STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495371	A. BUILDING _____ B. WING _____	C 01/28/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HALL-RICH CREEK	120 OLD VIRGINIA AVENUE RICH CREEK, VA 24147

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 01/23/19 through 01/28/19. The facility was in substantial compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities. Three complaints was investigated during the survey.	E 000		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 1/23/19 through 1/28/19. Three complaints were investigated during the survey. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. The census in this 120 certified bed facility was 117 at the time of the survey. The final survey sample consisted of 24 current Resident reviews and 5 closed record reviews.	F 000		
F 622 SS=C	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	F 622	Corrective Action(s): The facility staff failed to provide the receiving hospital with the appropriate information related to the transfer, contact information for the attending physician, contact information for the Resident Representative, Advance directive information, any special instructions or precautions for ongoing care, comprehensive care plan goals and all other necessary	

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

Jeremiah Fink Administrator 2-13-19

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

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F 622	Continued From page 1 endangered due to the clinical or behavioral status of the resident; (D) The health of individuals in the facility would otherwise be endangered; (E) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; 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	F 622	information including the residents discharge summary and the facility failed to document the information provided to the receiving hospital for Residents #267, #104, #83, #90, #36, #115, #218, #19, #25 and #69. A facility Incident & Accident Form has been completed for each resident involved. Identification of Deficient Practices/Corrective Action(s): All other residents discharged and/or transferred from the facility may have been affected. The DON/designee will conduct a 100% audit of all residents who have been discharged and/or transferred from the facility in the past 30 days to identify residents that did not have the required documentation submitted to the receiving facility. A facility Incident & Accident Form will be completed for each negative finding. Systemic Change(s): Facility policy and procedures have been reviewed. No revisions are warranted at this time. The DON and/or	

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F 622	Continued From page 2 must include: (A) The basis for the transfer per paragraph (c)(1)(i) of this section. (B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s). (ii) The documentation required by paragraph (c)(2)(i) of this section must be made by- (A) The resident's physician when transfer or discharge is necessary under paragraph (c) (1) (A) or (B) of this section; and (B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of 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, the facility staff failed to provide the receiving provider with the appropriate information to include basis for the transfer, contact information of the practitioner responsible for the care of the resident, resident	F 622	Regional Nurse Consultant will inservice facility licensed staff on the documentation required to be submitted to the receiving facility when a resident is being transferred or discharged to the hospital or other outside health care facility/provider. Monitoring: The DON/designee will be responsible for maintaining compliance. The DON and/or designee will conduct chart audits weekly of all residents who have been discharged and/or transferred from the facility to monitor for compliance. Any/all negative findings and or errors will be corrected at time of discovery. Aggregate findings of these audits will be reported to the Quality Assurance Committee quarterly for review, analysis, and recommendations for change in facility policy, procedure, and/or practice. Completion Date: 3/12/19	

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F 622	Continued From page 3 representative information including contact information, Advanced Directive information, all special instructions or precautions for ongoing care, comprehensive care plan goals, and all other necessary information including a copy of the resident's discharge summary and failed to document information provided to the receiving provider for 10 of 29 residents (Resident #267, Resident #104, Resident #83, Resident #90, Resident #36, Resident #115, Resident #218, Resident #19, Resident #25, and Resident #69). The findings included: 1. The facility staff failed to provide the receiving provider with information for on-going care when Resident #104 was transferred to the hospital. The clinical record of Resident #104 was reviewed 1/23/19 through 1/28/19. Resident #104 was admitted to the facility 12/10/18 and readmitted 1/2/19 with diagnoses that included but not limited to hypokalemia, dementia with behavioral disturbances, atrial fibrillation, restlessness and agitation, insomnia, infected left femur fracture, metabolic encephalopathy, urinary tract infection, and hypertension. Resident #104's significant change minimum data set (MDS) assessment with an assessment reference date (ARD) of 1/9/19 assessed the resident with a brief interview for mental status (BIMS) as 4/15. The departmental note dated 12/19/18 at 2:18 p.m. read in part "She is leaving facility at this time for direct admit to RGH (name of hospital omitted). Transported via (name of ambulance service omitted) and two attendants."	F 622		

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F 622	Continued From page 4 The departmental notes were reviewed on 1/24/19. The 12/19/18 5:32 p.m. departmental note read, "RGH (name of hospital) nurse called and wanted to know why resident was there. She did not get a report from this facility as to why. They do have a bed and she is been admitted (sic) at this time." The clinical record had no documentation of contact information, what information was provided to the hospital, advanced directive information, resident representative contact information, contact information from the facility, transfer form, comprehensive careplan goals sent, or any special instructions or bed hold offer. The surveyor informed the administrator, the director of nursing and the corporate registered nurse of the above concern during the end of the day meeting on 1/24/19 at 4:14 p.m. The survey team asked what information was provided when residents are transferred to the hospital. The director of nursing stated the face sheet and the medication administration record (MAR). The DON stated the facility was just beginning to work on a form called "Interact" but had to be completed. The surveyor requested the facility policy on transfers/discharges. The director of nursing provided the surveyor with the policy titled "Bed-Holds and Returns" on 1/25/19. The policy read in part "Prior to transfers and therapeutic leaves, residents or resident representatives will be informed in writing of the bed-hold and return policy." The director of nursing did not provide a policy for transfers/discharges prior to the exit conference	F 622		

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F 622	Continued From page 5 on 1/28/19.	F 622		

2. The facility staff failed to provide Resident #90's transfer/discharge information to the receiving provider when transferred to the hospital on 10/29/18 and 11/4/18.

The clinical record of Resident #90 was reviewed 1/23/19 through 1/28/19. Resident #61 was admitted to the facility 3/13/17 and readmitted 11/2/18 and 11/7/18 with diagnoses that included but not limited to vascular dementia without behavioral disturbances, type 2 diabetes mellitus, hypothyroidism, cervical disc disorder, right femur intertrochanteric fracture, osteoporosis, gastro-esophageal reflux disease, contusion of scalp, chronic diastolic heart failure, cerebral infarction, dysphagia, major depressive disorder, polyneuropathy, anemia, hypertension, and hyperlipidemia.

Resident #90's significant change in assessment minimum data set (MDS) assessment with an assessment reference date (ARD) of 1/2/19 assessed the resident with a brief interview for mental status (BIMS) as 7/15.

A telephone order dated 10/29/18 read "May send resident to ER (emergency room) for eval (evaluation) & treat (treatment)."

The surveyor reviewed the departmental note dated 10/29/18 10:44 p.m. The note read in part: "Late Entry: This nurse was called to therapy gym. Resident was found in floor on right side. Resident stated she had lost her balance and fell to the floor. Upon assessment resident stated she had pain in her right hip and right side of her head on a pain scale of 4 out of 10. Right side of

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F 622	Continued From page 6	F 622		

head had hematoma present. Resident was assisted to wheelchair and to her room. MD (medical doctor) notified (name omitted) concerned of resident on Coumadin with the fall and wanted resident to be sent to ER (name omitted). Transport arrived at 1820 (6:20 p.m.) and resident left via stretcher."

Departmental note dated 10/30/18 10:44 a.m. read in part "Resident admitted to hospital."

A second physician order dated 11/4/18 read "May send out to ER (name omitted) for eval & tx (treatment) due to increased confusion, combativeness, trying to harm self and decreased O2 (oxygen) sat (saturation)."

The surveyor reviewed the departmental note dated 11/4/18 6:46 p.m. The note read "Late entry 6p.m. Resident noted to have increased confusion with big change in personality. She has been very combative to staff this shift. Resident can normally hold a normal conversation, but cannot at this time. She began doing things to herself, such as, pulling her own hair, bending fingers backwards while looking at staff and stating "look here, I'm going to tell them you did this. You are going to be accused of it." This is not normal behavior for this resident. This nurse sent to ER for eval and tx. Physician aware and RP (responsible party) agrees with this nurses decision and is meeting resident at hospital."

