exploitation or mistreatment will be reported to the Administrator and reported to state agencies according to state and federal regulations and in accordance with the facility's abuse policy. Effective 11/15/18 the facility Administrator will report all allegations of abuse, neglect, exploitation or mistreatment and initiate the internal investigation. The QAPI Committee will review the facility's Grievance Log weekly x 3 months to validate potential abuse reporting, if applicable was completed in accordance with the facility's abuse reporting policy. 4.Monitoring The results of all audits will be forwarded to the QAPI Committee for review and recommendations. 5.Date of compliance 12/1/18	

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WESTPORT REHABILITATION AND NURSING CENTER	7300 FOREST AVE RICHMOND, VA 23226

(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
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On 10/23/18 at 3:54 p.m., ASM #2 and ASM #3, the assistant administrator were observed walking into Resident #23's room.

On 10/23/18 at approximately 5 p.m., administration presented witness statements from Resident #23 and her roommate. Neither could recall the above allegation according to the witness statements.

On 10/25/18 at 8:37 a.m., a copy of the FRI (facility reported incident) was requested from ASM #3. ASM #3 stated that she did not submit a FRI because she immediately went in to talk to Resident #23 on 10/23/18, and the resident had no recollection of her allegation being made. ASM #3 stated that Resident #23 had periods of confusion. ASM #3 stated that she had talked to Resident #23 and her roommate twice that day, and again that morning (10/24/18). ASM #3 stated that Resident #23 had stated that she felt safe at the facility during her investigation. ASM #3 stated that she had brought this writer a file of the investigation the day before. When asked who was responsible for reporting allegations of abuse, ASM #3 stated that she was. When asked the process for reporting abuse, ASM #3 stated that typically the process was to report abuse within a 2-hour window to the appropriate agencies. ASM #3 stated that during this two-hour window, she is also investigating the allegation. ASM #3 stated again that she did not report Resident #23's allegation because Resident #23 had no recollection of anyone hitting her in the head with a stick during the investigation. ASM #3 stated that her roommate was alert and oriented, and also stated that no one had come into the room at 2 a.m. When asked when a follow up report should be

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F 607	Continued From page 25 submitted to the state agency, ASM #3 stated, "within 5 working days." On 10/25/18 at 8:54 a.m., further interview was conducted with ASM #3. ASM #3 stated, "Just to be clear, I did not report just because she is confused. I did not report because she could not recall the event after I asked her about it." On 10/25/18 at 12:47 p.m., ASM #1, the senior administrator, ASM #2, the administrator, ASM #3, the assistant administrator, ASM #4, the other assistant administrator, ASM #5, the DON (Director of Nursing) and ASM #4, the medical director were all made aware of the above concerns. The facility policy titled, "Abuse Prevention," documents in part, the following: "Reporting: All alleged violations and substantiated incidents will be reported to the State Agency and to other other required agencies..."	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	F 609		12/1/18

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F 609	Continued From page 26 abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State 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 resident interview, staff interview, facility document review, and clinical record review, it was determined that facility staff failed to report an allegation of abuse to the appropriate agencies for one of 46 residents in the survey sample, Resident #23. The facility staff failed to report to the appropriate agencies, Resident #23's allegation of abuse made to this writer and reported to the administrator on 10/23/18. The findings include: Resident #23 was admitted to the facility on 6/24/16 with diagnoses that included but were not limited to Parkinson's disease, contractors of the muscles, difficulty swallowing, unspecified dementia, high blood pressure, major depressive disorder, and type two diabetes. Resident #23's most recent MDS (minimum data set) assessment was quarterly assessment with an	F 609	1. Corrective Action The Facility Reported Incident on resident # 23's allegation of abuse was faxed to the Office of Licensure and Certification on 11/16/18. 2. Other Potential Residents Any resident that has an allegation of abuse, neglect, exploitation or mistreatment has the potential to be affected. The facility's Assistant Administrator of Clinical Services was re-educated on 11/15/18 by the Administrator on requirements of reporting abuse allegations. 3. Systemic Changes Any allegations of abuse, neglect, exploitation or mistreatment will be	

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F 609	Continued From page 27 ARD (assessment reference date of 8/16/18. Resident #23 was coded as being severely impaired in cognitive function scoring 05 out of 15 on the BIMS (Brief Interview for Mental Status) exam. Resident #23 was coded as requiring total dependence on one staff member with dressing, personal hygiene, and bathing; and extensive assistance with two or more staff members with bed mobility, and transfers. Resident #23 was coded in Section B (Hearing, Speech, and Vision), as sometimes understanding others and sometimes being understood by others for communication. On 10/23/18 at 3:30 p.m., an interview was conducted with Resident #23. During the interview, Resident #23 had alleged that a woman had hit her with a stick. Resident #23 identified the woman as "the woman who runs this place." Resident #23 could not recall her name. Resident #23 then stated that the woman had then gone back to bed afterwards. When asked if this woman was her roommate, Resident #23 stated, "No." When asked what kind of stick was used, Resident #23 stated that is was the end of a broom handle. Resident #23 stated that it happened at 2 AM that morning. Resident #23 stated that she had not reported this to anyone and that it probably "should be looked at." Resident #23 stated that she still felt safe at the facility. On 10/23/18 at 3:46 p.m., this allegation was reported to ASM (administrative staff member) #2, the administrator. ASM #2 stated that she would take care of the situation. On 10/23/18 at 3:54 p.m., ASM #2 and ASM #3, the assistant administrator were observed	F 609	reported to the Administrator and reported to state agencies according to state and federal regulations and in accordance with the facility's abuse policy. Effective 11/15/18 the facility Administrator will report all allegations of abuse, neglect, exploitation or mistreatment and initiate the internal investigation. The QAPI Committee will review the facility's Grievance Log weekly x 3 months to validate any potential abuse reporting, if applicable was completed in accordance with the regulations. 4.Monitoring The results of all audits will be forwarded to the QAPI Committee for review and recommendations. 5.Date of compliance 12/1/18	

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walking into Resident #23's room.

On 10/23/18 at approximately 5 p.m., administration presented witness statements from Resident #23 and her roommate. Neither could recall the above allegation according to the witness statements.

On 10/25/18 at 8:37 a.m., a copy of the FRI (facility reported incident) was requested from ASM #3. ASM #3 stated that she did not submit a FRI because she immediately went in to talk to Resident #23 on 10/23/18, and the resident had no recollection of her allegation being made. ASM #3 stated that Resident #23 had periods of confusion. ASM #3 stated that she had talked to Resident #23 and her roommate twice that day, and again that morning (10/24/18). ASM #3 stated that Resident #23 had stated that she felt safe at the facility during her investigation. ASM #3 stated that she had brought this writer a file of the investigation the day before. When asked who was responsible for reporting abuse, ASM #3 stated that she was. When asked the process for reporting abuse, ASM #3 stated that typically the process was to report abuse within a 2-hour window to the appropriate agencies. ASM #3 stated that during this two-hour window, she is also investigating the allegation. ASM #3 stated again that she did not report Resident #23's allegation because Resident #23 had no recollection of anyone hitting her in the head with a stick during the investigation. ASM #3 stated that her roommate was alert and oriented and also stated that no one had come into the room at 2 AM. When asked when a follow up report should be submitted to the office, ASM #3 stated, "within 5 working days."

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F 609	Continued From page 29 On 10/25/18 at 8:54 a.m., further interview was conducted with ASM #3. ASM #3 stated, "Just to be clear, I did not report just because she is confused. I did not report because she could not recall the event after I asked her about it." On 10/25/18 at 12:47 p.m., ASM #1, the senior administrator, ASM #2, the administrator, ASM #3, the assistant administrator, ASM #4, the other assistant administrator, ASM #5, the DON (Director of Nursing) and ASM #4, the medical director were all made aware of the above concerns. Facility policy titled, "Abuse Prevention," documents in part, the following: "Reporting: All alleged violations and substantiated incidents will be reported to the State Agency and to other other required agencies..."	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	F 622		12/1/18

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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; 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.

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F 622	Continued From page 31 (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 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 staff interview, facility document review and clinical record review, it was determined the facility staff failed to evidence that all required paperwork was provided to the receiving facility at the time of transfer for six of 46 residents in the survey sample, Residents #73, #51, #52, #158, #117 and #114. 1. The facility staff failed to evidence that the	F 622	1.Corrective Action Resident # 73 returned from the hospital on 8/10/18. Providing Care plan goals to the hospital is no longer necessary. Resident # 51 returned form the hospital on 10/17/18. Providing Care plan goals to the hospital is no longer necessary.	

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F 622	Continued From page 32 comprehensive care plan goals were sent with Resident #73 upon transfer to the hospital on 8/6/18. 2. The facility staff failed to evidence the comprehensive care plan goals were sent with Resident # 51 upon transfer to the hospital on 9/10/18 and 9/21/18. 3. The facility staff failed to evidence that all required documentation and information was provided to the receiving provider for a facility-initiated transfer on 09/16/18 for Resident # 52. 4. The facility staff failed to evidence that all required documentation and information was provided to the receiving provider for a facility-initiated transfer on 10/14/18 for Resident # 158. 5. The facility staff failed to evidence that the comprehensive care plan goals for Resident #117 were sent to the receiving facility for a hospital transfer on 09/05/18. 6. The facility staff failed to evidence that the comprehensive care plan goals for Resident #114 were sent to the receiving facility for a hospital transfer on 09/21/18. The findings include: 1. The facility staff failed to evidence that the comprehensive care plan goals were sent with Resident #73 upon transfer to the hospital on 8/6/18.	F 622	Resident # 52 returned from the hospital on 9/20/18. Providing required documentation and information to the hospital is no longer necessary. Resident # 158 returned from the hospital on the same day that she was sent to the ER, 10/14/18. Providing required documentation and information to the hospital is no longer necessary. Resident # 117 returned from the hospital on 9/18/18. Providing Care plan goals to the hospital is no longer necessary. Resident # 114 returned from the hospital on 9/25/18. Providing Care plan goals to the hospital is no longer necessary. Licensed nurses responsible for transferring residents to the hospital were re-educated on 10/29/18 regarding all information that must be sent with the resident to the receiving provider including, but not limited to the following: Contact information of the practitioner responsible for the care of the resident, Resident representative information including contact information, Advance Directive information, All special instructions or precautions for ongoing care, as appropriate, Comprehensive care plan goals; All other necessary information, including a copy of the resident's discharge summary. 2.Other Potential Residents	

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F 622	Continued From page 33 Resident #73 was admitted to the facility on 12/12/97, with recent readmission on 8/10/18, with diagnoses that included but were not limited to: cerebral palsy [loss or deficiency of muscle control due to permanent, nonprogressive brain damage occurring before or at the time of birth. (1)], urinary retention, asthma [respiratory disorder characterized by recurrent episodes of difficulty in breathing, wheezing, cough, and thick mucus production, caused by inflammation of the bronchi. (2)], and respiratory failure with hypoxia [inadequate amount of available oxygen in the blood. (3)]. The most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 9/13/18, coded the resident as being in a persistent vegetative state/no discernable consciousness. The nurse's note dated, 8/6/18 at 11:45 (a.m.) documented in part, "Change in condition noted related to noted audible wheezing, gurgling, SOB (shortness of breath), elevated respirations, elevated temp (temperature). This change in condition started on 08/06/2018. Since this started, it has gotten worse... INTERVENTIONS: Emergency transfer to hospital. No additional recommendations made... Emergency contact person was notified on 08/06/2018 at 12:00 AM (sic)." The physician order dated 8/6/18 documented, "Send to ER (emergency Room) for eval (evaluation)." Further review of the clinical record failed to evidence any documentation that the resident's comprehensive care plan goals were provided to the receiving hospital at the time of transfer on 8/6/18.	F 622	Any resident who has been transferred to the hospital has the potential to be affected. A 50% audit was completed on 11/12/18 for all residents that have been sent to the hospital over the past 3 months. For any resident that did not have the required information sent with them to the hospital or documentation in the clinical record that the required information was sent with the resident, the licensed nurse responsible was counseled. 3.Systemic Changes A 50% audit will be completely weekly x 3 months for all residents that are transferred to the hospital to validate that the required information was sent with the resident to the hospital and documented in the clinical record. Any areas of non-compliance will be immediately corrected and responsible staff will be counseled. 4.Monitoring The results of all audits will be forwarded to the QAPI Committee for review and recommendations. 5.Date of compliance 12/1/18	

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An interview was conducted with LPN (licensed practical nurse) # 6 on 10/25/18 at 10:28 a.m., regarding what is sent to the hospital when a resident is transferred. LPN #6 stated the following go with the resident: Nursing Home Capabilities List (a list of services the nursing home can provide) Transfer form, Face sheet, Copy of Medication List - updated with changes of new medications, Notice of Transfer and Discharge form, and Care plan. LPN #6 stated the care plan was something new that goes with them (residents). When asked if they keep copies of the Notice of Transfer and Discharge Form, LPN #6 stated, "I would but not sure if it's needed. We also send the bed hold policy." LPN #6 stated there have been changes recently and they have instituted an action plan to follow the new regulation. It's new to send the care plan."

The "QA (quality assurance) Action Plan was received on 10/25/18 at 11:10 a.m. from ASM (administrative staff member) # 3, the assistant administrator. The Action Plan was dated 9/1/18. The Action Plan documented in part, "Factors identified in root cause analysis of this issue - Through chart review it was noted that residents' did not have complete documentation of all paperwork that was sent with or given to resident when being transferred to the hospital for evaluation. Actions planned: Licensed Nurses will be Re-educated on the importance of accurate documentation of all documents that are sent with resident to the hospital including but not limited to POS (physician order summary), Capabilities List, and transfer form with reason for transfer, bed hold policy and care plan."

The facility policy, "Transfer or Discharge Notice"

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failed to evidence documentation related to what is to be sent with the resident being transferred to the hospital.

ASM (administrative staff member) #2 (the administrator), ASM #3 (the assistant administrator), ASM #4 (another assistant administrator), ASM #5 (the director of nursing) and ASM #6 (the medical director) were made aware of the above concern on 10/25/18 at 12:41 p.m. ASM #3 stated the facility did not have any evidence that the comprehensive care plan was sent with the resident upon discharge.

No further information was provided prior to exit.

(1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 114.
(2) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 51.
(3) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 286.

2. The facility staff failed to evidence the comprehensive care plan goals were sent with Resident # 51 upon transfer to the hospital on 9/10/18.

Resident #51 was admitted to the facility on 8/29/18 with a most recent readmission on 9/17/18, with diagnoses that included but were not limited to: stroke, high blood pressure, atrial fibrillation [a condition characterized by rapid and random contraction of the atria of the heart causing irregular beats of the ventricles and

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resulting in decreased heart output and frequently clot formation in the atria. (1)], heart failure, peripheral vascular disease [any abnormal condition, including atherosclerosis, affecting blood vessels outside the heart. (2)], and presence of prosthetic heart valve.

The most recent MDS (minimum data set) assessment, a Medicare five day assessment, with an assessment reference date of 9/21/18, coded the resident as scoring a "7" on the BIMS (brief interview for mental status) score, indicating he is moderately impaired to made daily cognitive decisions.

Review of the nurse's notes revealed Resident #51 was transferred to the hospital on 9/10/18 at 9:20 a.m. Further review of the clinical record failed to evidence any documentation the residents comprehensive care plan goals were provided to the receiving hospital at the time of transfer on 9/10/18 and 9/21/18.

An interview was conducted with LPN (licensed practical nurse) # 6 on 10/25/18 at 10:28 a.m., regarding what is sent to the hospital when a resident is transferred. LPN #6 stated the following go with the resident: Nursing Home Capabilities List (a list of services the nursing home can provide) Transfer form, Face sheet, Copy of Medication List - updated with changes of new medications, Notice of Transfer and Discharge form, and Care plan. LPN #6 stated the care plan was something new that goes with them (residents). When asked if they keep copies of the Notice of Transfer and Discharge Form, LPN #6 stated, "I would but not sure if it's needed. We also send the bed hold policy." LPN #6 stated there have been changes recently and they have

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instituted an action plan to follow the new regulation. It's new to send the care plan."

The QA (quality assurance) Action Plan was received on 10/25/18 at 11:10 a.m. from ASM (administrative staff member) # 3, the assistant administrator. The Action Plan was dated 9/1/18. Resident #51 was documented on the QA plan as not having the transfer documentation in the clinical record for 9/10/18 transfer to the hospital.

ASM (administrative staff member) #2 (the administrator), ASM #3 (the assistant administrator), ASM #4 (another assistant administrator), ASM #5 (the director of nursing) and ASM #6 (the medical director) were made aware of the above concern on 10/25/18 at 12:41 p.m. ASM #3 the facility did not have any evidence that the comprehensive care plan was sent with the resident upon discharge.

(1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 55.
(2) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 447.

3. The facility staff failed to evidence that all required documentation and information was provided to the receiving provider for a facility-initiated transfer on 09/16/18 for Resident # 52.

Resident # 52 was admitted to the facility on 05/23/18 with diagnoses that included but were not limited to: dysphagia (1), hypertension (2), cerebral infarction (3) and hemiplegia (4).

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Resident # 52's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 09/06/18, coded Resident # 52 as scoring a 7 (seven) on the brief interview for mental status (BIMS) of a score of 0 - 15, 7 (seven) - being severely impaired of cognition for making daily decisions.

The nurse's "Progress Notes" for Resident # 52 dated 09/16/2018 "10:09 a.m. Change in condition noted related to Resident lethargic, unresponsive to tactile and verbal stimuli. Emergency transfer to hospital."

Review of the clinical record for Resident # 52 failed to the evidence required documentation was provided to the receiving facility at the time of Resident # 52's transfer to the hospital on 09/16/2018. There was no evidence, that Resident # 52's contact information of the practitioner responsible for the care of the resident; resident representative information including contact information, Advance Directive information, all special instructions or precautions for ongoing care, as appropriate, comprehensive care plan goals, all other necessary information was sent to the hospital.

On 10/25/18 at 1:45 p.m., an interview was conducted with ASM (administrative staff member) # 3, assistant administrator. When asked to provide documentation that Resident # 52's contact information of the practitioner responsible for the care of the resident, resident representative information including contact information, Advance Directive information, all special instructions or precautions for ongoing care, as appropriate, comprehensive care plan goals, all other necessary information, including a

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copy of the resident's discharge summary was provided to the receiving facility at the time of Resident # 52's transfer to the hospital on 09/16/2018, ASM # 3 stated, "We don't have anything regarding the resident's transfer."

On 10/25/18 at approximately 12:45 p.m., ASM (administrative staff member) # 2, the administrator and ASM # 2, assistant administrator, ASM # 4 assistant administrator, ASM # 5 director of nursing and ASM # 6, medical director were made aware of the findings.

No further information was provided prior to exit.

References:
(1) A swallowing disorder. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/swallowingdisorders.html.

(2) High blood pressure. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/highbloodpressure.html.

(3) A stroke. When blood flow to a part of the brain stops. A stroke is sometimes called a "brain attack." If blood flow is cut off for longer than a few seconds, the brain cannot get nutrients and oxygen. Brain cells can die, causing lasting damage. This information was obtained from the website: https://medlineplus.gov/ency/article/000726.htm .

(4) Also called: Hemiplegia, Palsy, Paraplegia, Quadriplegia. Paralysis is the loss of muscle function in part of your body. It happens when

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something goes wrong with the way messages pass between your brain and muscles. Paralysis can be complete or partial. It can occur on one or both sides of your body. It can also occur in just one area, or it can be widespread This information was obtained from the website: https://medlineplus.gov/paralysis.html.

4. The facility staff failed to evidence that all required documentation and information was provided to the receiving provider for a facility-initiated transfer on 10/14/18 for Resident # 158.

Resident # 158 was admitted to the facility on 06/26/17 with diagnoses that included but were not limited to: heart failure (1), depressive disorder (2), anemia (3) and chronic obstructive pulmonary disease (4).

Resident # 158's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 10/11/18, coded Resident # 158 as scoring a 13 on the brief interview for mental status (BIMS) of a score of 0 - 15, 13 - being cognitively intact for making daily decisions. Resident # 158 was coded as requiring extensive assistance of one staff member for all activities of daily living.

The nurse's "Progress Notes" for Resident # 158 documented, "10/14/2018. 11:20 a.m. Change in condition noted related to Resident complaining of burning at 7:30 a.m. At 10:45 a.m. found to be cool clammy, slow to respond. Transfer to hospital."

Review of the clinical record for Resident # 158, failed to evidence all required documentation was

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provided to the receiving facility at the time of Resident # 158's transfer to the hospital on 10/14/2018. There was no evidence Resident # 158's contact information of the practitioner responsible for the care of the resident, resident representative information including contact information, Advance Directive information, all special instructions or precautions for ongoing care, as appropriate, comprehensive care plan goals, all other necessary information, including a copy of the resident's discharge summary was sent to the hospital.

On 10/25/18 at approximately 12:45 ASM (administrative staff member) # 3, assistant administrator and ASM # 4, assistant administrator, were asked to provide documentation that all required documents were provided to the receiving hospital at the time of Resident #158's transfer to the hospital on 10/14/18. On 10/25/18, at 2:40 p.m., ASM # 4 stated, "We don't have anything regarding the resident's transfer."

On 10/25/18 at approximately 12:45 p.m., ASM (administrative staff member) # 2, the administrator and ASM # 2, assistant administrator, ASM # 4 assistant administrator, ASM # 5 director of nursing and ASM # 6, medical director were made aware of the findings.

No further information was provided prior to exit.

References:
(1) A condition in which the heart is no longer able to pump oxygen-rich blood to the rest of the body efficiently. This causes symptoms to occur throughout the body. This information was

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obtained from the website: https://medlineplus.gov/ency/article/000158.htm.

(2) Depression may be described as feeling sad, blue, unhappy, miserable, or down in the dumps. Most of us feel this way at one time or another for short periods. Clinical depression is a mood disorder in which feelings of sadness, loss, anger, or frustration interfere with everyday life for weeks or more. This information was obtained from the website: https://medlineplus.gov/ency/article/003213.htm.

(3) Low iron. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/anemia.html .

(4) Disease that makes it difficult to breath that can lead to shortness of breath. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/copd.html.
5. The facility staff failed to evidence that the comprehensive care plan goals for Resident #117 were sent to the receiving facility for a hospital transfer on 09/05/18.

Resident #117 was admitted to the facility on 02/24/18. Her diagnoses included Cerebral Vascular Accident (Stroke), Muscle Weakness, Dysphagia (difficulty swallowing), Aphasia (difficulty speaking), and Major Depressive Disorder. The Brief Interview for Mental Status (BIMS) scored Resident #117 at 13, indicating minor impairment. Her most recent Minimum Data Set (MDS) Assessment was a Significant Change Assessment with an Assessment Reference Date (ARD) of 10/04/18.

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A review of Resident #117's record was conducted on 10/24/18. It was noted that Resident #117 was discharged to the hospital on 09/05/18 following a change in condition. A progress note dated 09/05/18 at 11:18 a.m., reads: "911 in at this time to transport resident to [HOSPITAL]. All paperwork given to ambulance driver. Hospital updated on resident condition on arrival. RP made aware. Awaiting return."

While the note describes "paperwork given to ambulance driver", there was no documentation as to what that paperwork contained.

An interview was conducted with LPN (licensed practical nurse) # 6 on 10/25/18 at 10:28 a.m. When asked what paper work is sent to the hospital when a resident is transferred, LPN #6 stated the following go with the resident: Nursing Home Capabilities List (a list of services the nursing home can provide), Transfer form, Face sheet, Copy of Medication List - updated with changes of new medications, Notice of Transfer and Discharge form and Care plan. LPN #6 stated the care plan was something new that goes with them. When asked if the facility keeps copies of the Notice of Transfer and Discharge Form, LPN #6 stated,"I would but not sure if it's needed. We also send the bed hold policy." LPN #6 stated there have been changes recently and they have instituted an action plan to follow the new regulation. It's new to send the care plan."

The Administrator, ASM (administrative staff member) #1 and ASM #2, Director of Nursing were informed of the findings at the end of day meeting on 10/25/18. No further documentation was provided.

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6. The facility staff failed to evidence that the comprehensive care plan goals for Resident #114 were sent to the receiving facility for a hospital transfer on 09/21/18.

Resident #114 was originally admitted to the facility on 01/08/16. His most recent re-admission was 09/25/18. His diagnoses included Sepsis (1), Cerebral Vascular Accident (Stroke), Hemiplegia (weakness on one side of the body), Dysphagia (difficulty swallowing), Aphasia (difficulty speaking), Urinary Tract Infection, Diabetes Mellitus Type II (a condition causing excessive levels of sugar in the blood), Epilepsy (2), Atrial Fibrillation (3), and Heart Failure (4). The most recent MDS (minimum data set) Assessment was a 14-Day Admission Assessment with an ARD (assessment reference date) of 10/09/18. The BIMS scored Resident #114 at 11, indicating moderate impairment.

A Review of Resident #114's record revealed he had been discharged to the hospital on 09/21/18. A progress note dated 09/21/18 at 10:00 p.m.,. reads: "(Name of ambulance company) Ambulance here at this time to take resident to [HOSPITAL] via stretcher for evaluation and treatment. RP (responsible party) aware." There was no documentation of what, if anything, was sent with the resident to the emergency room.

An interview was conducted with LPN (licensed practical nurse) # 6 on 10/25/18 at 10:28 a.m. When asked what paper work is sent to the hospital when a resident is transferred, LPN #6 stated the following go with the resident: Nursing Home Capabilities List (a list of services the nursing home can provide), Transfer form,

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Face sheet, Copy of Medication List - updated with changes of new medications, Notice of Transfer and Discharge form and Care plan. LPN #6 stated the care plan was something new that goes with them. When asked if the facility keeps copies of the Notice of Transfer and Discharge Form, LPN #6 stated,"I would but not sure if it's needed. We also send the bed hold policy." LPN #6 stated there have been changes recently and they have instituted an action plan to follow the new regulation. It's new to send the care plan."

The Administrator, ASM (administrative staff member) #1 and ASM #2, Director of Nursing were informed of the findings at the end of day meeting on 10/25/18. No further documentation was provided.

1. Sepsis is a serious illness. It happens when your body has an overwhelming immune response to a bacterial infection. The chemicals released into the blood to fight the infection trigger widespread inflammation. This leads to blood clots and leaky blood vessels. They cause poor blood flow, which deprives your body's organs of nutrients and oxygen. In severe cases, one or more organs fail. In the worst cases, blood pressure drops and the heart weakens, leading to septic shock. This information was obtained from the website: https://medlineplus.gov/sepsis.html

2. Epilepsy is a brain disorder that causes people to have recurring seizures. The seizures happen when clusters of nerve cells, or neurons, in the brain send out the wrong signals. People may have strange sensations and emotions or behave strangely. They may have violent muscle spasms

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F 622	Continued From page 46 or lose consciousness. - This information was obtained from the website: https://medlineplus.gov/epilepsy.html 3. An arrhythmia is a problem with the speed or rhythm of the heartbeat. Atrial fibrillation (AF) is the most common type of arrhythmia. The cause is a disorder in the heart's electrical system. AF can lead to an increased risk of stroke. In many patients, it can also cause chest pain, heart attack, or heart failure. - This information was obtained from the website: https://medlineplus.gov/atrialfibrillation.html 4. Heart failure is a condition in which the heart can't pump enough blood to meet the body's needs. Heart failure does not mean that your heart has stopped or is about to stop working. It means that your heart is not able to pump blood the way it should. It can affect one or both sides of the heart. The weakening of the heart's pumping ability causes: Blood and fluid to back up into the lungs, The buildup of fluid in the feet, ankles and legs - called edema, Tiredness and shortness of breath. Common causes of heart failure are coronary artery disease, high blood pressure and diabetes. - This information was obtained from the website: https://medlineplus.gov/heartfailure.html 5. Rigors are episodes in which your temperature rises - often quite quickly - whilst you have severe shivering accompanied by a feeling of coldness ('the chills'). The fever may be quite high and the shivering may be quite dramatic. - This information was obtained from the website: https://patient.info/health/rigors-leaflet	F 622		
F 623	Notice Requirements Before Transfer/Discharge	F 623		12/1/18

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F 623 SS=E	Continued From page 47 CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs,	F 623		

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under paragraph (c)(1)(i)(A) of this section; or
(E) A resident has not resided in the facility for 30 days.

§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:
(i) The reason for transfer or discharge;
(ii) The effective date of transfer or discharge;
(iii) The location to which the resident is transferred or discharged;
(iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;
(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;
(vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and
(vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act.

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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 623	Continued From page 49 §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, and clinical record review, it was determined the facility staff failed to provide written notification to the resident and/or resident representative and the ombudsman for a facility initiated transfer for nine of 46 residents in the survey sample, Residents # 73, #51, #52, #158, #117, #114, #83, #108 and #133. 1. The facility staff failed to provide written notification to the resident and/or resident representative and failed to notify the ombudsman for a facility initiated transfer for Resident #73 on 8/6/18. 2. The facility staff failed to provide written notification to the resident and/or resident representative and failed to notify the ombudsman for a facility initiated transfer for Resident #51 on 9/10/18.	F 623	1.Corrective Action Resident #73 returned from the hospital on 8/10/18. Providing written notification to the resident and/or resident representative is no longer applicable. Resident # 51 returned form the hospital on 10/17/18. Providing written notification to the resident and/or resident representative is no longer applicable. Resident #52 returned from the hospital on 9/20/18. Providing written notification to the resident and/or resident representative is no longer applicable. Resident #158 returned from the hospital on the same day that she was sent to the ER, 10/14/18. Providing written	

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F 623	Continued From page 50 3. The facility staff failed to provide Resident # 52 or the resident's representative and the ombudsman written notification when the resident was transferred to the hospital on 09/16/18. 4. The facility staff failed to provide Resident # 158 or the resident's representative and the ombudsman written notification when the resident was transferred to the hospital on 10/14/18. 5. The facility staff failed to evidence documentation of written notification to the ombudsman of a facility initiated transfer to the hospital for Resident #117 on 09/05/18. 6. The facility staff failed to evidence documentation of written notification to the responsible representative and written notification to the ombudsman for Resident #114's facility initiated transfer to the hospital on 09/21/18 7. The facility staff failed to provide evidence that the long-term care ombudsman was notified of Resident #83's facility-initiated hospital transfer on 7/25/18. 8. The facility staff failed to provide evidence that the long term care ombudsman was was notified of Resident #108's facility-initiated hospital transfer on 10/8/18. 9. The facility staff failed to provide evidence that the long-term care ombudsman was notified of Resident #133's facility-initiated hospital transfer on 9/25/18. The findings include:	F 623	notification to the resident and/or resident representative is no longer applicable. Resident #117 returned from the hospital on 9/18/18. Providing written notification to the resident and/or resident representative is no longer applicable. Resident #114 returned from the hospital on 9/25/18. Providing written notification to the resident and/or resident representative is no longer applicable. Resident #83 was discharged home on 10/30/18. Providing written notification to the resident and/or resident representative is no longer applicable. Resident #108 was discharged home on 11/15/18. Providing written notification to the resident and/or resident representative is no longer applicable. Resident #133 was discharged home on 10/26/18. Providing written notification to the resident and/or resident representative is no longer applicable. The Office of the State Long-Term Care Ombudsman was notified of the transfers for Residents #73, #51, #52, #158, #117, #114, #83, #108 and #133 on 11/26/18. Licensed Nurses were re-educated on 10/29/18 on the requirement that the resident or the residents representative must receive written notice of a facility initiated transfer to the hospital.	

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F 623	Continued From page 51 1. The facility staff failed to provide written notification to the resident and/or resident representative and failed to notify the ombudsman for a facility initiated transfer for Resident #73 on 8/6/18. Resident #73 was admitted to the facility on 12/12/97, with recent readmission on 8/10/18, with diagnoses that included but were not limited to: cerebral palsy [loss or deficiency of muscle control due to permanent, nonprogressive brain damage occurring before or at the time of birth. (1)], urinary retention, asthma [respiratory disorder characterized by recurrent episodes of difficulty in breathing, wheezing, cough, and thick mucus production, caused by inflammation of the bronchi. (2)], and respiratory failure with hypoxia [inadequate amount of available oxygen in the blood. (3)]. The most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 9/13/18, coded the resident as being in a persistent vegetative state/no discernable consciousness. The nurse's note dated, 8/6/18 at 11:45 (a.m.) documented in part, "Change in condition noted related to noted audible wheezing, gurgling, SOB (shortness of breath), elevated respirations, elevated temp (temperature). This change in condition started on 08/06/2018. Since this started, it has gotten worse... INTERVENTIONS: Emergency transfer to hospital. No additional recommendations made... Emergency contact person was notified on 08/06/2018 at 12:00 AM (sic)." The physician order dated 8/6/18 documented,	F 623	Facility Social Workers were re-educated on 10/29/18 on the requirement that the ombudsman must receive written notice of a facility initiated transfer to the hospital 2.Other Potential Residents Residents who have been transferred to the hospital have the potential to be affected. A 50% audit was completed on 11/12/18 for all residents that have been sent to the hospital over the past 3 months. For any resident that did not have documentation of written notice of transfer to the resident/resident representative in the clinical record at the time of transfer, the licensed nurse responsible has been counselled. For any resident that did not have documentation that the Office of the State Long-Term Care Ombudsman was notified of the transfer, the notification has been sent. 3. Systemic Changes Documentation will be reviewed weekly x 3 months for all residents' that are transferred to the hospital to validate that written notice was provided to the resident/resident representative at the time of transfer and that notification of the transfer has been made monthly to the Office of the State Long-Term Care Ombudsman. Any areas of non-compliance will be immediately	

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F 623	Continued From page 52 "Send to ER (emergency Room) for eval (evaluation)." Further review of the clinical record failed to evidence the resident or resident representative were provided written notice of the facility initiated transfer on 8/6/18 and that the ombudsman was notified. An interview was conducted with LPN (licensed practical nurse) # 6 on 10/25/18 at 10:28 a.m., regarding what is sent to the hospital when a resident is transferred. LPN #6 stated the following go with the resident: Nursing Home Capabilities List (a list of services the nursing home can provide) Transfer form, Face sheet, Copy of Medication List - updated with changes of new medications, Notice of Transfer and Discharge form, and Care plan. LPN #6 stated the care plan was something new that goes with them (residents). When asked if they keep copies of the Notice of Transfer and Discharge Form, LPN #6 stated, "I would but not sure if it's needed. We also send the bed hold policy." LPN #6 stated there have been changes recently and they have instituted an action plan to follow the new regulation. It's new to send the care plan." On 10/25/18 at 12:13 p.m., an interview was conducted with OSM (other staff member) #3, the social worker. When asked if the long-term care ombudsman was notified of acute transfers to the hospital, OSM # stated, "No, we are not currently notifying the ombudsman for transfers to the hospital. Only for routine discharges." The facility policy, "Transfer and Discharge Notice" documented in part, "Our facility shall provide a resident and/or the resident's representative (sponsor) with a thirty (30) day written notice of an impending transfer or	F 623	corrected and the responsible staff will be counselled. 4. The results of all audits will be forwarded to the QAPI Committee for review and recommendations. 5.Date of compliance 12/1/18	

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discharge. 2. Under the following circumstances, the notice will be given as soon as it is practicable but before the transfer or discharge: a. The transfer is necessary for the resident's welfare and the resident's needs cannot be met in the facility....3. The resident and/or representative will be notified in writing for the following information: a. The reason for the transfer or discharge; b. The effective date of the transfer or discharge; c. The location to which the resident is being transferred or discharged...4. A copy of this notice will be sent to the Office of the State Long-Term Ombudsman."

ASM (administrative staff member) #2 (the administrator), ASM #3 (the assistant administrator), ASM #4 (another assistant administrator), ASM #5 (the director of nursing) and ASM #6 (the medical director) were made aware of the above concern on 10/25/18 at 12:41 p.m.

No further information was provided prior to exit.

(1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 114.
(2) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 51.
(3) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 286.

2. The facility staff failed to provide written notification to the resident and/or resident representative and failed to notify the ombudsman for a facility initiated transfer for Resident #51 on 9/10/18.

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Resident #51 was admitted to the facility on 8/29/18 with a most recent readmission on 9/17/18, with diagnoses that included but were not limited to: stroke, high blood pressure, atrial fibrillation [a condition characterized by rapid and random contraction of the atria of the heart causing irregular beats of the ventricles and resulting in decreased heart output and frequently clot formation in the atria. (1)], heart failure, peripheral vascular disease [any abnormal condition, including atherosclerosis, affecting blood vessels outside the heart. (2)], and presence of prosthetic heart valve.

The most recent MDS (minimum data set) assessment, a Medicare five day assessment, with an assessment reference date of 9/21/18, coded the resident as scoring a "7" on the BIMS (brief interview for mental status) score, indicating he is moderately impaired to made daily cognitive decisions.

The nurse's note dated, 9/10/18 at 9:20 a.m. documented in part, "Change in condition noted related to resident noted to be difficult to arouse, lethargic, bp (blood pressure) 78/43. This change in condition started on 9/10/18...Review and Notifications: (name of resident representative) was notified on 9/10/2018 at 9:15 a.m... Interventions: Emergency transfer to hospital. Emergency medical transportation. Additional recommendations as follows: Np (nurse practitioner) in to assess, 2 liters of oxygen applied via nasal cannula, EMS (emergency medical services) called, resident transferred to (Name of hospital) for evaluation."

The physician order dated, 9/10/18, documented,

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"Resident sent out to (Name of Hospital) for Evaluation." Further review of the clinical record failed to evidence the resident or resident representative were provided written notice of the facility initiated transfer on 9/10/18 and that the ombudsman was notified.

An interview was conducted with LPN (licensed practical nurse) # 6 on 10/25/18 at 10:28 a.m., regarding what is sent to the hospital when a resident is transferred. LPN #6 stated the following go with the resident: Nursing Home Capabilities List (a list of services the nursing home can provide) Transfer form, Face sheet, Copy of Medication List - updated with changes of new medications, Notice of Transfer and Discharge form, and Care plan. LPN #6 stated the care plan was something new that goes with them (residents). When asked if they keep copies of the Notice of Transfer and Discharge Form, LPN #6 stated, "I would but not sure if it's needed. We also send the bed hold policy." LPN #6 stated there have been changes recently and they have instituted an action plan to follow the new regulation. It's new to send the care plan."

On 10/25/18 at 12:13 p.m., an interview was conducted with OSM (other staff member) #3, the social worker. When asked if the long-term care ombudsman was notified of acute transfers to the hospital, OSM # stated, "No, we are not currently notifying the ombudsman for transfers to the hospital. Only for routine discharges."

ASM (administrative staff member) #2 (the administrator), ASM #3 (the assistant administrator), ASM #4 (another assistant administrator), ASM #5 (the director of nursing) and ASM #6 (the medical director) were made

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aware of the above concern on 10/25/18 at 12:41 p.m.

(1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 55.

(2) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 447.
3. The facility staff failed to provide Resident # 52 or the resident's representative and the ombudsman written notification when the resident was transferred to the hospital on 09/16/18.

Resident # 52 was admitted to the facility on 05/23/18 with diagnoses that included but were not limited to: dysphagia (1), hypertension (2), cerebral infarction (3) and hemiplegia (4).

Resident # 52's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 09/06/18, coded Resident # 52 as scoring a 7 (seven) on the brief interview for mental status (BIMS) of a score of 0 - 15, 7 (seven) - being severely impaired of cognition for making daily decisions.

The nurse's "Progress Notes" for Resident # 52 dated 09/16/2018 "10:09 a.m. Change in condition noted related to Resident lethargic, unresponsive to tactile and verbal stimuli. Emergency transfer to hospital." Further review of the record failed to evidence the resident's representative and the ombudsman were provided written notification when the resident was transferred to the hospital on 09/16/18.

On 10/25/18 at 12:11 p.m., an interview was

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conducted with OSM (other staff member) # 3, director of social services. When asked about the notification to the ombudsman regarding Resident # 52 transfer to the hospital transfer on 09/16/18, OSM # 3 stated, "Initially there was confusion of what the fax should include to the ombudsman. We are not currently notifying the ombudsman for transfers to hospital only for routine discharges."

On 10/25/18 at 1:45 p.m., an interview was conducted with ASM (administrative staff member) # 3, assistant administrator. When asked to provide documentation that Resident # 52 and Resident # 52's representative were provided with written notification of Resident # 52's transfer to the hospital on 09/16/2018, ASM # 3 stated, "We don't have anything regarding the resident's transfer."

On 10/25/18 at approximately 12:45 p.m., ASM (administrative staff member) # 2, the administrator and ASM # 2, assistant administrator, ASM # 4 assistant administrator, ASM # 5 director of nursing and ASM # 6, medical director were made aware of the findings.

No further information was provided prior to exit.

References:
(1) A swallowing disorder. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/swallowingdisorders.html.

(2) High blood pressure. This information was obtained from the website:

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https://www.nlm.nih.gov/medlineplus/highbloodpressure.html.

(3) A stroke. When blood flow to a part of the brain stops. A stroke is sometimes called a "brain attack." If blood flow is cut off for longer than a few seconds, the brain cannot get nutrients and oxygen. Brain cells can die, causing lasting damage. This information was obtained from the website: https://medlineplus.gov/ency/article/000726.htm .