The clinical record did not have documentation of resident information provided to the receiving provider of the advanced directive, contact information of the resident representative or contact information of the sending facility,

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F 622	Continued From page 7 comprehensive care plan goals, discharge summary/transfer form, or special instructions for care or bed hold offer. The surveyor informed the director of nursing of the above information not found in the clinical record for either of Resident #61's transfers to the emergency room and subsequent admissions to the hospital on 10/29/18 and 11/4/18 on 1/27/19 at 3:55 p.m. The director of nursing stated the only information sent with the resident was the face sheet and the medication administration record (MAR). The surveyor informed the administrator, the director of nursing and the corporate registered nurse of the above concern during the end of the day meeting on 1/24/19 at 4:14 p.m. The survey team asked what information was provided when residents are transferred to the hospital. The director of nursing stated the face sheet and the medication administration record (MAR). The DON stated the facility was just beginning to work on a form called "Interact" but had to be completed. The surveyor requested the facility policy on transfers/discharges. The director of nursing provided the surveyor with the policy titled "Bed-Holds and Returns" on 1/25/19. The policy read in part "Prior to transfers and therapeutic leaves, residents or resident representatives will be informed in writing of the bed-hold and return policy." The director of nursing did not provide a policy for transfers/discharges prior to the exit conference on 1/28/19. 3. The facility staff failed to provide	F 622		

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F 622	Continued From page 8 transfer/discharge information to the receiving provider when Resident #218 was transferred to the hospital. The clinical record of Resident #218 was reviewed 1/23/19 through 1/28/19. Resident #218 was admitted to the facility 4/6/18 and readmitted 1/21/19 with diagnoses that included but not limited to acute osteomyelitis, sepsis, cellulitis of right lower limb and chronic respiratory failure with hypercapnia. Resident #218's admission minimum data set (MDS) assessment with an assessment reference date (ARD) of 1/14/19 assessed the resident with a brief interview for mental status (BIMS) as 15/15. The clinical record revealed three emergency room visits with two requiring hospitalizations. Resident #218 was sent to the emergency room on 11/24/18 for abdominal pain and constipation. There was documentation that a report was called to the emergency room but no further evidence of what information was provided to the receiving provider. The clinical record revealed Resident #218 was admitted to the hospital 1/4/19 as evidenced by the physician discharge summary for 1/4/19-1/7/19. The departmental note dated 1/4/19 at 3:43 a.m. read "Resident left facility via wheelchair with son at 3:40 a.m. to go to an appointment. No skin issues or distress noted." The departmental note dated 1/4/19 at 11:44 a.m. read "Resident continues to be out of facility." The departmental note dated 1/4/19 at 10:44 p.m. read "Resident remains OOF (out of facility) at hospital."	F 622		

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F 622	Continued From page 9 None of the notes dated 1/4/19 detail information sent to the receiving provider when the resident did not return to the facility on 1/4/19. The clinical record revealed Resident #218 was admitted to the hospital 1/18/19-1/21/19 for acute kidney injury. The departmental note dated 1/18/19 at 1:53 p.m. read in part "Resident complains of feeling bad. Could not state exactly what her complaints were more specifically. Did state she was having double vision and that her vision was wavey. MD (medical doctor-name omitted) notified. Telephone order received to send patient to ER (emergency room) for evaluation and treatment of complaints." The departmental note dated 1/18/19 at 2:24 p.m. read "EMS (emergency medical services) notified for transport to the ED (emergency department), report called to ED (name omitted)." The departmental note dated 1/19/19 at 10:32 a.m. read in part "Resident was admitted 1/18/19 for acute kidney injury." None of the transfers/discharges/hospitalizations had documentation in the clinical record of information provided to the receiving provider-contact information of the practitioner, contact information of the resident representative, transfer form, advanced directive, comprehensive care plan goals, or any pertinent information pertaining to the ongoing care of the resident or offer of bed-hold information. The survey team met with the administrator, the director of nursing (DON), and the corporate registered nurse on 1/24/19 at 4:14 p.m. and	F 622		

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F 622	Continued From page 10	F 622		

informed them of the required information sent to the hospital when a resident was transferred. The DON stated a face sheet and a medication administration record (MAR).

The DON stated the facility was just beginning to work on a form called "Interact" but had to be completed. The surveyor requested the facility policy on transfers/discharges.

The director of nursing provided the surveyor with the policy titled "Bed-Holds and Returns" on 1/25/19. The policy read in part "Prior to transfers and therapeutic leaves, residents or resident representatives will be informed in writing of the bed-hold and return policy."

The director of nursing did not provide a policy for transfers/discharges prior to the exit conference on 1/28/19.

4. The facility staff failed to provide transfer/discharge information to the receiving provider when Resident #25 was sent to the hospital 1/11/19.

The clinical record of Resident #25 was reviewed 1/23/19 through 1/28/19. Resident #25 was admitted to the facility 2/10/18 and readmitted 7/3/18 with diagnoses that included but not limited to acute and chronic respiratory failure with hypoxia, hypothyroidism, hypercholesterolemia, major depressive disorder, hypertension, acute bronchitis, repeated falls, hyperlipidemia, pressure ulcer stage 2 right buttock, and discitis.

Resident #25's quarterly minimum data set (MDS) assessment with an assessment reference date (ARD) of 11/21/18 assessed the

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F 622	Continued From page 11 resident with a brief interview for mental status (BIMS) as 15/15. The clinical record revealed a telephone order dated 1/11/19 that read "May send out to ER (emergency room) (name of hospital omitted) for eval (evaluation)/tx (treatment) d/t (due to) fall & c/o (complaints of) pain." The surveyor reviewed the 1/11/19 6:07 p.m. departmental note. The note read in part: "@1728 (5:28 p.m.) staff stated that resident was in the floor. Resident was observed to be laying on his left side on the left side of the bed. Blood was coming from resident's head and left forearm. Pressure was held onto (sic) bleeding areas. 911 was called for transport. Resident stated that his left hip, left shoulder and head was hurting. Unable to do neuro checks due to resident's refusal. MD (medical doctor) and RP (responsible party) aware. Rescue squad arrived x3 attendants. Resident was assisted onto the stretcher x3 attendants and 2 employees. Resident left the facility at this time. Report was called to ER (emergency room) (name omitted)." The departmental note failed to have evidence of information sent with Resident #25 when the resident was transferred to the hospital-no transfer form/discharge form, contact information, resident representative contact information, comprehensive care plan goals, advanced directive, or any pertinent tests or bed hold information. The survey team had discussed the concerns with transfer/discharges and information sent with residents in the end of the day meeting on 1/24/19 at 4:14 p.m. with the administrator, the	F 622		

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F 622	Continued From page 12 director of nursing (DON) and the corporate registered nurse. The DON stated information sent with the resident when transferred included the face sheet and the medication administration record. No further information was provided prior to the exit conference on 1/28/19. 5. There were six other residents who were transferred to hospitals and the facility staff failed to provide information to the receiving providers. Those residents were identified as Resident #267, Resident #83, Resident #36, Resident #115, Resident #19, and Resident #69. The survey team met with the administrator, the director of nursing (DON) and the corporate registered nurse on 1/24/19 at 4:14 p.m. and during the meeting asked what information was provided to the receiving provider when transferred to the hospital. The DON stated the face sheet and the medication administration record were sent. The DON stated the facility was just beginning to work on paperwork to be sent with residents when they are transferred to the hospital. The DON stated the facility was reviewing a form called Interact for transfers. No further information was provided prior to the exit conference on 1/28/19.	F 622		
F 623 SS=C	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's	F 623	Corrective Action(s): Resident #104's responsible party has been notified that the facility failed to provide a discharge/transfer notice to the resident and the Respon-sible party for the resident's	

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F 623	Continued From page 13 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, 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	F 623	transfer to the hospital on 12/19/18 and the facility failed to document in the medical record the Ombudsman notifaction of the discharge. Resident #90's responsible party has been notified that the facility failed to provide a discharge/transfer notice to the resident and the Responsible party for the resident's transfer to the hospital on 10/29/18 & 11/4/18 and the facility failed to document in the medical record the Ombudsman notification of the discharge. Resident #218's responsible party has been notified that the facility failed to provide a discharge/transfer notice to the resident and the Responsible party for the resident's transfer to the hospital on 11/24/18, 1/4/19 & 1/18/19 and the facility failed to document in the medical record the Ombudsman noticication of the discharge. Resident #25's responsible party has been notified that the facility failed to provide a discharge/transfer notice to	

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F 623	Continued From page 14 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. §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.	F 623	to the resident and the Responsible party for the resident's transfer to the hospital on 1/11/19 and the facility failed to document in the medical record the Ombudsman notification of the discharge Residents #287, #83, #36, #115, #19, and #69,s responsible party has been notified that the facility failed to provide a discharge/transfer notice to the resident and the Responsible party for the resident's transfer to the hospital and the facility failed to document in the medical record the Ombudsman notification of the discharge. Identification of Deficient Practices/Corrective Action(s): All other residents discharged and/or transferred from the facility may have been affected. The Social Services Director and/or Admissions Director will conduct a 100% audit of all residents who have been discharged and/or transferred in the past 30 days. Residents identified at risk will be corrected at time of discovery and the required notifications to the residents' responsible	