(4) Also called: Hemiplegia, Palsy, Paraplegia, Quadriplegia. Paralysis is the loss of muscle function in part of your body. It happens when something goes wrong with the way messages pass between your brain and muscles. Paralysis can be complete or partial. It can occur on one or both sides of your body. It can also occur in just one area, or it can be widespread. This information was obtained from the website: https://medlineplus.gov/paralysis.html.

4. The facility staff failed to provide Resident # 158 or the resident's representative and the ombudsman written notification when the resident was transferred to the hospital on 10/14/18.

Resident # 158 was admitted to the facility on 06/26/17 with diagnoses that included but were not limited to: heart failure (1), depressive disorder (2), anemia (3) and chronic obstructive pulmonary disease (4).

Resident # 158's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 10/11/18, coded Resident # 158 as scoring a 13 on the brief interview for mental status (BIMS) of a score of 0

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- 15, 13 - being cognitively intact for making daily decisions. Resident # 158 was coded as requiring extensive assistance of one staff member for all activities of daily living.

The nurse's "Progress Notes" for Resident # 158 documented, "10/14/2018. 11:20 a.m. Change in condition noted related to Resident complaining of burning at 7:30 a.m. At 10:45 a.m. found to be cool clammy, slow to respond. Transfer to hospital." Further review of the record failed to evidence the resident's representative and the ombudsman were provided written notification when the resident was transferred to the hospital on 10/14/18.

On 10/25/18 at 12:11 p.m., an interview was conducted with OSM (other staff member) # 3, director of social services. When asked about the notification to the ombudsman regarding Resident # 158 transfer to the hospital transfer on 10/14/18 OSM # 3 stated, "Initially there was confusion of what the fax should include to the ombudsman. We are not currently notifying the ombudsman for transfers to hospital only for routine discharges."

On 10/25/18 at 1:45 p.m., an interview was conducted with ASM (administrative staff member) # 3, assistant administrator. When asked to provide documentation that Resident # 158 and Resident # 158's representative were provided with written notification of Resident # 158's transfer to the hospital on 10/14/2018, ASM # 3 stated, "We don't have anything regarding the resident's transfer."

On 10/25/18 at approximately 12:45 p.m., ASM (administrative staff member) # 2, the

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administrator and ASM # 2, assistant administrator, ASM # 4 assistant administrator, ASM # 5 director of nursing and ASM # 6, medical director were made aware of the findings.

No further information was provided prior to exit.

References:
(1) A condition in which the heart is no longer able to pump oxygen-rich blood to the rest of the body efficiently. This causes symptoms to occur throughout the body. This information was obtained from the website: https://medlineplus.gov/ency/article/000158.htm.

(2) Depression may be described as feeling sad, blue, unhappy, miserable, or down in the dumps. Most of us feel this way at one time or another for short periods. Clinical depression is a mood disorder in which feelings of sadness, loss, anger, or frustration interfere with everyday life for weeks or more. This information was obtained from the website: https://medlineplus.gov/ency/article/003213.htm.

(3) Low iron. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/anemia.html .

(4) Disease that makes it difficult to breath that can lead to shortness of breath. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/copd.html.
5. The facility staff failed to evidence documentation of written notification to the ombudsman of a facility initiated transfer to the hospital for Resident #117 on 09/05/18.

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Resident #117 was admitted to the facility on 02/24/18. Her diagnoses included Cerebral Vascular Accident (Stroke), Muscle Weakness, Dysphagia (difficulty swallowing), Aphasia (difficulty speaking), and Major Depressive Disorder. Her most recent Minimum Data Set (MDS) Assessment was a Significant Change Assessment with an Assessment Reference Date (ARD) of 10/04/18. The Brief Interview for Mental Status (BIMS) scored Resident #117 at 13, indicating minor impairment.

A review of Resident #117's record was conducted on 10/24/18. It was noted that Resident #117 was discharged to the hospital on 09/05/18 following a change in condition. A progress note dated 09/05/18 at 11:18 a.m., reads as follows: "911 in at this time to transport resident to [HOSPITAL]. All paperwork given to ambulance driver. Hospital updated on resident condition on arrival. RP made aware. Awaiting return." While the note describes "paperwork given to ambulance driver", there was no documentation evidencing written notification to the ombudsman of a facility-initiated transfer to the hospital for Resident #117 on 09/05/18.

On 10/25/18 at 12:13 p.m., an interview was conducted with OSM (other staff member) #3, the social worker. When asked if the long-term care ombudsman was notified of acute transfers to the hospital, OSM # stated, "No, we are not currently notifying the ombudsman for transfers to the hospital. Only for routine discharges."

The Administrator, ASM (administrative staff member) #1 and ASM #2, Director of Nursing were informed of the findings at the end of day

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meeting on 10/25/18. No further documentation was provided.

6. The facility staff failed to evidence documentation of written notification to the responsible representative and written notification to the ombudsman for Resident #114's facility initiated transfer to the hospital on 09/21/18

Resident #114 was originally admitted to the facility on 01/08/16. His diagnoses included Sepsis (1), Cerebral Vascular Accident (Stroke), Hemiplegia (weakness on one side of the body), Dysphagia (difficulty swallowing), Aphasia (difficulty speaking), Urinary Tract Infection, Diabetes Mellitus Type II (a condition causing excessive levels of sugar in the blood), Epilepsy (2), Atrial Fibrillation (3), and Heart Failure (4). His most recent re-admission was 09/25/18. His most recent MDS Assessment was a 14-Day Admission Assessment with an ARD of 10/09/18. The BIMS (brief interview for mental status) scored Resident #114 at 11, indicating moderate impairment.

A Review of Resident #114's record revealed he had been discharged to the hospital on 09/21/18. A progress note dated 09/21/18 at 10:00 p.m. reads: "(Name of ambulance company) Ambulance here at this time to take Resident to [HOSPITAL] via stretcher for evaluation and treatment. RP (responsible party) aware." There was no documentation of what, if anything was sent with the resident to the emergency room. There was no documentation of written notice being given to the responsible representative or that the ombudsman was notified of this facility initiated transfer to the hospital.

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On 10/25/18 at 12:13 p.m., an interview was conducted with OSM (other staff member) #3, the social worker. When asked if the long-term care ombudsman was notified of acute transfers to the hospital, OSM # stated, "No, we are not currently notifying the ombudsman for transfers to the hospital. Only for routine discharges."

The Administrator, ASM (administrative staff member) #1 and ASM #2, Director of Nursing were informed of the findings at the end of day meeting on 10/25/18. No further documentation was provided.

1. Sepsis is a serious illness. It happens when your body has an overwhelming immune response to a bacterial infection. The chemicals released into the blood to fight the infection trigger widespread inflammation. This leads to blood clots and leaky blood vessels. They cause poor blood flow, which deprives your body's organs of nutrients and oxygen. In severe cases, one or more organs fail. In the worst cases, blood pressure drops and the heart weakens, leading to septic shock. This information was obtained from the website: https://medlineplus.gov/sepsis.html

2. Epilepsy is a brain disorder that causes people to have recurring seizures. The seizures happen when clusters of nerve cells, or neurons, in the brain send out the wrong signals. People may have strange sensations and emotions or behave strangely. They may have violent muscle spasms or lose consciousness. - This information was obtained from the website: https://medlineplus.gov/epilepsy.html

3. An arrhythmia is a problem with the speed or

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rhythm of the heartbeat. Atrial fibrillation (AF) is the most common type of arrhythmia. The cause is a disorder in the heart's electrical system. AF can lead to an increased risk of stroke. In many patients, it can also cause chest pain, heart attack, or heart failure. - This information was obtained from the website: https://medlineplus.gov/atrialfibrillation.html

4. Heart failure is a condition in which the heart can't pump enough blood to meet the body's needs. Heart failure does not mean that your heart has stopped or is about to stop working. It means that your heart is not able to pump blood the way it should. It can affect one or both sides of the heart. The weakening of the heart's pumping ability causes: Blood and fluid to back up into the lungs, The buildup of fluid in the feet, ankles and legs - called edema, Tiredness and shortness of breath. Common causes of heart failure are coronary artery disease, high blood pressure and diabetes. - This information was obtained from the website: https://medlineplus.gov/heartfailure.html

5. Rigors are episodes in which your temperature rises - often quite quickly - whilst you have severe shivering accompanied by a feeling of coldness ('the chills'). The fever may be quite high and the shivering may be quite dramatic. - This information was obtained from the website: https://patient.info/health/rigors-leaflet
7. The facility staff failed to provide evidence that the long-term care ombudsman was notified of Resident #83's facility-initiated hospital transfer on 7/25/18.

Resident #83 was admitted to the facility on 11/28/17 and readmitted on 7/27/18 with

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diagnoses that included but were not limited to end stage renal disease, heart failure, high blood pressure, fracture of her right lower leg, and muscle weakness. Resident #83's most recent MDS (Minimum data set) assessment was a quarterly assessment with an ARD (assessment reference date) of 10/22/18. Resident #83 was coded as being intact in cognitive function scoring 13 out of possible 15 on the BIMS (Brief Interview for Mental Status) exam.

Review of Resident #83's clinical record revealed that she had been transferred to the hospital on 7/25/18. The following note was written: "Writer notified by therapy resident has a high temp (temperature). Writer assessed temp. (temperature) 102.1 PRN (as needed) Tylenol (1) given then increase 103.1 o2 (oxygen level) 84 % increased to 86 with 2 L (liters) applied. Writer notified MD (medical doctor) office and spoke to (Name of RN (registered nurse) (sic) send out 911 per request (Name of hospital) for eval. (evaluation). RP (responsible party) aware. Will continue to monitor."

Facility staff were able to present documents that were sent with Resident #83 at the time of the transfer, including written notification to the Responsible party.

Further review of the clinical record failed to evidence that written notification was provided to the long-term care ombudsman.

On 10/25/18 at 10:54 a.m., an interview was conducted with LPN (licensed practical nurse) #5. When asked who was notified when a resident was sent out to the hospital, LPN # stated that RP (responsible party) and the medical doctor were

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made aware. When asked if nursing notified the long term care ombudsman for a transfer to the hospital, LPN # stated that nursing did not notify the long-term care ombudsman.

On 10/25/18 at 12:13 p.m., an interview was conducted with OSM (other staff member) #3, the social worker. When asked if the long-term care ombudsman was notified of acute transfers to the hospital, OSM # stated, "No, we are not currently notifying the ombudsman for transfers to the hospital. Only for routine discharges."

On 10/25/18 at 12:47 p.m., ASM (administrative staff member) #1, the senior administrator, ASM #2, the administrator, ASM #3, the assistant administrator, ASM #4, the other assistant administrator, ASM #5, the DON (Director of Nursing) and ASM #4, the medical director were all made aware of the above concerns.

No further information was presented prior to exit.

(1) Tylenol Tablet 325 mg (Acetaminophen): Treats minor aches and pains and also reduces fever. This information was obtained from The National Institutes of Health. https://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0008785/?report=details.

8. The facility staff failed to provide evidence that the long-term care ombudsman was notified of Resident #108's facility-initiated hospital transfer on 10/8/18.

Resident #108 was admitted to the facility on 9/28/18 and readmitted on 10/17/18 with diagnoses that included but were not limited to

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acute and chronic respiratory failure with hypoxia, heart failure, chronic obstructive pulmonary disease, anemia, muscle weakness, and type two diabetes mellitus. Resident #108's comprehensive MDS (minimum data set) assessment had not yet been completed. Resident #108 was documented in the nursing notes as being alert and oriented x3 (person, place, time).

Review of Resident #108's nursing notes revealed that she had an acute care facility initiated transfer on 10/8/18. The following nursing note was documented at 11:16 a.m.: Change in condition noted related to 02 sats (saturation) noted at 59 percent on continuous oxygen via nasal cannula at 4 lpm (liters per minute). NP (nurse practitioner) made aware. Resident placed on 02 at 15 lpm via non-rebreather mask, sats ranging from 85-92...Interventions: Emergency transfer to hospital. Emergency medical transportation."

The next note dated 10/8/18 at 11:30 a.m.: "EMS (emergency medical services) arrived to facility to transport Resident to (Name of hospital) hospital, detailed report given to EMS per NP and all necessary documents sent with EMS, H&P (history and physical), bed hold, transfer form, progress notes, medication list, SBAR (situation, background, assessment, recommendation), recent labs (laboratory tests)/x rays, and care plan."

Facility staff were able to present documents that were sent with Resident #83 at the time of the transfer, including written notification to the Responsible party and written bed hold notification.

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Further review of the clinical record failed to evidence that written notification was provided to the long-term care ombudsman.

On 10/25/18 at 10:54 a.m., an interview was conducted with LPN (licensed practical nurse) #5. When asked who was notified when a resident was sent out to the hospital, LPN # stated that RP (responsible party) and the medical doctor were made aware. When asked if nursing notified the long term care ombudsman for a transfer to the hospital, LPN # stated that nursing did not notify the long-term care ombudsman.

On 10/25/18 at 12:13 p.m., an interview was conducted with OSM (other staff member) #3, the social worker. When asked if the long-term care ombudsman was notified of acute transfers to the hospital, OSM # stated, "No, we are not currently notifying the ombudsman for transfers to the hospital. Only for routine discharges."

On 10/25/18 at 12:47 p.m., ASM (administrative staff member) #1, the senior administrator, ASM #2, the administrator, ASM #3, the assistant administrator, ASM #4, the other assistant administrator, ASM #5, the DON (Director of Nursing) and ASM #4, the medical director were all made aware of the above concerns.

No further information was presented prior to exit.

9. The facility staff failed to provide evidence that the long-term care ombudsman was notified of Resident #133's facility-initiated hospital transfer on 9/25/18.

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Resident #133 was admitted to the facility on 9/24/18 and readmitted on 9/28/18 with diagnoses that included but were not limited to muscle weakness, pneumonia, hypothyroidism, high blood pressure, muscle weakness, and repeated falls. Resident #133 did not have a complete MDS assessment but was documented in the nursing notes as being alert and oriented x3 (person, place, time).

Review of Resident #133's nursing notes revealed that she had been transferred to the hospital on 9/25/18. The following note was documented: "New Order to send resident out to (Name of hospital) for further eval (evaluation) r/t (related to) increased confusion, increased respiratory rate, decreased sp02 (oxygen saturation). per (sic) NP (nurse practitioner) (Name of NP). RP (responsible party) aware noted at bedside."

The next noted dated 9/25/18 at 6:31 p.m. documented the following: "Report called to ER (emergency room) nurse (Name of ER nurse). Resident left building at approx. (approximately) 630 pm (sic) The following information was given/sent with the resident to the hospital: SBAR (situation, background, H &P (History and Physical), Physicians (sic) orders and progress notes, Bed (sic) Hold (sic) policy, Transfer (sic) notice and copy of care plan. RP noted at side."

Facility staff were able to present documents that were sent with Resident #83 at the time of the transfer, including written notification to the Responsible party.

Further review of the clinical record failed to evidence that written notification was provided to

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F 623	Continued From page 70 the long-term care ombudsman. On 10/25/18 at 10:54 a.m., an interview was conducted with LPN (licensed practical nurse) #5. When asked who was notified when a resident was sent out to the hospital, LPN # stated that RP (responsible party) and the medical doctor were made aware. When asked if nursing notified the long term care ombudsman for a transfer to the hospital, LPN # stated that nursing did not notify the long-term care ombudsman. On 10/25/18 at 12:13 p.m., an interview was conducted with OSM (other staff member) #3, the social worker. When asked if the long-term care ombudsman was notified of acute transfers to the hospital, OSM # stated, "No, we are not currently notifying the ombudsman for transfers to the hospital. Only for routine discharges." On 10/25/18 at 12:47 p.m., ASM #1, the senior administrator, ASM #2, the administrator, ASM #3, the assistant administrator, ASM #4, the other assistant administrator, ASM #5, the DON (Director of Nursing) and ASM #4, the medical director were all made aware of the above concerns. No further information was presented prior to exit.	F 623		
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	F 625		12/1/18

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F 625	Continued From page 71 the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, it was determined the facility staff failed to evidence that the resident and/or resident representative was provided with a written bed hold policy upon transfer for five of 46 residents in the survey sample, Residents #51, #52, #158, #117, and #114. 1. The facility staff failed to evidence a written bed hold policy was provided to the resident and/or resident representative for a facility initiated transfer pf Resident # 51 on 9/10/18. 2. The facility staff failed to provide Resident # 52 or the resident's representative written notification	F 625	1. Corrective Action Resident # 51 returned form the hospital on 10/17/18. Providing the resident and/or resident representative with a written bed hold policy upon transfer is no longer applicable Resident # 52 returned from the hospital on 9/20/18. Providing the resident and/or resident representative with a written bed hold policy upon transfer is no longer applicable	

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F 625	Continued From page 72 of the bed hold policy when the resident was transferred to the hospital on 09/16/18. 3. The facility staff failed to provide Resident # 158 or the resident's representative written notification of the bed hold policy when the resident was transferred to the hospital on 10/14/18. 4. The facility staff failed to evidence that written bed hold notification was provided to the resident representative for a hospital transfer pf Resident #117 on 09/05/18. 5. The facility staff failed to evidence that written bed hold notification was provided to the resident representative for a facility initiated hospital transfer of Resident #114 on 09/21/18. The findings include: 1. The facility staff failed to evidence a written bed hold policy was provided to the resident and/or resident representative for a facility initiated transfer pf Resident # 51 on 9/10/18. Resident #73 was admitted to the facility on 12/12/97, with recent readmission on 8/10/18, with diagnoses that included but were not limited to: cerebral palsy [loss or deficiency of muscle control due to permanent, nonprogressive brain damage occurring before or at the time of birth. (1)], urinary retention, asthma [respiratory disorder characterized by recurrent episodes of difficulty in breathing, wheezing, cough, and thick mucus production, caused by inflammation of the bronchi. (2)], and respiratory failure with hypoxia [inadequate amount of available oxygen in the blood. (3)].	F 625	Resident # 158 returned from the hospital on the same day that she was sent to the ER, 10/14/18. Providing the resident and/or resident representative with a written bed hold policy upon transfer is no longer applicable Resident # 117 returned from the hospital on 9/18/18. Providing the resident and/or resident representative with a written bed hold policy upon transfer is no longer applicable Resident # 114 returned from the hospital on 9/25/18. Providing the resident and/or resident representative with a written bed hold policy upon transfer is no longer applicable Licensed Nurses were re-educated on 10/29/18 on the requirement to provide written notification of the Bed Hold policy at the time of transfer to the hospital. 2. Other Potential Residents Residents who have been transferred to the hospital have the potential to be affected. A 50% audit was completed on 10/29/18 for all residents that have been sent to the hospital over the past 3 months. For any resident that did not have documentation of written notice of bed hold policy to the resident/resident representative in the clinical record at the time of transfer, the licensed nurse responsible has been counselled.	

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F 625	Continued From page 73 The most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 9/13/18, coded the resident as being in a persistent vegetative state/no discernable consciousness. The nurse's note dated, 8/6/18 at 11:45 (a.m.) documented in part, "Change in condition noted related to noted audible wheezing, gurgling, SOB (shortness of breath), elevated respirations, elevated temp (temperature). This change in condition started on 08/06/2018. Since this started, it has gotten worse... INTERVENTIONS: Emergency transfer to hospital. No additional recommendations made... Emergency contact person was notified on 08/06/2018 at 12:00 AM (sic)." The physician order dated 8/6/18 documented, "Send to ER (emergency Room) for eval (evaluation)." Further review of the clinical record failed to evidence the resident or resident representative were provided a bed hold policy at the time of transfer on 8/6/18. An interview was conducted with LPN (licensed practical nurse) # 6 on 10/25/18 at 10:28 a.m., regarding what is sent to the hospital when a resident is transferred. LPN #6 stated the following go with the resident: Nursing Home Capabilities List (a list of services the nursing home can provide) Transfer form, Face sheet, Copy of Medication List - updated with changes of new medications, Notice of Transfer and Discharge form, and Care plan. LPN #6 stated the care plan was something new that goes with them (residents). When asked if they keep copies of the Notice of Transfer and Discharge Form,	F 625	3. Systemic Changes Documentation will be reviewed weekly x 3 months for all residents' that are transferred to the hospital to validate that written notice of the bed hold policy was provided to the resident/resident representative at the time of transfer . Any areas of non-compliance will be immediately corrected and the responsible staff will be counselled. 4.Monitoring The results of all audits will be forwarded to the QAPI Committee for review and recommendations. 5.Date of compliance 12/1/18 4. The results of all audits will be forwarded to the QAPI Committee for review and recommendations. 5.Date of compliance 12/1/18	

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LPN #6 stated, "I would but not sure if it's needed. We also send the bed hold policy."

The facility policy, "Transfer or Discharge Notice" documented in part, "3. The resident and/or representative will be notified in writing of the following information: e. The facility bed-hold policy."