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F 623	Continued From page 15 §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, the facility staff failed to provide written notice of transfer/discharge to include the effective date of transfer or discharge; the location to which the resident is transferred or discharged; 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; the name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman and documentation in the medical record that the notice was sent to the Ombudsman for 10 of 29 residents (Resident #287, Resident #104, Resident #83, Resident #90, Resident #36, Resident #115, Resident #218, Resident #19, Resident #25, and Resident #69). The findings included: 1. The facility staff failed to provide written notice of transfer to the resident and the resident representative when Resident #104 was	F 623	party and the state ombudsman will be made. A facility Incident & Accident Form will be completed for each negative finding. Systemic Change(s): Facility policy and procedures have been reviewed. No revisions are warranted at this time. The Administrator and/or Regional Nurse Consultant will inservice the facility's social worker(s), nursing administration and licensed staff on the discharge and transfer requirements that are to be given to the resident and resident's responsible party and that the state ombudsman will be notified of resident discharges/transfers. Monitoring: The Social Services Director will be responsible for maintaining compliance. The Social worker, and/or Admissions Director will conduct chart audits weekly of all residents who have been discharged and/or transferred from the facility. Any/all negative findings and or errors will be corrected at time of discovery and disciplinary action will be taken as needed. Aggregate	

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F 623	Continued From page 16 transferred to the hospital and failed to document in the medical record ombudsman notification. The clinical record of Resident #104 was reviewed 1/23/19 through 1/28/19. Resident #104 was admitted to the facility 12/10/18 and readmitted 1/2/19 with diagnoses that included but not limited to hypokalemia, dementia with behavioral disturbances, atrial fibrillation, restlessness and agitation, insomnia, infected left femur fracture, metabolic encephalopathy, urinary tract infection, and hypertension. Resident #104's significant change minimum data set (MDS) assessment with an assessment reference date (ARD) of 1/9/19 assessed the resident with a brief interview for mental status (BIMS) as 4/15. The departmental note dated 12/19/18 at 2:18 p.m. read in part "She is leaving facility at this time for direct admit to RGH (name of hospital omitted). Transported via (name of ambulance service omitted) and two attendants." The departmental notes were reviewed on 1/24/19. The 12/19/18 5:32 p.m. departmental note read, "RGH (name of hospital) nurse called and wanted to know why resident was there. She did not get a report from this facility as to why. They do have a bed and she is been admitted (sic) at this time." The clinical record had no documentation that the written notice of transfer was given to the resident and the resident representative and there was no ombudsman notification documented in the clinical record.	F 623	findings of these audits will be reported to the Quality Assurance Committee quarterly for review, analysis, and recommendations for change in facility policy, procedure, and/or practice. Completion Date: 3/12/19	

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F 623	Continued From page 17 The surveyor informed the administrator, the director of nursing and the corporate registered nurse of the above concern during the end of the day meeting on 1/24/19 at 4:14 p.m. The survey team asked what information was provided when residents are transferred to the hospital. The director of nursing stated the face sheet and the medication administration record (MAR). The DON stated the facility was just beginning to work on a form called "Interact" but had to be completed. The surveyor requested the facility policy on transfers/discharges. The director of nursing provided the surveyor with the policy titled "Bed-Holds and Returns" on 1/25/19. The policy read in part "Prior to transfers and therapeutic leaves, residents or resident representatives will be informed in writing of the bed-hold and return policy." The director of nursing did not provide a policy for transfers/discharges prior to the exit conference on 1/28/19. 2. The facility staff failed to provide written notice of transfer to the resident and the resident representative when Resident #90 was transferred to the hospital on 10/29/18 and 11/4/18 and failed to document in the medical record ombudsman notification. The clinical record of Resident #90 was reviewed 1/23/19 through 1/28/19. Resident #90 was admitted to the facility 3/13/17 and readmitted 11/2/18 and 11/7/18 with diagnoses that included but not limited to vascular dementia without behavioral disturbances, type 2 diabetes mellitus, hypothyroidism, cervical disc disorder, right femur intertrochanteric fracture, osteoporosis,	F 623		

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gastro-esophageal reflux disease, contusion of scalp, chronic diastolic heart failure, cerebral infarction, dysphagia, major depressive disorder, polyneuropathy, anemia, hypertension, and hyperlipidemia.

Resident #90's significant change in assessment minimum data set (MDS) assessment with an assessment reference date (ARD) of 1/2/19 assessed the resident with a brief interview for mental status (BIMS) as 7/15.

A telephone order dated 10/29/18 read "May send resident to ER (emergency room) for eval (evaluation) & treat (treatment)."

The surveyor reviewed the departmental note dated 10/29/18 10:44 p.m. The note read in part: "Late Entry: This nurse was called to therapy gym. Resident was found in floor on right side. Resident stated she had lost her balance and fell to the floor. Upon assessment resident stated she had pain in her right hip and right side of her head on a pain scale of 4 out of 10. Right side of head had hematoma present. Resident was assisted to wheelchair and to her room. MD (medical doctor) notified (name omitted) concerned of resident on Coumadin with the fall and wanted resident to be sent to ER (name omitted). Transport arrived at 1820 (6:20 p.m.) and resident left via stretcher."

Departmental note dated 10/30/18 10:44 a.m. read in part "Resident admitted to hospital."

A second physician order dated 11/4/18 read "May send out to ER (name omitted) for eval & tx (treatment) due to increased confusion, combativeness, trying to harm self and

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F 623	Continued From page 19 decreased O2 (oxygen) sat (saturation)." The surveyor reviewed the departmental note dated 11/4/18 6:46 p.m. The note read "Late entry 6 p.m. Resident noted to have increased confusion with big change in personality. She has been very combative to staff this shift. Resident can normally hold a normal conversation, but cannot at this time. She began doing things to herself, such as, pulling her own hair, bending fingers backwards while looking at staff and stating "look here, I'm going to tell them you did this. You are going to be accused of it." This is not normal behavior for this resident. This nurse sent to ER for eval and tx. Physician aware and RP (responsible party) agrees with this nurses decision and is meeting resident at hospital." The clinical record had no documentation that the written notice of transfer was given to the resident and the resident representative and there was no ombudsman notification documented in the clinical record. The surveyor informed the director of nursing of the above information not found in the clinical record for either of Resident #90's transfers to the emergency room and subsequent admissions to the hospital on 10/29/18 and 11/4/18 on 1/27/19 at 3:55 p.m. The director of nursing stated the only information sent with the resident was the face sheet and the medication administration record (MAR). The surveyor informed the administrator, the director of nursing and the corporate registered nurse of the above concern during the end of the day meeting on 1/24/19 at 4:14 p.m. The survey	F 623		

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team asked what information was provided when residents are transferred to the hospital. The director of nursing stated the face sheet and the medication administration record (MAR). The DON stated the facility was just beginning to work on a form called "Interact" but had to be completed. The surveyor requested the facility policy on transfers/discharges.

The director of nursing provided the surveyor with the policy titled "Bed-Holds and Returns" on 1/25/19. The policy read in part "Prior to transfers and therapeutic leaves, residents or resident representatives will be informed in writing of the bed-hold and return policy."

The director of nursing did not provide a policy for transfers/discharges prior to the exit conference on 1/28/19.

3. The facility staff failed to provide written notice of transfer to the resident and resident representative and failed to document ombudsman notification in the clinical record when Resident #218 was transferred to the hospital.

The clinical record of Resident #218 was reviewed 1/23/19 through 1/28/19. Resident #218 was admitted to the facility 4/6/18 and readmitted 1/21/19 with diagnoses that included but not limited to acute osteomyelitis, sepsis, cellulitis of right lower limb and chronic respiratory failure with hypercapnia.