The "QA (quality assurance) Action Plan was received on 10/25/18 at 11:10 a.m. from ASM (administrative staff member) # 3, the assistant administrator. The Action Plan was dated 9/1/18. The Action Plan documented in part, "Factors identified in root cause analysis of this issue - Through chart review it was noted that residents' did not have complete documentation of all paperwork that was sent with or given to resident when being transferred to the hospital for evaluation. Actions planned: Licensed Nurses will be Re-educated on the importance of accurate documentation of all documents that are sent with resident to the hospital including but not limited to POS (physician order summary), Capabilities List, transfer form with reason for transfer, bed hold policy and care plan."

ASM (administrative staff member) #2 (the administrator), ASM #3 (the assistant administrator), ASM #4 (another assistant administrator), ASM #5 (the director of nursing) and ASM #6 (the medical director) were made aware of the above concern on 10/25/18 at 12:41 p.m. No further information was provided by completion of the survey.

(1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 55.

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(2) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 447.
2. The facility staff failed to provide Resident # 52 or the resident's representative written notification of the bed hold policy when the resident was transferred to the hospital on 09/16/18.

Resident # 52 was admitted to the facility on 05/23/18 with diagnoses that included but were not limited to: dysphagia (1), hypertension (2), cerebral infarction (3) and hemiplegia (4).
Resident # 52's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 09/06/18, coded Resident # 52 as scoring a 7 (seven) on the brief interview for mental status (BIMS) of a score of 0 - 15, 7 (seven) - being severely impaired of cognition for making daily decisions.

The nurse's "Progress Notes" for Resident # 52 dated 09/16/2018 "10:09 a.m. Change in condition noted related to Resident lethargic, unresponsive to tactile and verbal stimuli. Emergency transfer to hospital."

On 10/25/18 at 1:45 p.m., an interview was conducted with ASM (administrative staff member) # 3, assistant administrator. When asked to provide documentation that Resident # 52 or that Resident # 52's representative received written notification of the bed hold policy when the resident was transferred to the hospital on 09/16/18, ASM # 3 stated, "We don't have anything regarding the resident's transfer."

On 10/25/18 at approximately 12:45 p.m., ASM (administrative staff member) # 2, the administrator and ASM # 2, assistant

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administrator, ASM # 4 assistant administrator, ASM # 5 director of nursing and ASM # 6, medical director were made aware of the findings.

No further information was provided prior to exit.

References:
(1) A swallowing disorder. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/swallowingdisorders.html.

(2) High blood pressure. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/highbloodpressure.html.

(3) A stroke. When blood flow to a part of the brain stops. A stroke is sometimes called a "brain attack." If blood flow is cut off for longer than a few seconds, the brain cannot get nutrients and oxygen. Brain cells can die, causing lasting damage. This information was obtained from the website: https://medlineplus.gov/ency/article/000726.htm .

(4) Also called: Hemiplegia, Palsy, Paraplegia, Quadriplegia. Paralysis is the loss of muscle function in part of your body. It happens when something goes wrong with the way messages pass between your brain and muscles. Paralysis can be complete or partial. It can occur on one or both sides of your body. It can also occur in just one area, or it can be widespread This information was obtained from the website: https://medlineplus.gov/paralysis.html.

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3. The facility staff failed to provide Resident # 158 or the resident's representative written notification of the bed hold policy when the resident was transferred to the hospital on 10/14/18.

Resident # 158 was admitted to the facility on 06/26/17 with diagnoses that included but were not limited to: heart failure (1), depressive disorder (2), anemia (3) and chronic obstructive pulmonary disease (4). Resident # 158's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 10/11/18, coded Resident # 158 as scoring a 13 on the brief interview for mental status (BIMS) of a score of 0 - 15, 13 - being cognitively intact for making daily decisions.

The nurse's "Progress Notes" for Resident # 158 documented, "10/14/2018. 11:20 a.m. Change in condition noted related to Resident complaining of burning at 7:30 a.m. At 10:45 a.m. found to be cool clammy, slow to respond. Transfer to hospital."

On 10/25/18 at 1:45 p.m., an interview was conducted with ASM (administrative staff member) # 3, assistant administrator. When asked to provide documentation that Resident # 158 or that Resident # 158's representative received written notification of the bed hold policy when the resident was transferred to the hospital on 10/14/18, ASM # 3 stated, "We don't have anything regarding the resident's transfer."

On 10/25/18 at approximately 12:45 p.m., ASM (administrative staff member) # 2, the administrator and ASM # 2, assistant administrator, ASM # 4 assistant administrator,

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ASM # 5 director of nursing and ASM # 6, medical director were made aware of the findings.

No further information was provided prior to exit.

References:
(1) A condition in which the heart is no longer able to pump oxygen-rich blood to the rest of the body efficiently. This causes symptoms to occur throughout the body. This information was obtained from the website: https://medlineplus.gov/ency/article/000158.htm.

(2) Depression may be described as feeling sad, blue, unhappy, miserable, or down in the dumps. Most of us feel this way at one time or another for short periods. Clinical depression is a mood disorder in which feelings of sadness, loss, anger, or frustration interfere with everyday life for weeks or more. This information was obtained from the website: https://medlineplus.gov/ency/article/003213.htm.

(3) Low iron. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/anemia.html .

(4) Disease that makes it difficult to breath that can lead to shortness of breath. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/copd.html.
4. The facility staff failed to evidence that written bed hold notification was provided to the resident representative for a hospital transfer pf Resident #117 on 09/05/18.

Resident #117 was admitted to the facility on

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02/24/18. Her diagnoses included Cerebral Vascular Accident (Stroke), Muscle Weakness, Dysphagia (difficulty swallowing), Aphasia (difficulty speaking), and Major Depressive Disorder. Her most recent Minimum Data Set (MDS) Assessment was a Significant Change Assessment with an Assessment Reference Date (ARD) of 10/04/18. The Brief Interview for Mental Status (BIMS) scored Resident #117 at 13, indicating minor impairment.

A review of Resident #117's record was conducted on 10/24/18. It was noted that Resident #117 was discharged to the hospital on 09/05/18 following a change in condition. A progress note dated 09/05/18 at 11:18a.m., reads as follows: "911 in at this time to transport resident to [HOSPITAL]. All paperwork given to ambulance driver. Hospital updated on resident condition on arrival." While the note describes "paperwork given to ambulance driver", there was no documentation as to what that paperwork contained.

An interview was conducted with LPN (licensed practical nurse) # 6 on 10/25/18 at 10:28 a.m. When asked if they keep copies of the Notice of Transfer and Discharge Form, LPN #6 stated, "I would but not sure if it's needed. We also send the bed hold policy."

The Administrator, ASM (administrative staff member) #1 and Director of Nursing, ASM #2 were informed of the findings at the End of Day Meeting on 10/25/18. When asked if they could provide this surveyor with documentation requested, including proof of the bed hold policy being sent on hospital discharges, the Administrator, ASM #1 stated no.

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5. The facility staff failed to evidence that written bed hold notification was provided to the resident representative for a facility initiated hospital transfer of Resident #114 on 09/21/18.

Resident #114 was originally admitted to the facility on 01/08/16. His most recent re-admission was 09/25/18. His diagnoses included Sepsis (1), Cerebral Vascular Accident (Stroke), Hemiplegia (weakness on one side of the body), Dysphagia (difficulty swallowing), Aphasia (difficulty speaking), Urinary Tract Infection, Diabetes Mellitus Type II (a condition causing excessive levels of sugar in the blood), Epilepsy (2), Atrial Fibrillation (3), and Heart Failure (4). The most recent MDS (minimum data set) Assessment was a 14-Day Admission Assessment with an ARD (assessment reference date) of 10/09/18. The BIMS scored Resident #114 at 11, indicating moderate impairment.

A Review of Resident #114's record revealed he had been discharged to the hospital on 09/21/18. A progress note dated 09/21/18 at 10:00p.m. reads: "(Name of ambulance company) Ambulance here at this time to take resident to [HOSPITAL] via stretcher for evaluation and treatment. RP(responsible party) aware." There was no documentation of what, if anything, was sent with the resident to the emergency room.

An interview was conducted with LPN (licensed practical nurse) # 6 on 10/25/18 at 10:28 a.m. When asked if they keep copies of the Notice of Transfer and Discharge Form, LPN #6 stated, "I would but not sure if it's needed. We also send the bed hold policy."

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The facility staff were unable to provide any documentation to evidence that the bed hold policy was provided to the Resident or Responsible Party.

The Administrator, ASM (administrative staff member) #1 and Director of Nursing, ASM #2 were informed of the findings at the End of Day Meeting on 10/25/18. When asked if they could provide this surveyor with documentation requested, including proof of the bed hold policy being sent on hospital discharge with residents, the Administrator, ASM #1 stated no.

1. Sepsis is a serious illness. It happens when your body has an overwhelming immune response to a bacterial infection. The chemicals released into the blood to fight the infection trigger widespread inflammation. This leads to blood clots and leaky blood vessels. They cause poor blood flow, which deprives your body's organs of nutrients and oxygen. In severe cases, one or more organs fail. In the worst cases, blood pressure drops and the heart weakens, leading to septic shock. https://medlineplus.gov/sepsis.html

2. Epilepsy is a brain disorder that causes people to have recurring seizures. The seizures happen when clusters of nerve cells, or neurons, in the brain send out the wrong signals. People may have strange sensations and emotions or behave strangely. They may have violent muscle spasms or lose consciousness. - https://medlineplus.gov/epilepsy.html

3. An arrhythmia is a problem with the speed or rhythm of the heartbeat. Atrial fibrillation (AF) is the most common type of arrhythmia. The cause is a disorder in the heart's electrical system. AF

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F 625	Continued From page 82 can lead to an increased risk of stroke. In many patients, it can also cause chest pain, heart attack, or heart failure. - https://medlineplus.gov/atrialfibrillation.html 4. Heart failure is a condition in which the heart can't pump enough blood to meet the body's needs. Heart failure does not mean that your heart has stopped or is about to stop working. It means that your heart is not able to pump blood the way it should. It can affect one or both sides of the heart. The weakening of the heart's pumping ability causes: Blood and fluid to back up into the lungs, The buildup of fluid in the feet, ankles and legs - called edema, Tiredness and shortness of breath. Common causes of heart failure are coronary artery disease, high blood pressure and diabetes. - https://medlineplus.gov/heartfailure.html 5. Rigors are episodes in which your temperature rises - often quite quickly - whilst you have severe shivering accompanied by a feeling of coldness ('the chills'). The fever may be quite high and the shivering may be quite dramatic. - https://patient.info/health/rigors-leaflet	F 625		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive	F 656		12/1/18

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F 656	Continued From page 83 assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review and clinical record review, it was determined that the facility staff failed to implement the comprehensive care plan for three of 46 residents in the survey sample, Resident # 42, # 46, and # 73.	F 656	1. Corrective Action Nursing and Activity Staff were re-educated on 10/29/18 on the importance of knowing and following the residents care plan. The care plan for	

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F 656	Continued From page 84 1. The facility staff failed to implement the communication care plan for Resident # 42. 2. The facility staff failed to implement the activities care plan for Resident # 46. 3. The facility staff failed to implement the care plan for the administration of oxygen for Resident #73. The findings include: 1. The facility staff failed to implement the communication care plan for Resident # 42. Resident # 42 was admitted to the facility on 11/03/15 with diagnoses that included but were not limited to: vision loss, both eyes, hearing loss, heart failure (1), dysphagia (2), hemiplegia (3) and cerebrovascular disease (4). Resident # 42's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 08/23/18, coded Resident # 42 as scoring a 5 (five) on the brief interview for mental status (BIMS) of a score of 0 - 15, 5 (five) - being severely impaired of cognition for making daily decisions. Resident # 42 was coded as requiring extensive assistance of one staff member for locomotion, eating, toilet use and bed mobility and being totally dependent of one staff member for dressing, personal hygiene and bathing. Section B "Hearing, Speech and Vision" coded Resident # 42 as "B0200 Hearing: 2 (two) - Moderate difficulty, B1000 Vision: 4 (four) - Severely impaired - no vision or sees only light, colors or shapes, eyes do not appear to follow objects."	F 656	Residents # 42, # 73 and # 46 specifically have also been reviewed with the staff. 2.Other Potential Residents Residents that have a care plan that addresses communication problems, oxygen therapy and an activities care plan that they enjoy watching TV have the potential to be affected. An audit was completed on 11/9/18 for a random sample of these residents to validate that staff are familiar with and following the residents plan of care. Any areas of non-compliance has been corrected and the appropriate staff have been counselled. 3. Systemic Changes A 25% audit of care plans/observations for residents that have a care plan that addresses communication problems, oxygen therapy and an activities care plan that they enjoy watching TV will be completed weekly x 3 months to validate that staff are familiar with and following the residents plan of care. Any areas of non-compliance will be immediately corrected and the appropriate staff will be counselled. 4. Monitoring The results of all audits will be forwarded to the QAPI Committee for review and recommendations. 5.Date of compliance	

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F 656	Continued From page 85 On 10/24/18 at 9:07 a.m., an observation of resident # 42's room revealed CNA (certified nursing assistant) # 3 entered Resident # 42's room. CNA # 3 was observed speaking to Resident # 42 on the resident's right side. CNA # 3 set up the Resident # 42's breakfast tray on the over-the-bed table, sat in a chair on the right side of Resident # 42 and assisted her with breakfast from the resident's right side. CNA # 3 was observed speaking to Resident # 42 from her right side throughout the meal. Resident # 42 was sitting up in bed. During the observation, a second staff member CNA # 6 entered Resident # 42's room during the meal, stood at the right side of the bed and spoke to the resident. CNA # 6 was observed repeating her statement/questions to Resident # 42 and raising her volume until the resident heard her and answered. On 10/24/18 at approximately 9:07 a.m., an observation of Resident # 42's room revealed a sign posted above the head of the bed that documented, (Name of Resident) is completely blind and deaf in the right ear." On 10/24/18 at 5:50 p.m., an observation of Resident # 42 revealed she was lying in bed with headphones on. CNA # 4 entered the room and closed the door to provide personal care to Resident # 42. At 6:00 p.m., an interview was conducted with CNA # 4 when she finished providing care. When asked about Resident # 42's hearing CNA # 4 stated, "She's hard of hearing but she hears you pretty good. I take off her head set and tell her what I'm going to do. Sometimes I have to speak up or I get close to her ear." When asked which ear she speaks into,	F 656	12/1/18	

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CNA # 4 stated, "He right side."

On 10/25/18 at 8:55 a.m., a staff member on the right side of the bed was assisting Resident # 42 with breakfast. The staff member was observed speaking to Resident # 42 on her right side.

The POS (physician's order sheet) dated 10/01/2018 thru 10/31/2018 for Resident # 42 documented, "Diagnosis: Deaf in right ear."

The comprehensive care plan for Resident # 42 with a target date of 11/21/2018 documented, "Focus: Difficulty communicating related to hearing loss/deafness rt (right) ear. Need to talk directly into left ear." Under "Interventions/Tasks" it documented, "Remind staff to speak slower/louder into left ear. Revision on 01/23/2018."

Interview 10/25/18 09:02 a.m., an interview was conducted with CNA # 3. When asked if Resident # 42 had any hearing restrictions, CNA # 3 stated, "(Resident # 42) is blind and can't hear in her right ear." When asked if Resident # 42 had any specific approaches to be taken when speaking with her, CNA # 3 stated, "When we are working with her explain what I'm going to do before I do it. We talk loud so she can hear and talk into the left ear." After CNA #3 was informed of the observation on 10/24/18 during breakfast, CNA # 3 stated, "We talk loud enough so she can hear and there isn't enough room on the left side of her bed for a chair." When asked if there was a plan for Resident # 42 that outlined an approach to speak to her, CNA # 3 stated, "I'm not aware of any plan as to how to speak to her." When asked if she had access to Resident # 42's care plan, CNA # 3 stated, "We have access to

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the care plan on the electronic kiosk that tells us how to take care of the resident." The communication care plan for Resident # 42 was reviewed on the kiosk with CNA # 3. When asked to read the communication care plan, CNA # 3 stated, "To speak into the left ear." When asked if she was following Resident # 42's care plan for speaking into her left ear, CNA # 3 stated, "No not completely." When asked to describe the purpose of the care plan, CNA # 3 stated, "To know how to care for the resident and ensure you give them the proper care." When asked if interventions documented on the care plan should be followed, CNA # 3 stated, "Yes."

On 10/25/18 at 9:43 a.m., an interview was conducted with LPN (licensed practical nurse) # 9, unit manager. When asked what type of sensory deficits Resident # 42 had, LPN # 9 stated, "Her sensory deficits are that she is blind hard of hearing." When informed of the observation of the sign in the room and of the staff speaking to Resident # 42's right ear, LPN # 9 stated, "I mean partially deaf, deaf in right ear." When asked if there was a strategy for staff to use when communicating with the resident, LPN # 9 stated, "They should be speaking into her left side." After reviewing Resident # 42's communication care plan, LPN # 9 was asked if they were following the communication care plan for Resident # 42. LPN # 9 stated, "No."

The facility's policy "Comprehensive Assessments and the Care Delivery Process" documented, "Decision making leading to a person-centered plan of care includes: Selecting and implementing interventions."

On 10/25/18 at approximately 12:45 p.m., ASM

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(administrative staff member) # 2, the administrator and ASM # 2, assistant administrator, ASM # 4 assistant administrator, ASM # 5 director of nursing and ASM # 6, medical director were made aware of the findings.

No further information was provided prior to exit.

References:
(1) A condition in which the heart is no longer able to pump oxygen-rich blood to the rest of the body efficiently. This causes symptoms to occur throughout the body. This information was obtained from the website: https://medlineplus.gov/ency/article/000158.htm.

(2) A swallowing disorder. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/swallowingdisorders.html.

(3) Also called: Hemiplegia, Palsy, Paraplegia, Quadriplegia. Paralysis is the loss of muscle function in part of your body. It happens when something goes wrong with the way messages pass between your brain and muscles. Paralysis can be complete or partial. It can occur on one or both sides of your body. It can also occur in just one area, or it can be widespread. This information was obtained from the website: https://medlineplus.gov/paralysis.html.

(4) A stroke. When blood flow to a part of the brain stops. A stroke is sometimes called a "brain attack." If blood flow is cut off for longer than a few seconds, the brain cannot get nutrients and oxygen. Brain cells can die, causing lasting damage. This information was obtained from the

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website:
https://medlineplus.gov/ency/article/000726.htm .

2. The facility staff failed to implement the activities care plan for Resident # 46.

Resident # 46 was admitted to the facility on 10/31/16 with diagnoses that included but were not limited to: dementia (1), dysphagia (2), anemia (3) and spinal stenosis (4).

Resident # 46's most recent MDS (minimum data set), an annual assessment with an ARD (assessment reference date) of 08/30/18, coded Resident # 46 as scoring a 5 (five) on the brief interview for mental status (BIMS) of a score of 0 - 15, 5 (five) - being severely impaired of cognition for making daily decisions. Resident # 46 was coded as requiring extensive assistance of one staff member for locomotion, dressing, toilet use and bed mobility and being totally dependent of one staff member for transfers, eating, personal hygiene and bathing. Section F "Preferences for Customary Routine and Activities" coded Resident # 42 as 1 (one) - "Very important" under "D. how important is it to you to keep up on the news?"

On 10/24/18 at 5:50 p.m., observation of Resident # 46 revealed she was lying in bed awake looking/watching the television on her side of the room. Observation of her wall-mounted television revealed it was on and tuned into a television program. Further observation of the television revealed that there was no sound coming from the television. Observation of the room revealed Resident # 46's roommate, she was lying in bed with her eyes closed and head phones on her head and over her ears. When

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asked what Resident # 46's roommate was listening to, CNA (certified nursing assistant) # 4 stated, "The T.V." Observation of the television for Resident # 46's roommate, which was mounted on the wall at the foot of the bed, revealed that there was no picture and the television was off. When asked what television Resident # 46's roommate was listening to, CNA # 4 pointed to Resident # 46's television, which was mounted on the wall on the A-side of the room. CNA # 4 stated, "She's listening to that one." CNA # 4 stated, "(Resident # 42) listens to her roommate's (resident # 46) T.V." When asked if Resident # 46's roommate listens to Resident # 46's television while Resident # 46 looks at her own television without any sound, CNA # 4 verbally confirmed the arrangement. When asked if she thought that this arrangement was okay, CNA # 4 didn't have a response.