Resident #218's admission minimum data set (MDS) assessment with an assessment reference date (ARD) of 1/14/19 assessed the resident with a brief interview for mental status

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F 623	Continued From page 21 (BIMS) as 15/15. The clinical record revealed three emergency room visits with two requiring hospitalizations. Resident #218 was sent to the emergency room on 11/24/18 for abdominal pain and constipation. There was documentation that a report was called to the emergency room but no further evidence of what information was provided to the receiving provider. The clinical record had no documentation that the written notice of transfer was given to the resident and the resident representative on 11/24/18 and there was no ombudsman notification documented in the clinical record. The clinical record revealed Resident #218 was admitted to the hospital 1/4/19 as evidenced by the physician discharge summary for 1/4/19-1/7/19. The departmental note dated 1/4/19 at 3:43 a.m. read "Resident left facility via wheelchair with son at 3:40 a.m. to go to an appointment. No skin issues or distress noted." The departmental note dated 1/4/19 at 11:44 a.m. read "Resident continues to be out of facility." The departmental note dated 1/4/19 at 10:44 p.m. read "Resident remains OOF (out of facility) at hospital." The clinical record had no documentation that the written notice of transfer was given to the resident and the resident representative on 1/4/19 and there was no ombudsman notification documented in the clinical record. The clinical record revealed Resident #218 was admitted to the hospital 1/18/19-1/21/19 for acute kidney injury. The departmental note dated 1/18/19 at 1:53 p.m. read in part "Resident	F 623		

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F 623	Continued From page 22 complains of feeling bad. Could not state exactly what her complaints were more specifically. Did state she was having double vision and that her vision was wavey. MD (medical doctor-name omitted) notified. Telephone order received to send patient to ER (emergency room) for evaluation and treatment of complaints." The departmental note dated 1/18/19 at 2:24 p.m. read "EMS (emergency medical services) notified for transport to the ED (emergency department), report called to ED (name omitted)." The departmental note dated 1/19/19 at 10:32 a.m. read in part "Resident was admitted 1/18/19 for acute kidney injury." The clinical record had no documentation that the written notice of transfer was given to the resident and the resident representative and there was no ombudsman notification documented in the clinical record. The survey team met with the administrator, the director of nursing (DON), and the corporate registered nurse on 1/24/19 at 4:14 p.m. and informed them of the required information sent to the hospital when a resident was transferred. The DON stated only a face sheet and a medication administration record (MAR) are sent. The DON stated the facility was just beginning to work on a form called "Interact" but had to be completed. The surveyor requested the facility policy on transfers/discharges. The director of nursing provided the surveyor with the policy titled "Bed-Holds and Returns" on 1/25/19. The policy read in part "Prior to transfers	F 623		

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F 623	Continued From page 23 and therapeutic leaves, residents or resident representatives will be informed in writing of the bed-hold and return policy." The director of nursing did not provide a policy for transfers/discharges prior to the exit conference on 1/28/19. 4. The facility staff failed to provide written transfer/discharge information to the resident and resident representative and failed to document ombudsman notification in the clinical record when Resident #25 was sent to the hospital 1/11/19. The clinical record of Resident #25 was reviewed 1/23/19 through 1/28/19. Resident #25 was admitted to the facility 2/10/18 and readmitted 7/3/18 with diagnoses that included but not limited to acute and chronic respiratory failure with hypoxia, hypothyroidism, hypercholesterolemia, major depressive disorder, hypertension, acute bronchitis, repeated falls, hyperlipidemia, pressure ulcer stage 2 right buttock, and discitis. Resident #25's quarterly minimum data set (MDS) assessment with an assessment reference date (ARD) of 11/21/18 assessed the resident with a brief interview for mental status (BIMS) as 15/15. The clinical record revealed a telephone order dated 1/11/19 that read "May send out to ER (emergency room) (name of hospital omitted) for eval (evaluation)/tx (treatment) d/t (due to) fall & c/o (complaints of) pain." The surveyor reviewed the 1/11/19 6:07 p.m. departmental note. The note read in part:	F 623		

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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 24 "@1728 (5:28 p.m.) staff stated that resident was in the floor. Resident was observed to be laying on his left side on the left side of the bed. Blood was coming from resident's head and left forearm. Pressure was held onto (sic) bleeding areas. 911 was called for transport. Resident stated that his left hip, left shoulder and head was hurting. Unable to do neuro checks due to resident's refusal. MD (medical doctor) and RP (responsible party) aware. Rescue squad arrived x3 attendants. Resident was assisted onto the stretcher x3 attendants and 2 employees. Resident left the facility at this time. Report was called to ER (emergency room) (name omitted)." The departmental note failed to have evidence that written notice of transfer/discharge information was provided to the resident and resident representative when Resident #25 was transferred to the hospital and there was no documentation of ombudsman notification found in the clinical record. The survey team had discussed the concerns with transfer/discharges and information sent with residents in the end of the day meeting on 1/24/19 at 4:14 p.m. with the administrator, the director of nursing (DON) and the corporate registered nurse. The DON stated information sent with the resident when transferred included the face sheet and the medication administration record. No further information was provided prior to the exit conference on 1/28/19. 5. There were six other residents who were transferred to hospitals and the facility staff failed to provide written notice of transfer/discharge to	F 623		

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F 623	Continued From page 25 the resident and the resident representative and failed to document ombudsman notification in the clinical record. Those residents were identified as Resident #267, Resident #83, Resident #36, Resident #115, Resident #19, and Resident #69. The survey team met with the administrator, the director of nursing (DON) and the corporate registered nurse on 1/24/19 at 4:14 p.m. and during the meeting asked what information was provided to the receiving provider when transferred to the hospital. The DON stated the face sheet and the medication administration record were sent. The DON stated the facility does not give the resident and resident representative written notice of transfer/discharge. The DON stated the facility was reviewing a form called Interact for transfers. No further information was provided prior to the exit conference on 1/28/19.	F 623		
F 625 SS=C	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any;	F 625	Corrective Action(s): Residents #104, #90, #218, #25, #83, #36, #115,#69 and their RP's have been notified of the facilities bed-hold policy and procedure and the requirement that it reviewed and issued in writing to the resident and the RP when discharge to the hospital or when going out on therapeutic leave. An Incident and Accident report has been completed for each resident identified in the review.	

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F 625	Continued From page 26 (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, the facility staff failed to provide to the resident and the resident representative at the time of transfer/discharge written notice which specifies the duration of the bed-hold policy for 8 of 29 residents (Resident #104, Resident #83, Resident #90, Resident #36, Resident #115, Resident #218, Resident #25 and Resident #69). The findings included: 1. The facility staff failed to provide Resident #104 and the resident representative written information about bed-hold when the resident was transferred to the hospital 12/19/18. The clinical record of Resident #104 was reviewed 1/23/19 through 1/28/19. Resident #104 was admitted to the facility 12/10/18 and readmitted 1/2/19 with diagnoses that included but not limited to hypokalemia, dementia with behavioral disturbances, atrial fibrillation,	F 625	Identification of Deficient Practice(s) and Corrective Action(s): All other residents could potentially be affected. The Bed-Hold policy and forms are now kept at the nursing station for after hour's transfers to the hospital to be completed by the charge nurse. The Social Services director/Admissions director will be responsible for normal business hour transfer notification of all bed-holds to residents and/or Responsible parties. Systemic Change(s): The facility Policy and Procedure has been reviewed and no changes are warranted at this time. The Social Services Director, Admissions Director and licensed staff have been inserviced by the administrator on the bed-hold requirement and the proper use and notification of the Bed-Hold policy. Monitoring: The Admissions Director and Social Service Director are responsible for compliance. All transfer/discharges from the facility will be audited by the Social service director	

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F 625	Continued From page 27 restlessness and agitation, insomnia, infected left femur fracture, metabolic encephalopathy, urinary tract infection, and hypertension. Resident #104's significant change minimum data set (MDS) assessment with an assessment reference date (ARD) of 1/9/19 assessed the resident with a brief interview for mental status (BIMS) as 4/15. The departmental note dated 12/19/18 at 2:18 p.m. read in part "She is leaving facility at this time for direct admit to RGH (name of hospital omitted). Transported via (name of ambulance service omitted) and two attendants." The departmental notes were reviewed on 1/24/19. The 12/19/18 5:32 p.m. departmental note read, "RGH (name of hospital) nurse called and wanted to know why resident was there. She did not get a report from this facility as to why. They do have a bed and she is been admitted (sic) at this time." The clinical record had no documentation that a bed hold was offered to the resident and the resident representative prior to transfer to the hospital on 12/19/18. The surveyor informed the administrator, the director of nursing and the corporate registered nurse of the above concern during the end of the day meeting on 1/24/19 at 4:14 p.m. The survey team asked what information was provided when residents are transferred to the hospital. The director of nursing stated the face sheet and the medication administration record (MAR). The DON stated the nurses usually offer a bed hold when the residents are transferred. The DON	F 625	and/or Admissions Director to ensure proper bed-hold notification was completed at the time of transfer or therapeutic leave. Any/all negative findings will be corrected at time of discovery. The results of these audits will be forwarded to the Quality Assurance Committee quarterly for review, analysis, and recommendations for change in facility policy, procedure, and/or practice. Completion Date: 3/12/19	

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F 625	Continued From page 28 was asked if this information should be documented in the clinical record. The DON stated the nurses should document when bed holds are offered in the clinical record. The director of nursing provided the surveyor with the policy titled "Bed-Holds and Returns" on 1/25/19. The policy read in part "Prior to transfers and therapeutic leaves, residents or resident representatives will be informed in writing of the bed-hold and return policy." No further information was provided prior to the exit conference on 1/28/19. 2. The facility staff failed to provide Resident #90 and the resident representative written bed hold information when the resident was transferred to the hospital on 10/29/18 and 11/4/18. The clinical record of Resident #90 was reviewed 1/23/19 through 1/28/19. Resident #90 was admitted to the facility 3/13/17 and readmitted 11/2/18 and 11/7/18 with diagnoses that included but not limited to vascular dementia without behavioral disturbances, type 2 diabetes mellitus, hypothyroidism, cervical disc disorder, right femur intertrochanteric fracture, osteoporosis, gastro-esophageal reflux disease, contusion of scalp, chronic diastolic heart failure, cerebral infarction, dysphagia, major depressive disorder, polyneuropathy, anemia, hypertension, and hyperlipidemia. Resident #90's significant change in assessment minimum data set (MDS) assessment with an assessment reference date (ARD) of 1/2/19 assessed the resident with a brief interview for mental status (BIMS) as 7/15.	F 625		

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A telephone order dated 10/29/18 read "May send resident to ER (emergency room) for eval (evaluation) & treat (treatment)."

The surveyor reviewed the departmental note dated 10/29/18 10:44 p.m. The note read in part: "Late Entry: This nurse was called to therapy gym. Resident was found in floor on right side. Resident stated she had lost her balance and fell to the floor. Upon assessment resident stated she had pain in her right hip and right side of her head on a pain scale of 4 out of 10. Right side of head had hematoma present. Resident was assisted to wheelchair and to her room. MD (medical doctor) notified (name omitted) concerned of resident on Coumadin with the fall and wanted resident to be sent to ER (name omitted). Transport arrived at 1820 (6:20 p.m.) and resident left via stretcher."

Departmental note dated 10/30/18 10:44 a.m. read in part "Resident admitted to hospital."

A second physician order dated 11/4/18 read "May send out to ER (name omitted) for eval & tx (treatment) due to increased confusion, combativeness, trying to harm self and decreased O2 (oxygen) sat (saturation)."

The surveyor reviewed the departmental note dated 11/4/18 6:46 p.m. The note read "Late entry 6p.m. Resident noted to have increased confusion with big change in personality. She has been very combative to staff this shift. Resident can normally hold a normal conversation, but cannot at this time. She began doing things to herself, such as, pulling her own hair, bending fingers backwards while looking at

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F 625	Continued From page 30 staff and stating "look here, I'm going to tell them you did this. You are going to be accused of it." This is not normal behavior for this resident. This nurse sent to ER for eval and tx. Physician aware and RP (responsible party) agrees with this nurses decision and is meeting resident at hospital." The clinical record did not have documentation that written notice of bed hold information was provided to the resident and the resident representative when Resident #90 was transferred to the hospital 10/29/18 or 11/4/18. The surveyor informed the director of nursing of the above information not found in the clinical record for either of Resident #90's transfers to the emergency room and subsequent admissions to the hospital on 10/29/18 and 11/4/18 on 1/27/19 at 3:55 p.m. The director of nursing stated the only information sent with the resident was the face sheet and the medication administration record (MAR). The surveyor informed the administrator, the director of nursing and the corporate registered nurse of the above concern during the end of the day meeting on 1/24/19 at 4:14 p.m. The survey team asked what information was provided when residents are transferred to the hospital. The director of nursing stated the face sheet and the medication administration record (MAR). The DON stated the nurses usually offer a bed hold when the residents are transferred. The DON was asked if this information should be documented in the clinical record. The DON stated the nurses should document when bed holds are offered in the clinical record.	F 625		

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F 625	Continued From page 31 The director of nursing provided the surveyor with the policy titled "Bed-Holds and Returns" on 1/25/19. The policy read in part "Prior to transfers and therapeutic leaves, residents or resident representatives will be informed in writing of the bed-hold and return policy." No further information was provided prior to the exit conference on 1/28/19. 3. The facility staff failed to provide Resident #218 and the resident representative written information about bed-hold when the resident was transferred to the hospital 11/24/18, 1/4/19, and 1/18/19. The clinical record of Resident #218 was reviewed 1/23/19 through 1/28/19. Resident #218 was admitted to the facility 4/6/18 and readmitted 1/21/19 with diagnoses that included but not limited to acute osteomyelitis, sepsis, cellulitis of right lower limb and chronic respiratory failure with hypercapnia. Resident #218's admission minimum data set (MDS) assessment with an assessment reference date (ARD) of 1/14/19 assessed the resident with a brief interview for mental status (BIMS) as 15/15. The clinical record revealed three emergency room visits with two requiring hospitalizations. Resident #218 was sent to the emergency room on 11/24/18 for abdominal pain and constipation. There was documentation that a report was called to the emergency room but no further evidence of what information was provided to the receiving provider or that the resident and the resident representative was offered a bed hold	F 625		

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F 625	Continued From page 32 when transferred. The clinical record revealed Resident #218 was admitted to the hospital 1/4/19 as evidenced by the physician discharge summary for 1/4/19-1/7/19. The departmental note dated 1/4/19 at 3:43 a.m. read "Resident left facility via wheelchair with son at 3:40 a.m. to go to an appointment. No skin issues or distress noted." The departmental note dated 1/4/19 at 11:44 a.m. read "Resident continues to be out of facility." The departmental note dated 1/4/19 at 10:44 p.m. read "Resident remains OOF (out of facility) at hospital." None of the notes dated 1/4/19 detail information sent to the receiving provider when the resident did not return to the facility on 1/4/19 or information about bed holds was offered to the resident and the resident representative. The surveyor interviewed Resident #218 on 1/23/19 at 3:37 p.m. The resident stated she thought she was informed about bed-holds. The clinical record revealed Resident #218 was admitted to the hospital 1/18/19-1/21/19 for acute kidney injury. The departmental note dated 1/18/19 at 1:53 p.m. read in part "Resident complains of feeling bad. Could not state exactly what her complaints were more specifically. Did state she was having double vision and that her vision was wavey. MD (medical doctor-name omitted) notified. Telephone order received to send patient to ER (emergency room) for evaluation and treatment of complaints." The departmental note dated 1/18/19 at 2:24 p.m. read "EMS (emergency medical services) notified for transport to the ED (emergency department),	F 625		

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F 625	Continued From page 33 report called to ED (name omitted)." The departmental note dated 1/19/19 at 10:32 a.m. read in part "Resident was admitted 1/18/19 for acute kidney injury." The surveyor was unable to locate documentation in the clinical record of bed-hold. The surveyor informed the administrator, the director of nursing and the corporate registered nurse of the above concern during the end of the day meeting on 1/24/19 at 4:14 p.m. The survey team asked what information was provided when residents are transferred to the hospital. The director of nursing stated the face sheet and the medication administration record (MAR). The DON stated the nurses usually offer a bed hold when the residents are transferred. The DON was asked if this information should be documented in the clinical record. The DON stated the nurses should document when bed holds are offered in the clinical record. The director of nursing provided the surveyor with the policy titled "Bed-Holds and Returns" on 1/25/19. The policy read in part "Prior to transfers and therapeutic leaves, residents or resident representatives will be informed in writing of the bed-hold and return policy." No further information was provided prior to the exit conference on 1/28/19. 4. The facility staff failed to provide Resident #25 and the resident representative written information about bed-hold when the resident was transferred to the hospital 1/11/19. The clinical record of Resident #25 was reviewed	F 625		