On 10/25/18 at 8:55 a.m., observation of Resident # 46 revealed she was lying in bed awake looking/watching the television on her side of the room. Observation of her wall-mounted television revealed it was on and tuned into a television program. Further observation of the television revealed that there was no sound coming from the television. Observation of the room revealed Resident # 46's roommate revealed she was sitting up in bed with her eyes closed and the headphones on her head and over her ears and being assisted by a staff member with breakfast. When asked what Resident # 46's roommate was listening to, CNA # 3 stated, "The T.V." Observation of the television for Resident # 46's roommate, which was mounted on the wall at the foot of the bed, revealed that there was no picture and the television was off. When asked what television Resident # 46's

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roommate was listening to, CNA # 3 pointed to Resident # 46's television, which was mounted on the wall on the A-side of the room and stated, "She's listening to that one." CNA # 3 stated, "(Resident # 42) listens to her roommate's (Resident # 46) T.V." When asked if Resident # 46's roommate listens to Resident # 46's television while Resident # 46 looks at her own television without any sound CNA # 3 verbally confirmed the arrangement. When asked if she thought that this arrangement was okay, CNA # 3 didn't have a response.

On 10/25/18 at 9:14 a.m., an observation of Resident # 46 revealed she was in bed looking at her television. Observation of the television revealed it was on and there was no sound coming from it. When asked if she could hear the television Resident # 46 stated, "No." When asked if she wanted to hear her television Resident # 46 stated, "Yes but not loud."

The "Activity Evaluation" for Resident # 46 dated 10/17/2016 documented, "C. 11. TV Program Viewing/Radio" Current interest."

The comprehensive care plan with a revision date of 08/30/2018 for Resident # 46 documented, "Focus: Enjoys activities such as music, pets/animals, group activities, outdoors in appropriate weather, religious/spiritual, exercise, games and socials." Under "Goals" it documented, "Will participate in independent leisure activities of choice such as watching t.v., visitors."

On 10/25/18 at 9:43 a.m., an interview was conducted with LPN (licensed practical nurse) # 9, unit manager. LPN #9 was informed of the

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observations of Resident # 46 not being able to listen to her television or being given the choice to select preferred television programming. LPN # 9 was asked to review Resident # 46's activity care plan. LPN # 9 was asked if staff was following the activity care plan for Resident # 46. LPN # 9 stated, "No."

On 10/25/18 at approximately 12:45 p.m., ASM (administrative staff member) # 2, the administrator and ASM # 2, assistant administrator, ASM # 4 assistant administrator, ASM # 5 director of nursing and ASM # 6, medical director were made aware of the findings.

No further information was provided prior to exit.

References:
(1) A loss of brain function that occurs with certain diseases. It affects memory, thinking, language, judgment, and behavior. This information was obtained from the website: https://medlineplus.gov/ency/article/000739.htm.

(2) A swallowing disorder. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/swallowingdisorders.html.

(3) Low iron. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/anemia.html .

(4) A narrowing of the spinal column that causes pressure on the spinal cord, or narrowing of the openings (called neural foramina) where spinal nerves leave the spinal column. This information

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was obtained from the website: https://medlineplus.gov/ency/article/000441.htm.

3. The facility staff failed to implement the care plan for the administration of oxygen to Resident #73.

Resident #73 was admitted to the facility on 12/12/97, with recent readmission on 8/10/18, with diagnoses that included but were not limited to: cerebral palsy [loss or deficiency of muscle control due to permanent, nonprogressive brain damage occurring before or at the time of birth. (1)], urinary retention, asthma [respiratory disorder characterized by recurrent episodes of difficulty in breathing, wheezing, cough, and thick mucus production, caused by inflammation of the bronchi. (2)], and respiratory failure with hypoxia [inadequate amount of available oxygen in the blood. (3)].

The most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 9/13/18, coded the resident as being in a persistent vegetative state/no-discernable consciousness. The resident was coded as being totally dependent upon one or more staff members for all of his activities of daily living. In Section O - Special Treatments, Procedures and Programs, the resident was coded as using oxygen while a resident in the facility.

The comprehensive care plan dated, 5/27/15 and revised on 9/24/18, documented, "Focus: At risk for respiratory impairment related to aspiration, asthma." The "Interventions/Tasks" documented in part, "Administer oxygen per physician order."

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The physician order on the October POS (physician order summary) and signed by the physician on 10/18/18, documented, "O2 (oxygen) @ (at) 2 LPM (liters per minute) - may remove prn (as needed)." Observation was made of Resident # 73 on 10/23/18 at approximately 1:00 p.m. The resident was in the bed with the oxygen on via a nasal cannula [a tubing with two prongs that insert into the nose to deliver the oxygen], connected to an oxygen concentrator. The oxygen concentrator was set with the bottom of the ball resting on the line for 2 liters per minute and the top of the ball was sitting at the line for 2.5 liters per minute. The resident was observed a second time on 10/23/18 at 2:52 p.m. the oxygen was set at the same rate.

Observation was made on 10/24/18 at 8:28 a.m. The oxygen was in use via the nasal cannula, the oxygen concentrator was set with the bottom of the ball resting on the line for 2 liters per minute, and the top of the ball was sitting at the line for 2.5 liters per minute. Another surveyor verified this observation.

Observation was made of Resident # 73 with LPN (licensed practical nurse) #6 on 10/24/18 at 2:40 p.m. LPN #6 verified the rate was not set at 2 liters per minute. When asked how to read the flow meter of the oxygen concentrator, LPN #6 stated, the line for the prescribed rate should be through the center of the ball. When asked if Resident #73's oxygen was set at the correct rate when we entered the room, LPN #6 stated, "No, Ma'am. It was between the lines."

The October 2018 TAR (treatment administration record) documented the above order for oxygen. The oxygen was signed off as administered as

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F 656	Continued From page 95 prescribed from 10/1/18 through 10/25/18. An interview was conducted with LPN #7 on 10/25/18 at 10:16 a.m. When asked what the purpose of the care plan is, LPN #7 stated it is to make a plan of care for the patient, what is expected for the patient and certain things how to care for the patient. It is individualized to each resident. When asked if it's important to follow the care plan, LPN #7 stated, "Yes. We make changes as we go." The care plan above was reviewed with LPN #7. When asked if the oxygen was not set at the prescribed rate, would that be following the care plan, LPN #7 stated, "Not technically." ASM (administrative staff member) #2 (the administrator), ASM #3 (the assistant administrator), ASM #4 (another assistant administrator), ASM #5 (the director of nursing) and ASM #6 (the medical director) were made aware of the above concern on 10/25/18 at 12:41 p.m. No further information was provided prior to exit. (1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 114. (2) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 51. (3) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 286.	F 656		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii)	F 657		12/1/18

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F 657	Continued From page 96 §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and clinical record review, it was determined that the facility staff failed to review and/or revise the comprehensive care plan for one of 46 residents in the survey sample, Residents # 54. The facility staff failed to review and/or revise Resident # 54's care plan to reflect the physician's order to discontinue the fall mats.	F 657	1. Corrective Action The care plan for resident #54 has been revised to reflect the discontinuation of the fall mat. 2. Other Potential Residents Residents that have had a discontinued	

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F 657	Continued From page 97 The findings include: Resident # 54 was admitted to the facility on 09/07/13 with diagnoses that included but were not limited to: dysphagia (1), hemiplegia (2), cerebral infarction (3) and hypertension (4). Resident # 54's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 08/02/18, coded Resident # 54 as scoring a 15 on the brief interview for mental status (BIMS) of a score of 0 - 15, 15 - being cognitively intact for making daily decisions. Resident # 54 was coded as requiring extensive assistance of one staff member for locomotion, dressing and toilet use and being totally dependent with the assistance of one staff member for personal hygiene and bathing. On 10/23/18 at 11:56 a.m., an observation of Resident # 54 revealed he was lying in his bed. Observation of Resident # 54's room failed to evidence a fall mat. On 10/23/18 at 4:35 p.m., an observation of Resident # 54 revealed he was in bed watching television. Observation of Resident # 54's room failed to evidence a fall mat. On 10/24/18 at 8:41 a.m., an observation of Resident # 54 revealed he was in bed reading the paper. Observation of Resident # 54's room failed to evidence a fall mat. On 10/24/18 at 1:28 p.m., an observation of Resident # 54 revealed he was in bed watching television. Observation of Resident # 54's room failed to evidence a fall mat.	F 657	physicians order have the potential to be affected. Licensed Nurses responsible for revising the care plan were re-educated on 10/12/18 regarding the process for revising the care plan. A audit of physicians orders for the past 30 days was completed on 11/9/18 to validate that the care plan has been updated to reflect any discontinued orders are no longer on the current plan of care. Any areas of non-compliance will be immediately corrected and staff responsible will be counseled. 3. Systemic Changes A 25% audit of physicians orders will be completed weekly x 3 months to validate that the care plan has been updated to reflect that any discontinued orders are no longer on the current plan of care. Any areas of non-compliance will be immediately corrected and staff responsible will be counseled. 4.Monitoring The results of all audits will be forwarded to the QAPI Committee for review and recommendations. 5.Date of compliance 12/1/18	

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The comprehensive care plan with a revision date of 04/18/2018 for Resident # 54 documented, "Focus: At risk for falls/injuries due to decreased mobility, med (medication) use, cva (cerebrovascular accident) with left hemiparesis , hypertension, depression with med (medication) use bowel and bladder incontinent, vertigo." Under "Interventions/Tasks" it documented, "Bed against wall with fall mat to floor. Revision Date: 12/23/2017."

The "Physician's Telephone Order" dated 10/07/14 for Resident # 54 documented, "D/C (discontinue) Fall Mat (and) D/C Personal alarm > (secondary) to decreased fall risk."

The POS (physician's order sheet) for Resident # 54 dated "10/01/2018 thru 10/31/2018", signed by the physician on 10/18/18, for Resident # 54 failed to evidence orders for a fall mat or to maintain the bed close to the floor.

On 10/25/18 at 8:52 a.m., an interview was conducted with RN (registered nurse) # 1, MDS coordinator. RN #1 was informed of the observations of Resident # 54's room without fall mats, and review of the "Physician's Telephone Order" dated 10/07/14, the physician's order sheet for Resident # 54 dated "10/01/2018 thru 10/31/2018, and Resident # 54 's care plan. When RN # 1 was asked if the care plan had been reviewed or revised to reflect the physician's orders for the discontinuation of the fall mat, RN # 1 stated, "The care plan was not revised to reflect the physician's order." When asked to describe the process for reviewing or revising the care plan RN # 1 stated, "It's done quarterly and as needed when there is a change in the resident's status or

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function or physician's orders. The changes are communicated from nursing to us. This is done verbally through morning meeting every day and care plan meetings."

On 10/25/18 at approximately 12:45 p.m., ASM (administrative staff member) # 2, the administrator and ASM # 2, assistant administrator, ASM # 4 assistant administrator, ASM # 5 director of nursing and ASM # 6, medical director were made aware of the findings.

No further information was provided prior to exit.

References:
(1) A swallowing disorder. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/swallowingdisorders.html.

(2) Also called: Hemiplegia, Palsy, Paraplegia, Quadriplegia. Paralysis is the loss of muscle function in part of your body. It happens when something goes wrong with the way messages pass between your brain and muscles. Paralysis can be complete or partial. It can occur on one or both sides of your body. It can also occur in just one area, or it can be widespread. This information was obtained from the website: https://medlineplus.gov/paralysis.html.

(3) A stroke. When blood flow to a part of the brain stops. A stroke is sometimes called a "brain attack." If blood flow is cut off for longer than a few seconds, the brain cannot get nutrients and oxygen. Brain cells can die, causing lasting damage. This information was obtained from the website:

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F 657	Continued From page 100 https://medlineplus.gov/ency/article/000726.htm . (4) High blood pressure. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/highbloodpressure.html.	F 657		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review and clinical record review, it was determined the facility staff failed to follow professional standards of practice for one of 46 residents in the survey sample, Resident #74. The facility staff failed to clarify the physician orders for insulin (1) administration for Resident #74. The findings include: Resident #74 was admitted to the facility on 7/23/15 with diagnoses that included but were not limited to: Huntington's disease (2), Type 2 Diabetes (3), schizophrenia (4), depression, hypoglycemia (5) and repeated falls. The most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 9/13/18, coded the resident as having scored 13 out of 15 on the	F 658	1. Corrective Action The order for insulin administration for Resident # 74 has been clarified. 2.Other Potential Residents Residents with orders for insulin administration have the potential to be affected. An audit of physician orders for residents with orders for insulin administration were reviewed on 11/12/18 and no other insulin administration orders were in need of clarification. Licensed nurses were re-educated on 10/29/18 on appropriate physicians orders for insulin administration. 3.Systemic Changes A weekly audit of physician orders will be	12/1/18

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F 658	Continued From page 101 BIMS (brief interview for mental status) indicating the resident was cognitively intact to make daily decisions. The MDS also coded the resident as having the diagnosis of diabetes mellitus and as receiving insulin 7 days a week." Resident #74's care plan dated 9/24/18 titled "Endocrine system related to Insulin Dependent Diabetes & Hypoglycemia" documented, "Administer medication per physician orders. Report symptoms of hypoglycemia: weakness, pallor, diaphoresis, vision changes, changes in consciousness." Physician order sheet (POS) dated 10/18/18 documented, "NovoLog Flexpen 100 unit/ ML (milliliters) 4 units subcutaneous twice daily with lunch and dinner for diabetes may hold for low blood sugar." (6) The September 2018 and October 2018 medication administration record (MAR) also documented, "NovoLog Flexpen 100 unit/ ML (milliliters) 4 units subcutaneous twice daily with lunch and dinner for diabetes may hold for low blood sugar." Resident #74's "Blood Sugar Summary" dated 10/19/18 at 4:30 p.m., documented Resident #74's blood sugar was 62 mg/ dL [milligram per deciliter, normal blood glucose is between 75 mg/dL- 100 mg/ dL. (7)]". On 10/19/18 at 7:30 p.m., the residents documented blood sugar was 67 mg/ dL. On 10/16/18 at 4:23 p.m. the residents documented blood sugar reading was 62 mg/ dL. Review of the MAR (medication administration record) documented that the Novolog was	F 658	completed for 25% of residents with orders for insulin administration to validate that the orders are accurate and not in need of clarification. Any areas of non-compliance will be immediately corrected and staff responsible will be counselled. 4. Monitoring The results of all audits will be forwarded to the QAPI Committee for review and recommendations. 5.Date of compliance 12/1/18	

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administered on 10/19/18 at 4:30 p.m.

On 10/25/18 at approximately 10:49 a.m., Resident #74's POS (dated 10/18/18) documenting "NovoLog Flexpen 100 unit/ ML(milliliters) 4 units subcutaneous twice daily with lunch and dinner for diabetes may hold for low blood sugar" was reviewed with LPN #7. LPN #7 was asked if Resident #74's Novolog order was clear, LPN #7 replied "No. The part about the 'low blood sugar' is unclear." When asked when she would hold the insulin based on the order, LPN #7 replied, "I don't know." LPN #7 stated the Novolog order should be clarified with the doctor.

On 10/25/18 at approximately 10:49 a.m., Resident #74's POS (dated 10/18/18) documenting "NovoLog Flexpen 100 unit/ ML (milliliters) 4 units subcutaneous twice daily with lunch and dinner for diabetes may hold for low blood sugar" was reviewed with LPN #6, the Unit Manager. When asked if Resident #74's Novolog order was clear, LPN #6 replied "No, because we don't know what 'low' means. What I might think of as low another nurse might not." When asked what should be done with this order prior to giving the medication, LPN # 6 replied, "I would call the doctor and clarify the order."

On 10/25/18 at approximately 12:45 p.m., ASM (administrative staff member) #2, Assistant Administrator and ASM #5, the Director of Nursing were made aware of the findings.

The facility policy titled "Physician Orders: Obtaining and Transcribing" dated 9/29/15 documented, "Medication orders should include the following information in the text of the order: name of medication, strength, dosage, route,

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frequency, parameters pertaining to administration i.e. blood pressures; blood sugars, etc." The facility policy also documented, "High Risk Medications: Medications that have an increased potential of causing harm if used in error and the consequences of those errors can be devastating. Medications identified in this setting are: insulin, warfarin and heparin."

The facility Policy titled: "Insulin Administration" dated September 2014 documented, "To provide guidelines for the safe administration of insulin to residents with diabetes. The type of insulin, dosage requirements, strength, and method of administration must be verified before administration, to assure that it corresponds with the order on the medication sheet and the physicians order."

No further information was provided prior to exit.

1. Insulin is a hormone that helps glucose get into your cells to give them energy. Without insulin, too much glucose stays in your blood. This information was obtained from the website: https://medlineplus.gov/diabetesmedicines.html.

2. Huntington's disease (HD) is an inherited disease that causes certain nerve cells in the brain to waste away. People are born with the defective gene, but symptoms usually don't appear until middle age. Early symptoms of HD may include uncontrolled movements, clumsiness, and balance problems. Later, HD can take away the ability to walk, talk, and swallow. Some people stop recognizing family members. Others are aware of their environment and are able to express emotions. This information was obtained from the website:

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F 658	Continued From page 104 https://medlineplus.gov/huntingtonsdisease.html 3. A chronic disease in which the body cannot regulate the amount of sugar in the blood. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/ency/article/001214.htm. 4. A mental disorder that makes it hard to tell the difference between what is real and not real. This information was obtained from the website: https://medlineplus.gov/ency/article/000928.htm. 5. Hypoglycemia means low blood glucose, or blood sugar. Your body needs glucose to have enough energy. If you have hypoglycemia, your blood sugar can be dangerously low. Signs include: hunger, shakiness, dizziness, confusion, difficulty speaking, feeling anxious or weak. This information was obtained from the website: https://medlineplus.gov/hypoglycemia.html 6. Insulin aspart (NovoLog) is a short-acting, manmade version of human insulin. Insulin aspart works by replacing the insulin that is normally produced by the body and by helping move sugar from the blood into other body tissues where it is used for energy. It also stops the liver from producing more sugar. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a605013.html 7. Normal fasting glucose - 75-115 mg/dL. This information was obtained from: https://www.nejm.org/doi/suppl/10.1056/NEJMcpc049016/suppl_file/nejmcpc049016_tables.htm	F 658		
F 684	Quality of Care	F 684		12/1/18

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F 684 SS=D	Continued From page 105 CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and clinical record review, it was determined that facility staff failed to ensure care was provided in accordance the comprehensive person-centered care plan for one of 46 residents in the survey sample, Resident # 42. The facility staff failed to follow the physicians order and comprehensive care plan to communicate verbally with Resident # 42 by directing their speech to her left ear. The findings include: Resident # 42 was admitted to the facility on 11/03/15 with diagnoses that included but were not limited to: vision loss, both eyes, hearing loss, heart failure (1), dysphagia (2), hemiplegia (3) and cerebrovascular disease (4). Resident # 42's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 08/23/18, coded Resident # 42 as scoring a 5 (five) on the brief interview for mental status (BIMS) of a score of 0 - 15, 5 (five) - being severely impaired of	F 684	1. Corrective Action Facility staff have been re-educated on 10/29/18 on communicating with resident # 42 by speaking directly in her left ear. 2.Other Potential Residents Residents that have a care plan that addresses communication problems have the potential to be affected. An audit and observation of 25% of residents with communication problems has been completed to validate that staff are familiar with and following the residents plan of care. Any areas of non-compliance has been corrected and the appropriate staff have been counselled. 3. Systemic Changes A 25% audit was completed on 11/9/18 of care plans/observations for residents with	

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F 684	Continued From page 106 cognition for making daily decisions. Resident # 42 was coded as requiring extensive assistance of one staff member for locomotion, eating, toilet use and bed mobility and being totally dependent of one staff member for dressing, personal hygiene and bathing. Section B "Hearing, Speech and Vision" coded Resident # 42 as "B0200 Hearing: 2 (two) - Moderate difficulty, B1000 Vision: 4 (four) - Severely impaired - no vision or sees only light, colors or shapes, eyes do not appear to follow objects." On 10/24/18 at 9:07 a.m., an observation of resident # 42's room revealed CNA (certified nursing assistant) # 3 entered Resident # 42's room. CNA # 3 was observed speaking to Resident # 42 on the resident's right side. CNA # 3 set up the Resident # 42's breakfast tray on the over-the-bed table, sat in a chair on the right side of Resident # 42 and assisted her with breakfast from the resident's right side. CNA # 3 was observed speaking to Resident # 42 from her right side throughout the meal. Resident # 42 was sitting up in bed. During the observation, a second staff member CNA # 6 entered Resident # 42's room during the meal, stood at the right side of the bed and spoke to the resident. CNA # 6 was observed repeating her statement/questions to Resident # 42 and raising her volume until the resident heard her and answered. On 10/24/18 at approximately 9:07 a.m., an observation of Resident # 42's room revealed a sign posted above the head of the bed that documented, (Nam of Resident) is completely blind and deaf in the right ear." On 10/24/18 at 5:50 p.m., an observation of	F 684	communication problems will be completed weekly to validate that staff are familiar with and following the residents plan of care. Any areas of non-compliance will be immediately corrected and the appropriate staff will be counselled. 4. Monitoring The results of all audits will be forwarded to the QAPI Committee for review and recommendations. 5.Date of compliance 12/1/18 4. The results of all audits will be forwarded to the QAPI Committee for review and recommendations. 5.Date of compliance 12/1/18	

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Resident # 42 revealed she was lying in bed with headphones on. CNA # 4 entered the room and closed the door to provide personal care to Resident # 42. At 6:00 p.m., an interview was conducted with CNA # 4 when she finished providing care. When asked about Resident # 42's hearing CNA # 4 stated, "She's hard of hearing but she hears you pretty good. I take off her head set and tell her what I'm going to do. Sometimes I have to speak up or I get close to her ear." When asked which ear she speaks into, CNA # 4 stated, "He right side."

On 10/25/18 at 8:55 a.m., a staff member on the right side of the bed was assisting Resident # 42 with breakfast. The staff member was observed speaking to Resident # 42 on her right side.

The POS (physician's order sheet) dated 10/01/2018 thru 10/31/2018 for Resident # 42 documented, "Diagnosis: Deaf in right ear."

The comprehensive care plan for Resident # 42 with a target date of 11/21/2018 documented, "Focus: Difficulty communicating related to hearing loss/deafness rt (right) ear. Need to talk directly into left ear." Under "Interventions/Tasks" it documented, "Remind staff to speak slower/louder into left ear. Revision on 01/23/2018."

Interview 10/25/18 09:02 a.m., an interview was conducted with CNA # 3. When asked if Resident # 42 had any hearing restrictions, CNA # 3 stated, "(Resident # 42) is blind and can't hear in her right ear." When asked if Resident # 42 had any specific approaches to be taken when speaking with her, CNA # 3 stated, "When we are working with her explain what I'm going to do

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before I do it. We talk loud so she can hear and talk into the left ear." After CNA #3 was informed of the observation on 10/24/18 during breakfast, CNA # 3 stated, "We talk loud enough so she can hear and there isn't enough room on the left side of her bed for a chair." When asked if there was a plan for Resident # 42 that outlined an approach to speak to her, CNA # 3 stated, "I'm not aware of any plan as to how to speak to her." When asked if she had access to Resident # 42's care plan, CNA # 3 stated, "We have access to the care plan on the electronic kiosk that tells us how to take care of the resident." The communication care plan for Resident # 42 was reviewed on the kiosk with CNA # 3. When asked to read the communication care plan, CNA # 3 stated, "To speak into the left ear." When asked if she was following Resident # 42's care plan for speaking into her left ear, CNA # 3 stated, "No not completely."

On 10/25/18 at 9:43 a.m., an interview was conducted with LPN (licensed practical nurse) # 9, unit manager. When asked what type of sensory deficits Resident # 42 had, LPN # 9 stated, "Her sensory deficits are that she is blind hard of hearing." When informed of the observation of the sign in the room and of the staff speaking to Resident # 42's right ear, LPN # 9 stated, "I mean partially deaf, deaf in right ear." When asked if there was a strategy for staff to use, LPN # 9 stated, "They should be speaking into her left side."

On 10/25/18 at approximately 12:45 p.m., ASM (administrative staff member) # 2, the administrator and ASM # 2, assistant administrator, ASM # 4 assistant administrator, ASM # 5 director of nursing and ASM # 6,

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F 684	Continued From page 109 medical director were made aware of the findings. No further information was provided prior to exit. References: (1) A condition in which the heart is no longer able to pump oxygen-rich blood to the rest of the body efficiently. This causes symptoms to occur throughout the body. This information was obtained from the website: https://medlineplus.gov/ency/article/000158.htm. (2) A swallowing disorder. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/swallowingdisorders.html. (3) Also called: Hemiplegia, Palsy, Paraplegia, Quadriplegia. Paralysis is the loss of muscle function in part of your body. It happens when something goes wrong with the way messages pass between your brain and muscles. Paralysis can be complete or partial. It can occur on one or both sides of your body. It can also occur in just one area, or it can be widespread. This information was obtained from the website: https://medlineplus.gov/paralysis.html. (4) A stroke. When blood flow to a part of the brain stops. A stroke is sometimes called a "brain attack." If blood flow is cut off for longer than a few seconds, the brain cannot get nutrients and oxygen. Brain cells can die, causing lasting damage. This information was obtained from the website: https://medlineplus.gov/ency/article/000726.htm .	F 684		
F 695	Respiratory/Tracheostomy Care and Suctioning	F 695		12/1/18

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F 695 SS=E	Continued From page 110 CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review, and clinical record review, it was determined that facility staff failed to provide respiratory care and services consistent with professional standards of practice for six of 46 residents in the survey sample, Residents #108, 110, 64, 265, 266, and 73. 1. The facility staff failed to clarify oxygen orders; and failed to adequately monitor Resident #108's oxygen saturation. 2. The facility staff failed to ensure Resident #110's oxygen tubing; including the nasal cannula was not on the floor. 3. The facility staff failed to clarify Resident #64's oxygen orders; and failed to monitor the resident's oxygen saturation adequately. 4. The facility staff failed to store Resident # 265's C-PAP (continuous positive air pressure) mask in a sanitary manner. 5. The facility staff failed to store Resident # 266's nasal cannula and oxygen tubing in a	F 695	1. Corrective Action Oxygen orders have been clarified for Residents # 108 and # 64. The physicians order for oxygen for resident #110 has been discontinued on 10/24/18. C-PAP mask for resident # 265 was covered on 10/25/18. Oxygen tubing for resident #266 was replaced on 10/25/18 replaced and stored in a sanitary manner The oxygen flow rate for Resident #73 was set to 2 lpm per physician order on 10/24/18. Nursing staff were re-educated on 10/29/18 on acceptable oxygen orders and the need to include the specific amount of liters per minute of oxygen the resident is receiving.	

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F 695	Continued From page 111 sanitary manner. 6. The facility staff failed to administer oxygen per the physician order for Resident #73. The findings include: 1. Resident #108 was admitted to the facility on 9/28/18 and readmitted on 10/17/18 with diagnoses that included but were not limited to acute and chronic respiratory failure with hypoxia, heart failure, chronic obstructive pulmonary disease, anemia, muscle weakness, and type two diabetes mellitus. Resident #108's comprehensive MDS (minimum data set) assessment had not yet been completed. Resident #108 was documented in the nursing notes as being alert and oriented x3 (person, place, time). On 10/23/18 at 7:54 a.m., an observation was made of Resident #108. She was sitting up in her wheelchair with her nasal cannula in place. Her oxygen flow rate was set at 4 liters per minute. On 10/23/18 at 2:25 p.m., an observation was made of Resident #108. She was sitting up in her wheelchair with her nasal cannula in place. Her oxygen flow rate was set at 4 liters per minute. On 10/24/18 at 11:00 a.m., an observation was made of Resident #108. She was sitting up in her wheelchair with her nasal cannula in place. Her oxygen flow rate was set at 4 liters per minute. On 10/25/18 at 8:00 a.m., an observation was Resident #108. She was sitting up in her wheelchair with her nasal cannula in place. Her oxygen flow rate was set at 2 liters per minute.	F 695	Nursing staff were re-educated on 10/29/18 on following physicians orders for amount of liters per minute of oxygen the resident is receiving and adequately monitoring the residents oxygen saturation level. Nursing staff were re-educated on 10/29/18 on sanitary storage and practices in regard to respiratory equipment. 2.Other Potential Residents Residents who are receiving respiratory therapy have the potential to be affected. An audit/observation of residents receiving respiratory therapy has been completed to validate that they have an appropriate order for oxygen, including the specific flow rate, adequate monitoring of the residents oxygen saturation level and to validate that all respiratory equipment is store in a sanitary manner. Any areas of non-compliance has been corrected and staff responsible have been counseled. 3. Systemic Changes An audit/observation of residents receiving respiratory therapy will be completed weekly x 3 months to validate that the resident has an appropriate order for oxygen, including the specific flow rate, adequate monitoring of the residents oxygen saturation level and to validate	

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F 695	Continued From page 112 Review of Resident #108's most recent telephone order sheet dated 10/17/18 revealed the following oxygen order: "02 (oxygen) 2-4 lpm (liters per minute) via NC (nasal cannula) cont (continuous) - may remove prn (as needed)." This order was discontinued on 10/24/18 with the following active order: "02 C (continuous) 2-5 lpm via nasal cannula - may remove prn (as needed)." Review of her October 2018 TARs (treatment administration record) revealed that staff were signing off on the TAR every shift that oxygen 2-4 liters was in place until October 24th when the order was changed to 2-5 liters. There was no evidence showing the exact amount of liters Resident #108 was receiving per shift. Further review of the October 2018 TARS revealed that staff were signing off on the TAR that oxygen 2-5 liters was in place every shift from October 24th until current date of October 25th. There was no evidence showing the exact amount of liters Resident #108 was receiving per shift. Review of the weights and vital sign log revealed oxygen saturations for the month of October. There was no evidence showing the exact amount of liters Resident #108 was wearing when her oxygen saturation was obtained. Review of the October 2018 nursing notes failed to evidence consistent oxygen monitoring. A nursing note dated 10/24/18 documented the following: "Resident seen by MD (medical doctor) -- see TO (telephone order) for adjustment with 02, RP (responsible party) made aware." There	F 695	that all respiratory equipment is store in a sanitary manner. 4. Monitoring The results of all audits will be forwarded to the QAPI Committee for review and recommendations. 5.Date of compliance 12/1/18	

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were no other notes in the clinical record documenting the reason Resident #108's oxygen order was changed on 10/24/18.

On 10/25/18 at 9:35 a.m., an interview was conducted with LPN (licensed practical nurse) #4, the nurse manager. When asked if nurses can determine how many liters of oxygen a resident is on, LPN #4 stated that there had to be a physician's order for oxygen. LPN #4 stated that sometimes the doctor would give an order for oxygen ranges such as 2-4 liters etc. When asked how the nurses know exactly how many liters of oxygen to administer to a resident, LPN #4 stated that she personally liked having ranges so that nurses could use their nursing judgement. When asked how nursing would know when to adjust the oxygen flow meter, LPN #4 stated that if a resident's pulse ox (oxygen saturation reading showing the amount of oxygen in the blood) would drop, then they would bump it up until the resident's pulse ox was stable. LPN #4 stated that they would bump up the flow meter or lower the flow meter within the ordered ranges as needed. When asked how often they would monitor to see if oxygen needed to be adjusted, LPN #4 stated that vitals were taken at least once a day or as needed. When asked how nursing would monitor a resident wearing oxygen if the amount of liters was not documented on the TARS or on the vital sign log, LPN #4 stated, "Looking at this (TARS and Log) you would not know how many liters a resident was on when the 02 (oxygen) was checked." LPN #4 stated, "I see what you're saying. I wouldn't know to bump resident up or lower." LPN #4 stated that the liters of 02 could be documented in a nursing note.

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When asked why Resident #108's oxygen order was changed from 2-4 to 2-5 lpm on 10/24/18, LPN #4 stated that on 10/24/18 Resident #108 was in a pulmonary crises from pulmonary fibrosis. LPN #4 stated that Resident #108 was bumped up to 5 liters on 10/24/18. When asked if Resident #108 was still on 5 liters, LPN #4 stated that she wasn't sure and would have to check. When asked how nursing staff would know to decrease her 5 liters if there was no documentation evidencing monitoring, LPN #4 stated that she would see if monitoring was documented in the nursing notes.

On 10/25/18 at 10:54 a.m., an interview was conducted with LPN #5. When asked how nurses determine how many liters of oxygen to administer to a resident with an order for a range of 2-4 lpm or 2-5 lpm, LPN #5 stated that she would personally start the resident on the lowest amount of liters (2 lpm) and gradually increase if needed within the ordered parameters. When asked if all nurses would know to do this, LPN #5 stated that she was not sure. LPN #5 stated that nurses could determine that amount of liters of oxygen a resident needs within the ordered range. When asked how oxygen saturations (amount of oxygen in the blood) was monitored, LPN #5 stated that vital signs were obtained once a shift. LPN #5 stated that vitals were also obtained as needed. When asked how she would know how many liters of 02 (oxygen) a resident was on at the time of the oxygen saturation check if the amount of liters the resident was receiving is not documented in the clinical record, LPN #5 stated that she would only know for her shift when she checked. When asked how nursing would monitor the need for oxygen if there was no evidence of this

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documentation, LPN #5 stated that she wouldn't know.

On 10/25/18 at 12:47 p.m., ASM #1, the senior administrator, ASM #2, the administrator, ASM #3, the assistant administrator, ASM #4, the other assistant administrator, ASM #5, the DON (Director of Nursing) and ASM #4, the medical director were all made aware of the above concerns.

The facility policy titled, "Oxygen Administration" did not address clarifying orders oxygen orders. The facility policy documented the following: "Documentation: After completing the oxygen set-up or adjustment, the following information should be recorded in the resident's medical record: ...3. The rate of oxygen flow, route and rationale."

2. The facility staff failed to ensure Resident #110's oxygen tubing; including the nasal cannula was not on the floor.

Resident #110 was admitted to the facility on 9/24/18 with diagnoses that included but were not limited to Parkinson's disease, unspecified dementia without behavioral disturbance, hypothyroidism, high blood pressure, and congestive heart failure. Resident #110's most recent MDS (minimum data set) assessment was a thirty day scheduled assessment with an ARD (assessment reference date) of 10/22/18. Resident #110 was coded as being cognitively intact in the ability to make daily decisions scoring 13 out of possible 15 on the BIMS (Brief Interview for Mental Status) exam. Resident #110 was coded as requiring extensive assistance from two plus persons with bed mobility and transfers; and

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extensive assistance from one staff member with walking, locomotion, dressing, eating, toileting, and personal hygiene.

On 10/23/18 at 4:04 p.m., an observation was made of Resident #110. She was sitting up in her wheelchair. She had an oxygen concentrator in her room that was off. The oxygen tubing (nasal cannula included) was laying on the floor. The tubing was dated 10/20. Resident #110 was asked if she used her oxygen. Resident #110 stated that sometimes she wore it at night.

On 10/24/18 at 9:51 a.m., an observation was made of Resident #110. Resident #110 was sitting up in her wheelchair. Her oxygen concentrator was off. Her oxygen tubing dated 10/20 was rolled up and stored in a plastic bag. Resident #110 stated that she didn't need her oxygen the night prior. Resident #110 stated that she could not reach her concentrator from her wheelchair.

On 10/24/18 at 4:57 p.m., Resident #110's oxygen tubing dated 10/20 was still rolled up and stored in a plastic bag.

On 10/25/18 at 10:06 a.m., Resident #110's oxygen concentrator was removed from her room.

Review of Resident #110's telephone order sheet dated 10/2/18 documented the following order: "May wear 02 via NC (nasal cannula) @ 2 lm (liters a minute) for SOB (short of breath) prn (as needed)."

Review of Resident #110's October 2018 TAR (treatment administration record) revealed no

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evidence that Resident #110 had needed her oxygen since it was ordered.

On 10/25/18 at 9:35 a.m., an interview was conducted with LPN (licensed practical nurse) #4, the nurse manager. When asked what should be done if nursing staff see a residents oxygen tubing on the floor, LPN #4 stated nursing staff should be throwing the contaminated tubing in the trash and getting a new one. When asked if it was ever okay to place the contaminated tubing in a plastic bag for use, LPN #4 stated, "Not if it's been on the floor."

On 10/25/18 at 10:54 a.m., an interview was conducted with LPN #5. When asked what should be done if nursing staff see oxygen tubing on the floor, LPN #5 stated that the tubing should be changed and not reused. LPN #5 stated that the oxygen tubing should be changed for sanitary reasons. When asked if Resident #110 was able to reach her own oxygen tubing from her bed or wheelchair, LPN #5 stated that Resident #110 could not reach her concentrator from her bed or wheelchair.

On 10/25/18 at 12:47 p.m., ASM #1, the senior administrator, ASM #2, the administrator, ASM #3, the assistant administrator, ASM #4, the other assistant administrator, ASM #5, the DON (Director of Nursing) and ASM #4, the medical director were all made aware of the above concerns.

The facility policy titled, "Oxygen Administration" did not address the above concerns.

3. The facility staff failed to clarify Resident #64's

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oxygen orders; and failed to evidence adequate monitoring of the residents oxygen saturation.

Resident #64 was admitted to the facility on 9/7/18 with diagnoses that included but were not limited to nondisplaced fracture of the left femur, repeated falls, unspecified osteoarthritis, COPD (chronic obstructive pulmonary disease), muscle weakness, and unspecified dementia without behavioral disturbance. Resident #64's most recent MDS (minimum data set) assessment was a thirty day scheduled assessment with an ARD (assessment reference date of 10/4/18. Resident #64 was coded as being moderately impaired in cognitive function scoring 09 out of possible 15 on the BIMS (Brief Interview for Mental Status Exam). Resident #64 was coded in Section O (Special Treatments, Procedures, and Programs) as receiving Oxygen therapy.

On 10/23/18 at 11:20 a.m., 12:21p.m., 2:30 p.m., and 4:18 p.m., observations were made of Resident #64. He was on 2 liters of oxygen via nasal cannula connected to an oxygen concentrator that was running.

On 10/24/18 at 9:00 a.m., an observation was made of Resident #64. He was on 2 liters of oxygen via nasal cannula connected to an oxygen concentrator.

Review of Resident #64's most recent POS (physician order sheet) documented the following order: "02 2-3 lpm (liter per minute) via nasal cannula- may remove prn (as needed)."

Review of his October 2018 TARs (treatment administration record) revealed that staff were signing off on the TAR every shift that oxygen 2-3

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liters was in place. There was no evidence showing the exact amount of liters Resident #64 was receiving per shift.

Review of the weights and vital sign log revealed oxygen saturations for the month of October. There was no evidence showing the exact amount of liters Resident #64 was receiving when his oxygen saturation was obtained.

Review of the October 2018 nursing notes failed to evidence consistent oxygen monitoring.

Review of Resident #64's respiratory care plan dated 9/14/18 documented the following: "Resident is at risk for respiratory impairment related to lung disease...Interventions: Administer medications/treatments per physician's orders, Administer oxygen per physician order, Obtain labs [laboratory tests]/diagnostic tests as ordered the (sic) notify physician of results..."

On 10/25/18 at 9:35 a.m., an interview was conducted with LPN (licensed practical nurse) #4, the nurse manager. When asked if nurses can determine how many liters of oxygen a resident is on, LPN #4 stated that there had to be a physician's order for oxygen. LPN #4 stated that sometimes the doctor would give an order for oxygen ranges such as 2-4 liters etc. When asked how the nurses know exactly how many liters of oxygen to administer to a resident, LPN #4 stated that she personally liked having ranges so that nurses could use their nursing judgement. When asked how nursing would know when to adjust the oxygen flow meter, LPN #4 stated that if a resident's pulse ox (oxygen saturation reading showing the amount of oxygen in the blood) would drop, then they would bump it up until the

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resident's pulse ox was stable. LPN #4 stated that they would bump up the flow meter or lower the flow meter within the ordered ranges as needed. When asked how often they would monitor to see if oxygen needed to be adjusted, LPN #4 stated that vitals were taken at least once a day or as needed. When asked how nursing would monitor a resident wearing oxygen if the amount of liters was not documented on the TARS or on the vital sign log, LPN #4 stated, "Looking at this (TARS and Log) you would not know how many liters a resident was on when the 02 (oxygen) was checked." LPN #4 stated, "I see what your saying. I wouldn't know to bump resident up or lower." LPN #4 stated that the liters of 02 could be documented in a nursing note.

On 10/25/18 at 10:54 a.m., an interview was conducted with LPN #5. When asked how nurses determine how many liters of oxygen to administer to a resident with an order for a range of 2-4 lpm or 2-5 lpm, LPN #5 stated that she would personally start the resident on the lowest amount of liters (2 lpm) and gradually increase if needed within the ordered parameters. When asked if all nurses would know to do this, LPN #5 stated that she was not sure. LPN #5 stated that nurses could determine that amount of liters of oxygen a resident needs within the ordered range. When asked how oxygen saturations (amount of oxygen in the blood) was monitored, LPN #5 stated that vital signs were obtained once a shift. LPN #5 stated that vitals were also obtained as needed. When asked how she would know how many liters of 02 (oxygen) a resident was on at the time of the oxygen saturation check if the amount of liters the resident was receiving is not documented in the

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clinical record, LPN #5 stated that she would only know for her shift when she checked. When asked how nursing would monitor the need for oxygen if there was no evidence of this documentation, LPN #5 stated that she wouldn't know.