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F 625	Continued From page 34 1/23/19 through 1/28/19. Resident #25 was admitted to the facility 2/10/18 and readmitted 7/3/18 with diagnoses that included but not limited to acute and chronic respiratory failure with hypoxia, hypothyroidism, hypercholesterolemia, major depressive disorder, hypertension, acute bronchitis, repeated falls, hyperlipidemia, pressure ulcer stage 2 right buttock, and discitis. Resident #25's quarterly minimum data set (MDS) assessment with an assessment reference date (ARD) of 11/21/18 assessed the resident with a brief interview for mental status (BIMS) as 15/15. The clinical record revealed a telephone order dated 1/11/19 that read "May send out to ER (emergency room) (name of hospital omitted) for eval (evaluation)/tx (treatment) d/t (due to) fall & c/o (complaints of) pain." The surveyor reviewed the 1/11/19 6:07 p.m. departmental note. The note read in part: "@1728 (5:28 p.m.) staff stated that resident was in the floor. Resident was observed to be laying on his left side on the left side of the bed. Blood was coming from resident's head and left forearm. Pressure was held onto (sic) bleeding areas. 911 was called for transport. Resident stated that his left hip, left shoulder and head was hurting. Unable to do neuro checks due to resident's refusal. MD (medical doctor) and RP (responsible party) aware. Rescue squad arrived x3 attendants. Resident was assisted onto the stretcher x3 attendants and 2 employees. Resident left the facility at this time. Report was called to ER (emergency room) (name omitted)." The departmental note failed to have evidence of	F 625		

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F 625	Continued From page 35 information that Resident #25 bed hold information was offered to the resident and the resident representative. The surveyor informed the administrator, the director of nursing and the corporate registered nurse of the above concern during the end of the day meeting on 1/24/19 at 4:14 p.m. The survey team asked what information was provided when residents are transferred to the hospital. The director of nursing stated the face sheet and the medication administration record (MAR). The DON stated the nurses usually offer a bed hold when the residents are transferred. The DON was asked if this information should be documented in the clinical record. The DON stated the nurses should document when bed holds are offered in the clinical record. No further information was provided prior to the exit conference on 1/28/19. 5. There were four other residents who were transferred to hospitals and the facility staff failed to provide written bed hold information to the resident and the resident representative. Those residents were identified as Resident #83, Resident #36, Resident #115, and Resident #69. The survey team met with the administrator, the director of nursing (DON) and the corporate registered nurse on 1/24/19 at 4:14 p.m. and during the meeting asked what information was provided to the receiving provider when transferred to the hospital. The DON stated the face sheet and the medication administration record were sent. The DON stated the nurses usually offer a bed hold when the residents are transferred. The DON was asked if this	F 625		

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F 625	Continued From page 36 information should be documented in the clinical record. The DON stated the nurses should document when bed holds are offered in the clinical record. The director of nursing provided the surveyor with the policy titled "Bed-Holds and Returns" on 1/25/19. The policy read in part "Prior to transfers and therapeutic leaves, residents or resident representatives will be informed in writing of the bed-hold and return policy." No further information was provided prior to the exit conference on 1/28/19.	F 625		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on, clinical record review, staff interview, observation, resident interview, and facility document review, the facility staff failed to ensure a hazard free environment for 1 of 29 residents, Resident #36. The findings included: The facility staff failed to ensure a hazard free environment while transferring Resident #36. Resident #36 sustained a skin tear to the left	F 689	Corrective Action(s): Resident #36's attending physician has been notified that facility staff failed to maintain a hazard free area during a resident transfer which resulted in a skin tear to the lower leg. A facility incident and accident form has been completed for this incident. Identification of Deficient Practices/Corrective Action(s): All other residents requiring assistance with transfers from the wheelchair may have been potentially affected. The DON, ADON, Therapist and/or Unit Manager will conduct a 100% review of all residents transfer status to identify residents	

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F 689	Continued From page 37 lower leg during a transfer from the wheelchair to the bed. Resident #36 was admitted to the facility on 10/28/18. Diagnoses included, but were not limited to, fracture of unspecified tarsal bone of left foot, Alzheimer's disease, cognitive communication deficit, hypertension, unsteadiness on feet, depression, and atrial fibrillation. Section C (cognitive patterns) of Resident #36's most recent comprehensive MDS (minimum data set) assessment with an ARD (assessment reference date) of 11/25/18 included a BIMS (brief interview for mental status) summary score of 10 out of a possible 15 points. Section G (functional status) had been coded to indicate extensive assistance with two persons physical assist (3/3) for transfer. Resident #36's comprehensive care plan included the focus area: "ADL (activities of daily living) Function: Resident requires assistance from staff for daily ADL care ...," has interventions that included but were not limited to, "Encourage Resident to participate in ADL care as tolerated". The surveyor interviewed Resident #36 on 01/24/19 9:05 am. Resident #36 stated "The CNA (certified nursing assistant) was trying to put me to bed and she did something that made the blood run out. It's been there for a month". The surveyor spoke to RN (registered nurse) #1 on 01/24/19 10:39 am. RN #1 voiced that Resident #36 acquired a laceration while being transferred to the bed from wheel chair. RN #1 stated, "The foot rest on the wheel chair swung around and caught her left leg. The foot rest are	F 689	at risk for injury related to improper transfer techniques from the wheelchair. All residents identified at risk will be screened for the appropriate transfer technique to prevent accidents and/or injury at time of discovery and an Incident & Accident form will be completed for each negative finding. Systemic Change(s): The facility policy and procedure for accident and fall prevention and management has been reviewed and no revisions are warranted at this time. The DON and/or regional nurse consultant will inservice all nursing staff on proper transfer techniques to include removing and/or securing wheelchair leg rests and arm rests prior to transfers to prevent injury. Monitoring: The DON is responsible for maintaining compliance. The DON and/or Unit Manager will perform daily rounds throughout the day to monitor for improper transfers from the wheelchair to monitor for	

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F 689	Continued From page 38 off her wheel chair now". On 01/25/19 at 11:35am, the surveyor interviewed CNA #1 via phone. CNA #1 stated, "Resident #36's wheelchair was locked. Resident #36 was assisted to standing and I was using the gait belt per policy. Resident #36 is a one person assist per CNA care plan. Resident #36 was standing with the back of her legs up against the wheelchair. Resident #36's blanket was wrapped around leg rest of wheelchair. She started shaking the wheelchair to loosen the blanket. When the blanket came loose the leg rest swung in, hitting Resident #36 in the left leg causing a skin tear". CNA #1 voiced that she sat Resident #36 on her bed and provided pressure to the wound with a clean towel. CNA #1 called the nurse to evaluate Resident #36 and provide treatment. CNA #1 stated "I forgot to take the leg rest off of the wheelchair, but I didn't realize it until Resident #36 was standing to be transferred. I didn't want to leave her standing unsupported or lay the leg rest in the floor as that could be a potential hazard". CNA #1 voiced that she typically transfers Resident #36 without any issue. The surveyor reviewed a facility document titled "Resident Incident Report", under the section titled "Incident Witness Statement" read in part: "I was assisting Resident into the bed when the chair got stuck on her bed and blanket. Resident started to tug on her chair while I was holding her up and the chair had gotten free. That's when the leg of the wheelchair came around and knocked into her leg. Resident belted out a loud scream and when I checked her leg she had blood coming out and her leg had a deep skin tear. So I called for the LPN. I held a rag around the wound until the LPN arrived". The foretold statement was	F 689	compliance. Any/all negative findings will be corrected at time of discovery and disciplinary action will be taken as needed. Aggregate findings of these reviews will be reported to the Quality Assurance Committee quarterly for review, analysis, and recommendations for change in facility policy, procedure, and/or practice. Completion Date: 3/12/19	

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F 689	Continued From page 39 signed by CNA #1 and dated 12/15/18. The surveyor reviewed Resident #36's clinical record on 01/28/19 at 10:49am. A nursing note dated 12/15/18 at 10:14pm documented by LPN (licensed practical nurse) #1 read in part: "7:20 pm called to Resident's room. CNA was assisting Resident to bed. Her leg got caught on wheelchair. Place on left leg about 4 inches long and at one point an inch wide, ¼ inch deep. Bleeding from area. Pressure applied to stop bleeding. Steri-strips used to pull area together and triple antibiotic ointment applied. 4x4 applied and wrapped. Resting in bed. Took pain pill and all meds without difficulty ...Doctor and responsible party (son) notified. Call light in reach". LPN #1 documented a nursing note dated 12/21/18 at 4:30pm that read in part: "New order from doctor received to send Resident to ER (emergency room) for evaluation of wound ...". ED (emergency department) summary dated 12/21/18 read in part under diagnoses: "Skin tear to left lower leg without complication" under instructions of ED Summary it read in part: "... skin tear though painful does not appear infected....All labs fine...x-ray shows no deep infection...". RN #2 documented a nursing note dated 12/22/18 at 1:13am that read in part: "Resident returned back to facility ...Orders received from doctor to start Norco 5/325 every 8 hours as needed ...He also wants facility's wound care nurse to follow up on wound care ..." The administrative team was made aware of the	F 689		