On 10/25/18 at 12:47p.m., ASM #1, the senior administrator, ASM #2, the administrator, ASM #3, the assistant administrator, ASM #4, the other assistant administrator, ASM #5, the DON (Director of Nursing) and ASM #4, the medical director were all made aware of the above concerns.

4. The facility staff failed to store Resident # 265's C-PAP (continuous positive air pressure) mask in a sanitary manner.

Resident # 265 was admitted to the facility on 10/16/18 with diagnoses that included but were not limited to: Parkinson's disease (1), anemia (2), and hypertension (3).

Resident # 265'sMDS (minimum data set) was not due to be completed at the time of survey. The facility's "Admission Assessment" dated 10/16/18 for Resident # 265 documented, "BIMS (brief interview for mental status) - Severe impairment." Resident # 265 was coded as requiring assistance of one staff member for activities of daily living.

On 10/23/18 at 2:03 p.m., an interview was conducted with Resident # 265 in her room. During the interview, an observation of the room revealed the top drawer of the bedside table was open and the C-PAP mask lying inside the drawer uncovered. Resident #265 stated she uses the C-PAP every night.

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On 10/23/18 at 4:25 p.m. Resident # 265 in wheelchair. Observation revealed the top drawer of the bedside table was open and the C-PAP mask lying inside the drawer uncovered.

10/24/18 08:36 a.m., Resident # 265 in wheelchair eating breakfast in her room. Observation revealed the top drawer of the bedside table was open and the C-PAP mask lying inside the drawer uncovered.

Review of the TAR (treatment administration record) for Resident # 265 dated "10/16/18 thru 10/31/18" failed to evidence the use of a C-PAP.

Review of the POS (physician's order sheet) dated for Resident # 265 dated "10/16/18 thru 10/31/18" failed to evidence the use of a C-PAP.

At the time of the survey, the comprehensive care plan was not due to be completed for Resident # 265. Review of the baseline care plan for Resident # 265 dated 10/17/2018 failed to evidence the use of a C-PAP.

Review of the facility's nursing admission assessment for Resident # 265 dated 10/16/2018 failed to evidence the use of a C-PAP.

On 10/24/18 at 2:32 p.m., an interview with LPN (licensed practical nurse) # 8. When asked how respiratory equipment (nasal cannula, oxygen tubing, C-PAP mask and nebulizer mask) should be stored, LPN # 8 stated, "It should be stored in a bag." When asked who was responsible for ensuring the respiratory equipment is stored properly, LPN # 8 stated, "The nurse." When asked why they should be stored in a bag LPN #

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8 stated, "For infection control." When informed of the observation of Resident # 265's C-PAP mask, LPN # 8 stated, "It should be bagged."

On 10/24/18 03:06 p.m., an interview was conducted with Resident # 265 in the presence of LPN # 8. Resident # 265 was asked when the C-PAP was brought into the facility. Resident # 265 stated, "This past Sunday (10/21/18) but I haven't used it yet."

On 10/25/18 at approximately 12:45 p.m., ASM (administrative staff member) # 2, the administrator and ASM # 2, assistant administrator, ASM # 4 assistant administrator, ASM # 5 director of nursing and ASM # 6, medical director were made aware of the findings.

No further information was provided prior to exit.

References:
(1) A type of movement disorder. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/parkinsonsdisease.html.

(2) Low iron. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/anemia.html .

(3) High blood pressure. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/highbloodpressure.html.

5. The facility staff failed to store Resident # 266's nasal cannula and oxygen tuning in a

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sanitary manner.

Resident # 266 was admitted to the facility on 10/16/18 with diagnoses that included but were not limited to: atrial fibrillation (1), anemia (2), and hypertension (3).

Resident # 266'sMDS (minimum data set) was not due to be completed at the time of survey. The facility's "Admission Assessment" dated 10/16/18 for Resident # 266 documented, "BIMS (brief interview for mental status) - Severe impairment." Resident # 266 was coded as requiring assistance of one staff member for activities of daily living. Section "I. Respiratory Evaluation" documented oxygen at two liters per minute by nasal cannula.

On 10/23/18 at 2:24 p.m., an observation of Resident # 266 revealed she was in bed sitting up. Observation of the O2 (oxygen) concentrator revealed the O2 tubing and nasal cannula were coiled on top of the concentrator, lying on top of a plastic bag, uncovered.

On 10/23/18 at 4:30 p.m., Resident # 266 was observed in bed sitting up. Observation of O2 concentrator revealed the O2 tubing and nasal cannula were coiled on top of the concentrator, lying on top of a plastic bag, uncovered.

The physician's orders dated 10/16/18 for Resident # 622 documented, "O2 (oxygen) via (by) nasal cannula @ (at) 2LPM (two liters per minute)."

The TAR (treatment administration record) for Resident # 266 dated "10/16/18 thru 10/31/18 documented "O2 via nasal cannula @ 2LPM."

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Review of the TAR revealed Resident # 266 received oxygen by nasal cannula at two liter per minute from 10/17/18 through 10/24/18. Further review of the TAR revealed Resident # 266's oxygen was discontinued on 10/24/18.

The "Physician's telephone Order" dated 10/24/18 documented, D/C oxygen."

At the time of the survey, the comprehensive care plan was not due to be completed for Resident # 266. Review of the baseline care plan for Resident # 266 dated 10/17/2018 did not evidence an intervention for the storage of Resident # 266's nasal cannula or oxygen tubing.

On 10/24/18 at 2:32 p.m., an interview with LPN (licensed practical nurse) # 8. When asked how respiratory equipment (nasal cannula, oxygen tubing, C-PAP mask and nebulizer mask) should be stored, LPN # 8 stated, "It should be stored in a bag." When asked who was responsible for ensuring the respiratory equipment is stored properly, LPN # 8 stated, "The nurse." When asked why they should be stored in a bag, LPN # 8 stated, "For infection control." When informed of the observation of Resident # 266's nasal cannula and oxygen tubing, LPN # 8 stated, "It should be bagged."

On 10/25/18 at approximately 12:45 p.m., ASM (administrative staff member) # 2, the administrator and ASM # 2, assistant administrator, ASM # 4 assistant administrator, ASM # 5 director of nursing and ASM # 6, medical director were made aware of the findings.

No further information was provided prior to exit.

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References:
(1) A problem with the speed or rhythm of the heartbeat. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/atrialfibrillation.html.

(2) Low iron. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/anemia.html.

(3) High blood pressure. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/highbloodpressure.html.
6. The facility staff failed to administer oxygen per the physician order for Resident #73.

Resident #73 was admitted to the facility on 12/12/97, with a recent readmission on 8/10/18 with diagnoses that included but were not limited to: cerebral palsy [loss or deficiency of muscle control due to permanent, nonprogressive brain damage occurring before or at the time of birth. (1)], urinary retention, asthma [respiratory disorder characterized by recurrent episodes of difficulty in breathing, wheezing, cough, and thick mucus production, caused by inflammation of the bronchi. (2)], and respiratory failure with hypoxia [inadequate amount of available oxygen in the blood (3)].

The most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 9/13/18, coded the resident as being in a persistent vegetative

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state/no discernable consciousness. The resident was coded as being totally dependent upon one or more staff members for all of his activities of daily living. In Section O - Special Treatments, Procedures and Programs, the resident was coded as using oxygen while a resident in the facility.

The physician order on the October POS (physician order summary), signed by the physician on 10/18/18, documented, "O2 (oxygen) @ (at) 2 LPM (liters per minute) - may remove prn (as needed)."

Observation was made of Resident # 73 on 10/23/18 at approximately 1:00 p.m. The resident was in bed with oxygen on via a nasal cannula, [a tubing with two prongs that insert into the nose to deliver the oxygen] connected to an oxygen concentrator. The oxygen concentrator was set with the bottom of the ball resting on the line for 2 liters per minute and the top of the ball was sitting at the line for 2.5 liters per minute. The resident was observed a second time on 10/23/18 at 2:52 p.m. the oxygen was set at the same rate.

Observation was made on 10/24/18 at 8:28 a.m. The oxygen was in use via the nasal cannula. The oxygen concentrator flow meter was set with the bottom of the ball, resting on the line for 2 liters per minute and the top of the ball was sitting at the line for 2.5 liters per minute.
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Observation was made of Resident # 73 with LPN (licensed practical nurse) #6 on 10/24/18 at 2:40 p.m. LPN #6 verified the rate was not set at 2 liters per minute. When asked how to read the flow meter of the oxygen concentrator, LPN #6 stated, the line for the prescribed rate should be

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through the center of the ball. When asked if Resident #73's oxygen was set at the correct rate when we entered the room, LPN #6 stated, "No, Ma'am. It was between the lines."

The October 2018 TAR (treatment administration record) documented the above order for oxygen. The oxygen was signed off as administered as prescribed from 10/1/18 through 10/25/18.

The comprehensive care plan dated, 5/27/15 and revised on 9/24/18, documented, "Focus: AT risk for respiratory impairment related to aspiration, asthma." The "Interventions/Tasks" documented in part, "Administer oxygen per physician order."

The manufacturer's manual documented, "Flowrate: 1. Turn the flowrate knob to the setting prescribed by your physician or therapist. To properly read the flowmeter, locate the prescribed flowrate line on the flowmeter. Next, turn the flow know until the ball rises to the line. Now, center the ball on the L/Min (liters per minute) line prescribed. WARNING: DO NOT change the L/min setting on the flowmeter unless a change has been prescribed by your physician or therapist."

ASM (administrative staff member) #2 (the administrator), ASM #3 (the assistant administrator), ASM #4 (another assistant administrator), ASM #5 (the director of nursing) and ASM #6 (the medical director) were made aware of the above concern on 10/25/18 at 12:41 p.m.

No further information was provided prior to exit.

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F 695	Continued From page 129 (1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 114. (2) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 51. (3) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 286.	F 695		
F 697 SS=D	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview, clinical record review, and review of facility documentation, it was determined that the facility staff failed to maintain a complete pain management program for one of 46 residents in the survey sample, Resident #316. The facility staff failed to offer Resident #316 non-pharmacological interventions prior to the administration of as needed pain medication to on 10/19/18. The findings include: Resident #316 was admitted to the facility on 10/11/18. Resident #316's diagnoses included but were not limited to muscle weakness, urinary tract infection and left knee osteoarthritis.	F 697	1. Corrective Action Resident # 316 was discharged from the facility on 10/26/18. Licensed Nurses were re-educated on 11/5/18 on the requirement to offer and document non-pharmacological interventions (Ice, Heat, Massage ETC) for relief of pain prior to administration of as needed pain medication. 2. Other Potential Residents Residents that have pain issues and have a physicians order for as needed pain medication have the potential to be affected. An audit of 25% of residents with	12/1/18

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F 697	Continued From page 130 Resident #316's most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 10/18/18, coded the resident as being cognitively intact. Section J coded Resident #316 as reporting occasional pain over the last five days and as not having received non-medication interventions for pain. Review of Resident #316's clinical record revealed a physician's order dated 10/11/18, signed by the physician on 10/14/18 for oxycodone (1) 5 mg (milligrams)- one tablet every three hours as needed for moderate pain. Review of Resident 316's October 2018 MAR (medication administration record) revealed the resident was administered oxycodone on 10/19/18. Further review of Resident #316's clinical record (including the back of the October 2018 MAR and nurses' notes) failed to reveal non-pharmacological interventions were offered to Resident #316 prior to the administration of as needed oxycodone on 10/19/18. Resident #316's pain care plan initiated on 10/16/18 documented, "Pain related to recent surgery, left total knee replacement, osteoarthritis, DJD (degenerative joint disease)." The care plan failed to document information regarding non-pharmacological interventions. On 10/23/18 at 4:16 p.m., an interview was conducted with Resident #316. Resident #316 was asked if nurses offer non-medication interventions prior to administering as needed pain medication to her. Resident #316 stated, "Sometimes the nurse does when she comes in.	F 697	as needed orders for pain medication was completed on 11/12/18 to validate the use and documentation of non-pharmacological interventions for relief of pain . Any areas of non-compliance was immediately corrected and staff responsible have been counseled. 3.Systemic Changes An 25% audit will be completed weekly x 3 months of residents with as needed orders for pain medication to validate the use and documentation of non-pharmacological interventions for relief of pain . Any areas of non-compliance was immediately corrected and staff responsible have been counseled. 4. Monitoring The results of all audits will be forwarded to the QAPI Committee for review and recommendations. 5.Date of compliance 12/1/18	

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I don't think it's every time. I think they ask every other time. Maybe sometimes they offer an ice pack."

On 10/24/18 at 4:00 p.m., an interview was conducted with LPN (licensed practical nurse) #1. LPN #1 was asked what should be done prior to administering as needed pain medication to residents. LPN #1 stated, "Pain assessment and should probably try something before we administer pain medications. Ice the area, elevate the area." When asked if offered non-pharmacological interventions should be documented, LPN #1 stated, "If they do it. Because we want to try to- we don't want to result in always giving medication. We want to try something else before doing that." When asked why offered non-pharmacological interventions should be documented, LPN #1 stated, "To show that they did try to do something different before administration of pain medication. When asked what is meant if offered non-pharmacological interventions are not documented, LPN #1 stated, "If it's not documented, technically it means it's not done. I can't always say it's the cause. Sometimes we do offer other things prior to giving pain medication but we don't give ourselves credit for that."

On 10/24/18 at 4:08 p.m., an interview was conducted with LPN #2 (the nurse who administered oxycodone to Resident #316 on 10/19/18). LPN #2 was asked what should be done prior to administering as needed pain medication to residents. LPN #2 stated, "Ask what pain they are in and where it is. Make sure they are alert enough to be able to take it." When asked if she attempts non-pharmacological interventions prior to administering as needed

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F 697	Continued From page 132 pain medication, LPN #2 stated, "Yeah. Reposition. If we have ice available, something like that. Maybe a pillow." When asked if she offered non-pharmacological interventions prior to administering as needed pain medication to Resident #316, LPN #3 stated she did not recall. On 10/24/18 at 5:46 p.m., ASM (administrative staff member) #2 (the administrator), ASM#3 (the assistant administrator), ASM#4 (another assistant administrator), ASM#5 (them director of nursing) and ASM #6 (the medical director) were made aware of the above concern. The facility policy titled, "Pain-Clinical Protocol" documented, "3. Staff will provide the elements of a comforting environment and appropriate physical and complementary interventions; for example, local heat or ice, repositioning, massage, and the opportunity to talk about chronic pain..." No further information was presented prior to exit. (1) Oxycodone is used to treat pain. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a682132.html	F 697		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.	F 761		12/1/18

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F 761	Continued From page 133 §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and facility document review, it was determined that the facility staff failed to store medications according to professional standards for one of eight medications carts, a wing four medication cart. A medication cup containing various pills was stored in the top drawer of a medication cart on wing four. The findings include: On 10/25/18 at 11:48 a.m., observation of a medication cart on wing four was conducted. A medication cup labeled "407b," containing various pills was observed in the top drawer of the medication cart. On 10/25/18 at 11:52 a.m., an interview was	F 761	1. Corrective Action The pills that were stored in the medication cups were discarded. 2.Other Potential Residents Residents that receive medications from the identified medication cart on wing four have the potential to be affected. The nurses responsible have been counseled. Licensed nurses have been re-educated on medication pass procedures 3.Systemic Changes	

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F 761	Continued From page 134 conducted with LPN (licensed practical nurse) #6 (the nurse who was responsible for that medication cart). LPN #6 confirmed medications should be administered as soon as they are prepared. LPN #6 was asked if a medication cup containing various pills should be left in the medication cart. LPN #6 stated, "No." LPN #6 stated the pills should be discarded if not needed. LPN #6 stated one resident had refused his medication earlier in the morning. At this time, LPN #6 was shown the medication cup containing various pills located in the top of the medication cart. LPN #6 stated she was unaware of the cup of pills because another nurse was recently "on the cart." LPN #6 stated the other nurse should have discarded the pills when the resident refused them. When asked why, LPN #6 stated, "Well because once you open them it can compromise the medication, not to say it would, even though we have the medication cart locked. Again, it's not a policy that we do." On 10/25/18 at 10:12 a.m., ASM (administrative staff member) #2 (the administrator), ASM#3 (the assistant administrator), ASM#4 (another assistant administrator), ASM#5 (them director of nursing) and ASM #6 (the medical director) were made aware of the above concern. The facility policy titled, "Storage of Medications" documented, "1. Drugs and biologicals shall be stored in the packaging, containers or other dispensing systems in which they are received...2. The nursing staff shall be responsible for maintaining medication storage AND preparation areas in a clean, safe, and sanitary manner..." No further information was presented prior to exit.	F 761	A weekly observation of 50% of medication carts will be conducted x 3 months to validate that there are no pills left in a cup in the medication carts. Any areas of non-compliance will be immediately corrected and staff responsible will be counseled. 4. Monitoring The results of all audits will be forwarded to the QAPI Committee for review and recommendations. 5.Date of compliance 12/1/18	

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F 804 SS=B	Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview and staff interview, it was determined the facility staff failed to serve food at a palatable temperature on one of four wings, wing one. The facility staff failed to serve food at a palatable temperature on 10/24/18. The findings include: On 10/24/18 at approximately 5:00 p.m., an observation was made of the tray line in the kitchen. The holding temperatures were taken of all of the food from the tray line by OSM (other staff member) #5 using a calibrated facility thermometer. The temperature of the food in Fahrenheit is as follows: Puree Chicken - 170 degrees Puree Vegetables - 160 degrees Mashed Potatoes - 146 degrees Gravy - 181 degrees Greens - 145 degrees Pasta Primavera - 166 degrees Chicken Salad - 38.9	F 804	1.Corrective Action Dietary staff were re-educated on 10/29/18 on appropriate temperatures for food service. Nursing staff were re-educated on 10/29/18 on prompt tray delivery The facility has ordered a new plate heating system and we expect delivery within 30 days. 2.Other Potential Residents Residents that receive meals in their room on unit 1 have the potential to be affected. 3. Systemic Changes An audit/observation will be completed monthly x 3 months to include taking and recording temperatures of a test tray on unit 1. Any areas of non-compliance will be immediately corrected and staff responsible will be counseled.	12/1/18

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F 804	Continued From page 136 The trays, including a test tray, left the kitchen and arrived at wing one at 6:05 p.m. The last resident was served at 6:15 p.m. Testing of temperature was conducted at 6:15 p.m. by OSM (other staff member) #1, the Dietary Manager using a calibrated facility thermometer. Test tray consisted of puree chicken, puree vegetables, mashed potatoes, pasta primavera, chicken salad and lemon mousse. The recorded serving temperatures in Fahrenheit is as follows: Puree Chicken - 121 degrees (decrease of 49 degrees) Puree Vegetables - 112 degrees (decrease of 48 degrees) Mashed Potatoes - 115 degrees (decrease of 31 degrees) Pasta Primavera - 126 degrees (decrease of 30 degrees) Chicken Salad - 32 degrees Lemon mousse - 63 degrees Three surveyors and OSM #1, the Dietary Manager then tested the test tray for taste and palatability. When asked to describe the food's temperature, OSM #1 replied, "It should be hotter, it fails." Resident #128 was admitted to the facility on 9/21/18. Resident #128's diagnoses included but were not limited to diabetes, high blood pressure and urinary retention. Resident #128's most recent MDS (minimum data set), a 30 day Medicare assessment with an ARD (assessment reference date) of 10/19/18, coded the resident as being cognitively intact. On 10/23/18 at approximately 1:59 p.m., an interview was conducted with Resident #128.	F 804	4. Monitoring The results of all audits will be forwarded to the QAPI Committee for review and recommendations. 5.Date of compliance 12/1/18	

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F 804	Continued From page 137 During the interview, Resident #128 stated he eats dinner in his room (on wing one) and the food is lukewarm. Resident #119 was admitted to the facility on 9/7/18. Resident #119's diagnoses included but were not limited to pneumonia, heart failure and shortness of breath. Resident #119's most recent MDS (minimum data set), a 30 day Medicare assessment with an ARD (assessment reference date) of 10/3/18, coded the resident as being cognitively intact. On 10/23/18 at approximately 3:59 p.m., an interview was conducted with Resident #119. During the interview, Resident #119 stated she eats dinner in her room (on wing one) and the food is hard and cold. On 10/24/18 at approximately 1:55 p.m., ASM (administrative staff member) #2 the Assistant Administrator stated that the facility did not have a policy on the temperature and/or palatability of food. On 10/25/18 at approximately 12:45 p.m., ASM (administrative staff member) #2, Assistant Administrator and ASM #5, the Director of Nursing were made aware of the findings. No further information was obtained prior to exit.	F 804		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources	F 812		12/1/18

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F 812	Continued From page 138 approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and facility document review, it was determined that the facility staff failed to store, prepare and distribute food in a sanitary manner. 1. The facility staff failed to maintain the kitchen floor in a sanitary manner. 2. The facility staff failed to ensure sanitation of dishes in the three-compartment sink. 3. The facility staff failed to ensure OSM (other staff member) #9's (the cook) beard was covered in the food preparation area. 4. The facility staff failed to ensure tray line serving utensils were clean. 5. The facility staff failed to ensure dishes were dried on the dish rack in a sanitary manner. 6. The facility staff failed to clean thermometer	F 812	1.Corrective Action Food Service staff have been re-educated on kitchen sanitation requirements including, but not limited to drying of dishes, hair covering, including beards, fully immersing dishes in 3 compartment sink, keeping kitchen floor clean, ensuring utensils on tray line are clean and using clean thermometers to check food temperatures. 2. Other Potential Residents All residents have the potential to be affected. Food Service staff have been re-educated on kitchen sanitation requirements including, but not limited to drying of dishes, hair covering, including beards, fully immersing dishes in 3 compartment sink, keeping kitchen floor clean, ensuring	

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F 812	Continued From page 139 prior to use for obtaining food temperatures on the dining room tray line. The findings included: 1. The facility staff failed to maintain the kitchen floor in a sanitary manner. Observation was made of the kitchen on 10/23/18 at approximately 11:02 a.m., with two state surveyors and one federal surveyor. Upon entering the kitchen, the surveyors were met by ASM (administrative staff member) #2, the Assistant Administrator, OSM (other staff member) #1, the Dietary Manager and OSM #5, the Chef for the initial tour. During the initial tour in the kitchen on 10/23/18, at approximately 11:05 a.m., an observation was made of the floors throughout the food kitchen. The kitchen floor surface throughout the food preparation area appeared dirty with copious black debris, food and grease. OSM #1 was asked what the black debris was on the floor, OSM #1 stated, "The black debris on the floor comes off the shoes." Review of the kitchen cleaning logs for October 2018, documented the floors in the kitchen and dish area were singed off as being swept and moped after each service with the exception of 10/1/18. An interview was conducted on 10/24/18 at approximately 1:35 p.m., with OSM #1 and OSM #5. When asked why it is important for the floors in the kitchen be clean, OSM #1 responded, "To keep the kitchen sanitary and prevent infection. Keeping the kitchen free of debris helps keep it	F 812	utensils on tray line are clean and using clean thermometers to check food temperatures. 3. Systemic Changes An audit/observation will be completed weekly x 3 months to validate that sanitary conditions are being met in the kitchen. Any areas of non-compliance will be immediately corrected and staff responsible will be counseled. 4. Monitoring The results of all audits will be forwarded to the QAPI Committee for review and recommendations. 5.Date of compliance 12/1/18	

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sanitary and helps prevents slips, trips and falls." When asked how often the floors in the kitchen are cleaned, OSM #5 stated, "Daily and the person who does it signs it off in a log."