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F 689	Continued From page 40 above findings on 01/25/19 at 1:57pm. No further information regarding this issue was provided to the survey team prior to the exit conference on 01/28/19.	F 689		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must	F 690	Corrective Action(s): Resident #104, #34 and #69's Foley catheters are now anchored per policy and procedure to reduce friction, pulling and movement to prevent injury. The resident's care plan has been revised to reflect accurate Foley catheter care to include proper placement and anchoring of the Foley catheter. Identification of Deficient Practice(s) and Corrective Action(s): All other residents with a Foley catheter may have been potentially affected. The DON,ADON and or Unit Manager will conduct a 100% review of all residents with a Foley catheter to identify residents at risk. Residents identified will be corrected at time of discovery and a Facility Incident & Accident Form will be completed. Systemic Change(s): The facility Policy and	

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F 690	Continued From page 41 ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review and clinical record review, the facility staff failed to provide appropriate treatment and services for care of a resident with a clinically justified indwelling catheter when the indwelling Foley catheters were not anchored for 3 of 29 residents (Resident #104, Resident #34, and Resident #69). The findings included: 1. The facility staff failed to anchor Resident #104's indwelling Foley catheter. The clinical record of Resident #104 was reviewed 1/23/19 through 1/28/19. Resident #104 was admitted to the facility 12/10/18 and readmitted 1/2/19 with diagnoses that included but not limited to hypokalemia, dementia with behavioral disturbances, atrial fibrillation, restlessness and agitation, insomnia, infected left femur fracture, metabolic encephalopathy, urinary tract infection, and hypertension. Resident #104's significant change minimum data set (MDS) assessment with an assessment reference date (ARD) of 1/9/19 assessed the resident with a brief interview for mental status (BIMS) as 4/15. Section H Bladder and Bowel was coded for an indwelling catheter (H0100) and urinary continence (H0300) was coded as "9=not rated"-resident had a catheter (indwelling, condom), urinary ostomy, or no urine output for	F 690	Procedure for Foley Catheter usage and Foley Catheter Care has been reviewed and no changes are warranted at this time. The nursing staff will be inserviced by the DON on the policy and procedures for proper Foley Catheter care to include the proper anchoring of Foley catheter tubing and proper placement of the drainage bag to prevent infection and injury. Monitoring: The Director of Nursing is responsible for maintaining compliance. The DON and/or Unit Manager will make daily random audits of all Foley Catheter's to ensure compliance with anchoring of tubing and proper placement of drainage bags to monitor compliance. All negative findings will be corrected at time of discovery. Detailed findings of this audit will be reported to the Quality Assurance Committee for change in facility policy, procedure, and/or practice. Completion Date: 3/12/19	

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F 690	Continued From page 42 entire 7 days. Current comprehensive care plan initiated 1/10/19 identified urinary incontinency/Foley catheter. Resident is at risk for UTIs (urinary tract infections) r/t (related to) Foley placement. Approaches: change Foley catheter every month and as needed (prn), monitor for changes in urine. The January 2019 physician orders read "Change 16 F (16 French) Foley catheter month (every month)." The surveyor observed Resident #104 on 1/23/19 at 2:37 p.m. Resident #104 was in bed. The surveyor observed a Foley drainage bag attached to the bed frame. Resident #104 was being attended to by licensed practical nurse #1. L.P.N. #1 asked if indwelling Foley catheters were anchored. L.P.N. #1 stated, "They are supposed to be." When L.P.N. #1 checked the Foley for anchorage, the Foley was not anchored. L.P.N. #1 stated she would get a leg strap. The surveyor observed Resident #104 again on 1/24/19 at 8:36 a.m. Resident #104 was in bed. Licensed practical nurse #2 was attending to the resident. Foley catheter was observed to be unanchored. L.P.N. #2 stated Foleys were supposed to be anchor. The surveyor and L.P.N. # attempted to view the size of the Foley catheter. The only readable number was 10 ml (milliliter). The January 2019 physician orders did not have a bulb size identified in the physician order. The surveyor informed the administrator, the director of nursing and the corporate registered of	F 690		

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F 690	Continued From page 43 the above concern and requested the facility policy on Foley catheter care during the end of the day meeting on 1/24/19 at 4:14 p.m. The surveyor asked the DON if she would expect the staff to anchor indwelling Foley catheters. The DON stated she would expect staff to anchor Foleys. The surveyor reviewed the facility policy titled "Catheter Care, Urinary" on 1/25/19. The policy read in part "2. Ensure that the catheters remains secured with a leg strap to reduce friction and movement at the insertion site. (Catheter tubing should be strapped to the resident's inner thigh.) No further information was provided prior to the exit conference on 1/28/19. 2. The facility staff failed to anchor Resident #34's indwelling Foley catheter. The clinical record of Resident #34 was reviewed 1/23/19 through 1/28/19. Resident #34 was admitted to the facility 8/23/18 with diagnoses that included but not limited to multiple rib fractures, hyperglycemia, chronic kidney disease, chronic diastolic heart failure, urine retention, hypothyroidism, anemia, hypertension, and benign prostatic hypertrophy. Resident #34's quarterly minimum data set (MDS) assessment with an assessment reference date (ARD) of 11/21/18 assessed the resident with a BIMS (brief interview for mental status) as 13/15. Section H Bladder and Bowel was coded for an indwelling catheter (H0100) and urinary continence (H0300) was coded as "9=not rated"-resident had a catheter (indwelling, condom), urinary ostomy, or no urine output for	F 690		

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F 690	Continued From page 44 entire 7 days. The January 2019 physician orders read "Change 18 F (French) Foley catheter q month (every month)." The order did not contain the bulb size of the Foley catheter. The surveyor interviewed Resident #34 on 1/24/19 at 9:58 a.m. The resident was asked if the staff used a strap to hold the catheter to the leg. The resident stated he didn't think it was strapped. Certified nursing assistant #1 was attending to the resident's roommate and was asked to check for anchorage. C.N.A. #1 stated Foleys were supposed to be anchored. When checked, C.N. A. #1 stated the catheter was not anchored but "they're supposed to be." The surveyor informed the administrator, the director of nursing, and the corporate registered nurse in the end of the day meeting on 1/24/19 at 4:14 p.m. The surveyor asked the DON if she would expect the staff to anchor indwelling Foley catheters. The DON stated she would expect staff to anchor Foleys. The surveyor reviewed the facility policy titled "Catheter Care, Urinary" on 1/25/19. The policy read in part "2. Ensure that the catheters remains secured with a leg strap to reduce friction and movement at the insertion site. (Catheter tubing should be strapped to the resident's inner thigh.) No further information was provided prior to the exit conference on 1/28/19. 3. For Resident #69 the facility staff failed to ensure Foley catheter tubing was anchored.	F 690		

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F 690	Continued From page 45 Resident #69 was admitted to the facility on 12/03/18. Diagnoses included but not limited to chronic diastolic (congestive) heart failure, chronic obstructive pulmonary disease, and chronic respiratory failure. The most recent MDS (minimum data set) with an ARD (assessment reference date) of 12/10/18 coded the Resident 11 of 15 in section C, cognitive patterns. Resident #69's CCP (comprehensive care plan) was reviewed and contained a focus area of "Urinary incontinence/foley catheter: Resident at risk for UTI (urinary tract infection) related to chronic foley catheter placement..." Interventions included but were not limited to, "Provide foley catheter care every shift and as needed". Resident #69's clinical record was reviewed on 01/28/18. It contained a physician's order summary which read in part, " Provide foley catheter care every shift and as needed ". Resident #69 was observed by the surveyor on 01/23/19 at approximately 1:13 pm. Resident was resting in bed. Surveyor asked Resident #69 if her catheter was anchored. Resident #69 pulled back her sheets and stated "No". The surveyor observed the catheter tubing not anchored and was positioned across Resident #69's right thigh. The concern of the Foley catheter not being anchored was discussed with the administrative team during a meeting on 01/24/19 at approximately 4:36pm. The surveyor asked director of nursing (DON) if she expects urinary catheters to be anchored. The DON stated "Yes". The surveyor requested a policy on catheter care	F 690		

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F 690	Continued From page 46 at this time. The administrator provided the surveyor with said policy titled "Catheter Care, Urinary" on 01/25/19. This policy read in part under sectioned titled "Steps in the Procedure"18. Secure catheter utilizing a leg band". No further information was provided prior to exit.	F 690		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning 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, the facility staff failed to provide respiratory care and services in accordance with professional standards of care, the resident's care plan and the resident's choice for 3 of 29 residents (Resident #37, Resident #108, and Resident #25). The findings included: 1. The facility staff failed to ensure the physician ordered oxygen amount was delivered to Resident #37 and failed to change the oxygen tubing weekly. The clinical record of Resident #37 was reviewed	F 695	Corrective Action(s): Resident #37's attending physician was notified that resident #37 did not receive oxygen at the correct flow rate as ordered by the physician. A facility Incident & Accident form has been completed for this incident. Resident #25's attending physician was notified that resident #25 did not receive oxygen at the correct flow rate as ordered by the physician and the oxygen tubing was noted with no date to indicate it was changed weekly as ordered. A facility Incident & Accident form has been completed for this incident. Resident #108's attending physician was notified that the facility failed to store resident #108's nebulizer mask in a plastic bag when not in use. A facility Incident & Accident form has been completed for this incident.	