Review of facility policy titled, "Sanitization" documented "All kitchens, kitchen area and dining area shall be kept clean, free from litter and rubbish and protected from rodents, roaches, flies and other insects."

On 10/25/18 at approximately 12:45 p.m., ASM (administrative staff member) #2, Assistant Administrator and ASM #5, the Director of Nursing were made aware of the findings.

No further information was obtained prior to exit.

2. The facility staff failed to ensure sanitation of dishes in the three-compartment sink.

During the initial tour in the kitchen on 10/23/18, at approximately 11:10 a.m., an observation was made of three-compartment sink in the kitchen. The three-compartment sink was observed filled with dishes including large mixing bowls. The dishes were observed not completely submerged in the sanitization solution.

On 10/23/18 at approximately 11:12 a.m., an observation was made of three-compartment sink in the kitchen by OSM #5. OSM #5 was asked what he saw in the three-compartment sink, OSM #5 replied "A lot of large dishes and mixing bowel in the sink waiting to be clean. Some of the dishes are not in the sanitization solution."

On 10/24/18 at approximately 1:40 p.m., an interview was conducted with OSM #1 and OSM

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#5. When asked were all the dishes in the three compartment sink submerged in sanitization prior to being cleaned, OSM #5 replied "No." When asked why it is important that the dishes be submerged in sanitization solution, OSM #1 replied, "If the dishes are not submerged the sanitization solution can't clean them."

Review of the facility policy titled, "Sanitization" dated 5/2/2018 documented, "c. Then submerge objects in sanitizer sink (Sink 3) for one minute or as specified by the Oasis 146 Multi-Quat Sanitizer product label and/ or local guidelines."

On 10/25/18 at approximately 12:45 p.m., ASM (administrative staff member) #2, Assistant Administrator and ASM #5, the Director of Nursing were made aware of the findings.
No further information was obtained prior to exit.

3. The facility staff failed to ensure OSM (other staff member) #9's (the cook) beard was covered in the food preparation area.

During the initial tour in the kitchen on 10/23/18, at approximately 11:13 a.m., an observation was made OSM #9, Cook. OSM #9 was observed with a beard cover that covered approximately 2/3rd's of his beard.

On 10/24/18 at approximately 1:42 p.m., an interview was conducted with OSM #1 and OSM #5. When asked how a beard is supposed to be covered, OSM #5 replied, "The beard should be completely covered."

Review of the facility policy titled, "Preventing Foodborne Illness- Employee Hygiene and

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Sanitary Practices" dates October 2017 documented, "Hair nest or caps and/or beard restraints must be worn to keep hair from contacting exposed food, clean equipment, utensils and linens."

On 10/25/18 at approximately 12:45 p.m., ASM (administrative staff member) #2, Assistant Administrator and ASM #5, the Director of Nursing were made aware of the findings. No further information was obtained prior to exit.

4. The facility staff failed to ensure tray line serving utensils were clean.

During the initial tour in the kitchen on 10/23/18, at approximately 11:50 a.m., an observation was made prior to the start of tray line. Observation was made of the two large ladles, a spatula; a green handled a scoop and a slotted spoon. Both the green handled spoon and slotted spoon were observed to have pooled water in them. The spatula was observed to have old food debris.

On 10/23/18 at approximately 11:51 a.m., observation was made with OSM #5 of the tray line serving utensils. When asked what OSM #5 observed, OSM #5 replied, "Ladles with water in them and spatula with some food debris."

On 10/23/18 at approximately 11:52 a.m., an interview was conducted with OSM #5. When asked if utensils used to serve food should have pooled water in them, OSM #5 replied "No, because bacteria can grow there." When asked how are utensils supposed to be kept, OSM #1 replied "clean, dry and without food debris.

Review of the facility policy titled, "Sanitization"

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dated 5/2/18 documented, "2. All utensils, counters, shelves, and equipment shall be kept clean, maintained in good repair. 3. All equipment, food contact surfaces and utensils shall be washed to remove or completely loosen soils by using manual or mechanical means necessary and sanitized using hot water and/or chemical sanitization solutions."

On 10/25/18 at approximately 12:45 p.m., ASM (administrative staff member) #2, Assistant Administrator and ASM #5, the Director of Nursing were made aware of the findings.

No further information was obtained prior to exit.

5. The facility staff failed to ensure dishes were dried on the dish rack in a sanitary manner.

During the initial tour in the kitchen on 10/23/18, at approximately 11:55 a.m., an observation was made of dishes on the drying rack adjacent to the three-compartment sink. One large clear plastic tub on the bottom drying rack positioned right side up, was observed to contain a pool of water in the bottom.

On 10/23/18 at approximately 11:56 a.m., observation was made with OSM #5 of the drying rack. When asked what OSM #5 observed, OSM #5 replied "A dish with water in the bottom of it."

On 10/23/18 at approximately 11:58 a.m., an interview was conducted with OSM #5. OSM #5 was asked how the tub should be stored on a drying rack. OSM #5 replied "Upside down. If not water can pool in it and cause bacteria to grow. When asked how dishes are supposed to be

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stored on a drying rack, OSM #1 replied "Upside down."

On 10/25/18 at approximately 12:45 p.m., ASM (administrative staff member) #2, Assistant Administrator and ASM #5, the Director of Nursing were made aware of the findings.

No further information was obtained prior to exit.

6. The facility staff failed to clean a thermometer prior to use for obtaining temperatures on the dining room tray line.

On 10/23/18 at approximately 12:05 a.m., an observation was made of OSM #6 obtaining tray line temperatures in the dining room. OSM #6 informed the surveyors that he did not have a thermometer and proceeded to ask OSM #7 if she had a thermometer. OSM #7 proceeded to take a thermometer out of her jacket pocket and gave the thermometer to OSM #6. OSM #6 then took the temperature probe cover off the thermometer and began to take the tray line temperatures in the dining room. OSM #6 did not clean the thermometer probe prior to taking the first temperature.

On 10/24/18 at approximately 1:45 p.m., an interview was conducted with OSM #1 and OSM #5. When asked if thermometers should be cleaned prior to checking temperatures on the flood tray line, OSM #1 replied, "Yes, before use and in between use on different foods."

Review of the facility policy titled, "Preventing Foodborne Illness- Food Handling" dated July 2014 documented, "Food will be stored, prepared, handled and served so that the risk of

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F 812	Continued From page 145 foodborne illness is minimized." On 10/25/18 at approximately 12:45 p.m., ASM (administrative staff member) #2, Assistant Administrator and ASM #5, the Director of Nursing were made aware of the findings. No further information was obtained prior to exit.	F 812		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law;	F 842		12/1/18

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F 842	Continued From page 146 (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. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview and	F 842	1. Corrective Action	

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F 842	Continued From page 147 clinical record review, it was determined that the facility staff failed to maintain a complete and accurate clinical record for one of 46 residents in the survey sample, Resident #316. The facility staff failed to document non-pharmacological interventions that were offered to Resident #316, prior to administering as needed pain medication on multiple dates in October 2018. The findings include: Resident #316 was admitted to the facility on 10/11/18. Resident #316's diagnoses included but were not limited to muscle weakness, urinary tract infection and left knee osteoarthritis. Resident #316's most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 10/18/18, coded the resident as being cognitively intact. Section J coded Resident #316 as reporting occasional pain over the last five days and as not having received non-medication interventions for pain. Review of Resident #316's clinical record revealed a physician's order dated 10/11/18 and signed by the physician on 10/14/18 for oxycodone (1) 5 mg (milligrams)- one tablet every three hours as needed for moderate pain. Review of Resident 316's October 2018 MAR (medication administration record) revealed the resident was administered oxycodone on the following dates (including but not limited to): 10/17/18 10/20/18 10/21/18 10/22/18	F 842	Licensed Nurses were re-educated on 11/5/18 on the requirement to document specific non-pharmacological interventions for relief of pain, prior to administration of as needed pain medication. It was reviewed with the nurses the importance of documenting the specific intervention and the effectiveness of the intervention. 2. Other Potential Residents Residents that have pain issues and have a physicians order for as needed pain medication have the potential to be affected. An audit of 25% of residents with as needed orders for pain medication was completed on 11/12/18 to validate documentation of non-pharmacological interventions for relief of pain . Any areas of non-compliance was immediately corrected and staff responsible have been counseled. 3.Systemic Changes An 25% audit will be completed weekly x 3 months of residents with as needed orders for pain medication to validate appropriate documentation of non-pharmacological interventions for relief of pain . Any areas of non-compliance was immediately corrected and staff responsible have been counseled. 4. Monitoring	

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F 842	Continued From page 148 Further review of Resident #316's clinical record (including the back of the October 2018 MAR and nurses' notes) failed to reveal non-pharmacological interventions were offered to Resident #316 prior to the administration of as needed oxycodone on all of the above dates. Resident #316's pain care plan initiated on 10/16/18 documented, "Pain related to recent surgery, left total knee replacement, osteoarthritis, DJD (degenerative joint disease)." The care plan failed to document information regarding the documentation of non-pharmacological interventions. On 10/23/18 at 4:16 p.m., an interview was conducted with Resident #316. Resident #316 was asked if nurses offer non-medication interventions prior to administering as needed pain medication to her. Resident #316 stated, "Sometimes the nurse does when she comes in. I don't think it's every time. I think they ask every other time. Maybe sometimes they offer an ice pack." On 10/24/18 at 3:54 p.m., an interview was conducted with LPN (licensed practical nurse) #3 (the nurse who administered as needed oxycodone to Resident #316 on the above dates). LPN #3 was asked what should be done prior to administering as needed pain medication to residents. LPN #3 stated she assesses residents' pain and asks if there is anything else, she can do such as, reposition the resident or offer an ice pack. When asked if she documents the non-pharmacological interventions that she offers to residents, LPN #3 stated, "No." When asked if she should document, LPN #3 stated,	F 842	The results of all audits will be forwarded to the QAPI Committee for review and recommendations. 5.Date of compliance 12/1/18	

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F 842	Continued From page 149	F 842		

"Probably." When asked why she should document the non-pharmacological interventions that she offers, LPN #3 stated, "I really don't have to. It's more for my assessment to see what else I can do to help her pain." LPN #3 stated she does give Resident #316 an ice pack.

On 10/24/18 at 4:00 p.m., an interview was conducted with LPN #1. LPN #1 was asked what should be done prior to administering as needed pain medication to residents. LPN #1 stated, "Pain assessment and should probably try something before we administer pain medications. Ice the area, elevate the area." When asked if offered non-pharmacological interventions should be documented, LPN #1 stated, "If they do it. Because we want to try to, we don't want to result in always giving medication. We want to try something else before doing that." When asked why offered non-pharmacological interventions should be documented, LPN #1 stated, "To show that they did try to do something different before the administration of pain medication."

On 10/24/18 at 5:46 p.m., ASM (administrative staff member) #2 (the administrator), ASM#3 (the assistant administrator), ASM#4 (another assistant administrator), ASM#5 (them director of nursing) and ASM #6 (the medical director) were made aware of the above concern.

The facility policy titled, "Pain-Clinical Protocol" failed to document information regarding the documentation of non-pharmacological interventions.

No further information was presented prior to exit.

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F 842	Continued From page 150 (1) Oxycodone is used to treat pain. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a682132.html	F 842		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of	F 880		12/1/18

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F 880	Continued From page 151 communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, facility document review, and clinical record review, it was determined that facility staff failed to provide care in a manner to prevent infection for one of 46 residents in the survey	F 880	1. Corrective Action The physician order for oxygen for resident #110 was discontinued 10/24/18	

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F 880	Continued From page 152 sample, Resident #110; and failed to maintain the drainage system for one of two ice machines, (the ice machine adjacent to the kitchen), in a sanitary manner to prevent infection. 1. The facility staff failed to ensure Resident #110's contaminated oxygen tubing was discarded and not available for use. 2. The facility staff failed to maintain an ice machine drainage system in a sanitary manner for one of two ice machines, the one on adjacent to the kitchen. The findings include: 1. The facility staff failed to ensure Resident #110's contaminated oxygen tubing was discarded and not available for use. Resident #110 was admitted to the facility on 9/24/18 with diagnoses that included but were not limited to Parkinson's disease, unspecified dementia without behavioral disturbance, hypothyroidism, high blood pressure, and congestive heart failure. Resident #110's most recent MDS (minimum data set) assessment was a thirty day scheduled assessment with an ARD (assessment reference date) of 10/22/18. Resident #110 was coded as being cognitively intact in the ability to make daily decisions scoring 13 out of possible 15 on the BIMS (Brief Interview for Mental Status) exam. Resident #110 was coded as requiring extensive assistance from two plus persons with bed mobility and transfers; and extensive assistance from one staff member with walking, locomotion, dressing, eating, toileting, and personal hygiene.	F 880	The end of the drainpipe for the ice machine adjacent to the kitchen was corrected on 10/23/18 to allow a 2" clearance above the surface of the drain. 2. Other Potential Residents Residents who are receiving respiratory therapy have the potential to be affected. An audit/observation of residents receiving respiratory therapy was completed on 11/9/18 to validate that they have an appropriate order for oxygen, including the specific flow rate, adequate monitoring of the residents oxygen saturation level and to validate that all respiratory equipment is stored in a sanitary manner. Any areas of non-compliance has been corrected and staff responsible have been counseled. Residents that receive ice from the ice machine adjacent to the kitchen have the potential to be affected. The end of the drainpipe for the ice machine adjacent to the kitchen has been corrected to allow a 2" clearance above the surface of the drain. 3. Systemic Changes A weekly audit of 25% of residents receiving oxygen therapy will be completed to validate that they have an appropriate order for oxygen, including the specific flow rate, adequate monitoring of	

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F 880	Continued From page 153 On 10/23/18 at 4:04 p.m., an observation was made of Resident #110. She was sitting up in her wheelchair. She had an oxygen concentrator in her room that was off. The oxygen tubing (nasal cannula included) was laying on the floor. The tubing was dated 10/20. When asked Resident #110 if she used her oxygen, Resident #110 stated that sometimes she wore it at night. On 10/24/18 at 9:51 a.m., an observation was made of Resident #110. Resident #110 was sitting up in her wheelchair. Her oxygen concentrator was off. Her oxygen tubing dated 10/20 was rolled up and stored in a plastic bag. Resident #110 stated that she didn't need her oxygen the night prior. Resident #110 stated that she could not reach her concentrator from her wheelchair. On 10/24/18 at 4:57 p.m., Resident #110's oxygen tubing dated 10/20 was still rolled up and stored in a plastic bag. On 10/25/18 at 10:06 a.m., Resident #110's oxygen concentrator was removed from her room. Review of Resident #110's telephone order sheet dated 10/2/18 documented the following order: "May wear 02 via NC (nasal cannula) @ 2 lm (liters a minute) for SOB (short of breath) prn (as needed)." Review of Resident #110's October 2018 TAR (treatment administration record) revealed no evidence that Resident #110 had needed her oxygen since it was ordered. On 10/25/18 at 9:35 a.m., an interview was	F 880	the residents oxygen saturation level and to validate that all respiratory equipment is stored in a sanitary manner. 4. Monitoring The results of all audits will be forwarded to the QAPI Committee for review and recommendations. 5.Date of compliance 12/1/18	

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conducted with LPN (licensed practical nurse) #4, the nurse manager. When asked what should be done if nursing staff were to see oxygen tubing on the floor, LPN #4 stated nursing staff should be throwing the contaminated tubing in the trash and getting a new one. When asked if it was ever okay to place the contaminated tubing in a plastic bag for use, LPN #4 stated, "Not if it's been on the floor."

On 10/25/18 at 10:54 a.m., an interview was conducted with LPN #5. When asked what should be done if nursing staff were to see oxygen tubing on the floor, LPN #5 stated that the tubing should be changed and not reused. LPN #5 stated that the oxygen tubing should be changed for sanitary reasons. When asked if Resident #110 was able to reach her own oxygen tubing from her bed or wheelchair and roll it up in a plastic bag, LPN #5 stated that Resident #110 could not reach her concentrator from her bed or wheelchair.

On 10/25/18 at 12;47 p.m., ASM #1, the senior administrator, ASM #2, the administrator, ASM #3, the assistant administrator, ASM #4, the other assistant administrator, ASM #5, the DON (Director of Nursing) and ASM #4, the medical director were all made aware of the above concerns.

A policy could not be provided regarding the above concerns.

2. The facility staff failed to maintain an ice machine drainage system in a sanitary manner for one of two ice machines, the one adjacent to the kitchen.

Observation was made of the ice machine adjacent to the kitchen on 10/23/18 at

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approximately 11:10 a.m., with ASM (administrative staff member) #2, the Assistant Administrator and OSM (other staff member) #5, the Chef. The drainpipe was not visible with an opening of two inches above the surface of the drain. A white PVC (Polyvinyl chloride) cuffed flange had been attached to the drain. ASM #2 stated the facility was having trouble with splashing from the drainpipe causing water on the floor, thus having a hazard. The end of the drainpipe was not visible, thus the drainage pipe from the ice machine was not above the surface of the drain and could have backflow of water into the drainage pipe.

On 10/23/18 at approximately 11:11 a.m., an interview was conducted with ASM #2. ASM #2 was asked is there should there be space in between the drainpipe and the drain, ASM #2 responded "Yes, because if there is a backflow of water it will go up the drainpipe."

On 10/24/18 at approximately 1:11 p.m., an interview was conducted with OSM #10, the Director of Maintenance. OSM #10 was asked if the drainpipe on the ice machine should come into contact with a drain or any of its components, OSM #10 replied "No, I don't know how much space there should be but I know the drain pipe should have a space between it and the drain." When asked why there should be a space, OSM #10 replied "In case water backs up from the drain."

On 10/24/18 at approximately 1:30 p.m., OSM #10 stated the he could not locate any facility policy on the specification of an ice machine drain.

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F 880	Continued From page 156 On 10/25/18 at approximately 12:45 p.m., ASM (administrative staff member) #2, Assistant Administrator and ASM #5, the Director of Nursing were made aware of the findings. No further information was obtained prior to exit.	F 880		