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F 695	Continued From page 47 1/23/19 through 1/28/19. Resident #37 was admitted to the facility 8/11/18 and readmitted 10/6/18. Diagnoses included but were not limited to fracture of right tibia, end stage renal disease, candida stomatitis, renal dialysis dependence, type 2 diabetes mellitus, chronic obstructive pulmonary disease, anemia, hypertension, hyperlipidemia, chronic pain, and gastro-esophageal reflux disease. Resident #37's quarterly minimum data set (MDS) assessment with an assessment reference date (ARD) of 1/23/19 assessed the resident with a BIMS (brief interview for mental status) as 15/15. Section O Special Treatments, Procedures, and Programs was coded for oxygen use. Resident #37's current comprehensive care plan identified respiratory as a problem with an onset date of 1/24/19. Resident #37 was at risk for respiratory complications related to COPD and allergies. The resident wears O2 at 2 L/M (liters per minute) at all times. Approaches: Administer meds (medications) as ordered, O2 per MD (medical doctor) order, monitor O2 sats (saturation levels) q shift (every shift), monitor for respiratory complications, monitor lung sounds qshift, and notify MD prn (as needed). The surveyor observed Resident #37 on 1/23/19 4:01 PM. Resident #37 was in bed with oxygen via nasal cannula at 3 liters. The oxygen tubing had a pink sticker that was dated 1/12/19. The surveyor observed Resident #37 again on 1/24/19 at 9:21 a.m. Resident #37 was in bed and finishing breakfast. O2 was at 3 liters and the tubing was dated 1/12/19	F 695	Identification of Deficient Practices & Corrective Action(s): All residents receiving oxygen and nebulizer therapy may have potentially been affected. A 100% review of all residents receiving oxygen and nebulizers will be conducted by the DON,ADON and/or Unit Manager to identify residents at risk for not having oxygen administered per MD order and improper storage of oxygen/ nebulizer equipment when not in use. Residents found to be at risk will be corrected at the time of discovery. A facility Incident & Accident form will be completed for each item discovered. Systemic Change(s): The facility policy and procedure for Oxygen administration has been reviewed and no changes were warranted at this time. All licensed nursing staff will be inserviced on the facility policy and procedure for accurate oxygen administration and monitoring per physician order. Inservices will include the delivery of oxygen per physician order, monitoring of oxygen per physician order, monitoring of oxygen flow rates during shift	

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	495371	A. BUILDING _____ B. WING _____	C 01/28/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HALL-RICH CREEK	120 OLD VIRGINIA AVENUE RICH CREEK, VA 24147

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F 695	Continued From page 48 The surveyor interviewed licensed practical nurse #3 what oxygen amount was ordered for Resident #37. L.P.N. #3 stated Resident #37 was supposed to have 2 liters. L.P.N. #2 observed the oxygen at 3 liters/nc and changed the liter amount to 2. The surveyor reviewed the December 2018 physician's orders. The oxygen order dated 10/9/18 read "O2 via NC (nasal cannula) @ 2L/M (liters per minute) continuous." The surveyor informed the administrator, the director of nursing and the corporate registered nurse of the above concern during the end of the day meeting on 1/24/19 at 4:14 p.m. The surveyor requested the facility policy on respiratory care. The surveyor reviewed the facility policy titled "Respiratory Therapy-Prevention of Infection" on 1/25/19. The policy read in part "Infection Control Considerations Related to Oxygen Administration 7. Change the oxygen cannulae and tubing every seven (7) days, or as needed." No further information was provided prior to the exit conference on 1/28/19. 2. The facility staff failed to ensure Resident #25 received the amount of oxygen ordered by the physician and failed to date oxygen tubing. The clinical record of Resident #25 was reviewed 1/23/19 through 1/28/19. Resident #25 was admitted to the facility 2/10/18 and readmitted 7/3/18 with diagnoses that included but not limited to acute and chronic respiratory failure with	F 695	and the proper storage of oxygen/nebulizer equipment when not in uwe. Monitoring: The DON is responsible for maintaining compliance. The DON, ADON and/or Unit manager will perform daily audits of all residents using oxygen to monitor for compliance. All negative findings will be corrected at time of discovery and appropriate disciplinary action will be taken as needed. All negative findings will be reported to the Quality Assurance Committee for review, analysis, and recommendations for change in facility policy, procedure, and/or practice. Completion Date: 3/12/19	

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F 695	Continued From page 49 hypoxia, hypothyroidism, hypercholesterolemia, major depressive disorder, hypertension, acute bronchitis, repeated falls, hyperlipidemia, pressure ulcer stage 2 right buttock, and discitis. Resident #25's quarterly minimum data set (MDS) assessment with an assessment reference date (ARD) of 11/21/18 assessed the resident with a brief interview for mental status (BIMS) as 15/15. Section O Special Treatments, Procedures, and Programs was coded for oxygen use. Resident #25's current comprehensive care plan initiated 11/23/18 identified the resident to be at risk for respiratory complications related to hx (history) of CHF (congestive heart failure), neb (nebulizer) treatments daily, wears O2 (oxygen) at all times and 1500 fluid restriction. Approaches: Administer meds (medications) per MD (medical doctor) order. The December 2018 physician's orders read "O2 2l (liters) nasal cannula continuous." The surveyor observed Resident #25 during the initial tour on 1/23/19 beginning at 12:26 p.m. Resident #25 was in bed. An oxygen concentrator was sitting to the left side of the bed and the amount of oxygen was set at 1 and ½ liters. There was no date on the oxygen tubing. The surveyor observed Resident #25 again on 1/23/19 at 2:41 p.m. Resident #25 was in bed with oxygen via the concentrator set on 1 and ½ liters. No date was observed on the oxygen tubing. The surveyor observed Resident #25 on 1/24/19	F 695		

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F 695	Continued From page 50 at 9:09 a.m. Resident #25 was in bed and eating breakfast. The oxygen concentrator was on 1 and ½ liters. No date was observed on the oxygen tubing. The surveyor informed licensed practical nurse #3 of the above observation at 9:30 a.m. L.P.N #3 observed the liter of oxygen setting and moved the concentrator to 2. L.P.N. #3 was asked if the nasal cannula was changed weekly. L.P.N. #3 stated usually done on 11-7 shift. The surveyor informed the administrator, the director of nursing and the corporate registered nurse of the above observation during the end of the day meeting on 1/24/19 at 4:14 p.m. The surveyor requested the facility policy on respiratory care. The surveyor reviewed the facility policy titled "Respiratory Therapy-Prevention of Infection" on 1/25/19. The policy read in part "Infection Control Considerations Related to Oxygen Administration 7. Change the oxygen cannulae and tubing every seven (7) days, or as needed." No further information was provided prior to the exit conference on 1/28/19. 3. The facility staff failed to store a nebulizer mask in a plastic bag for Resident #108. Resident #108 was admitted to the facility on 2/22/15 with the following diagnoses of, but not limited to stroke, anxiety disorder and depression. On the quarterly MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 1/15/19, the resident was coded as having a BIMS (Brief Interview for Mental Status) score of 12 out of a possible score of 15. Resident #108	F 695		

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F 695	Continued From page 51 was also coded as requiring limited supervision of 1 staff member for dressing, extensive assistance of 1 staff member for personal hygiene and being totally dependent on 1 staff member for bathing. During the initial tour of the facility on 1/23/19 at 12:33 pm, the surveyor observed Resident #108's nebulizer mask sitting on the table bedside of the bed. The mask was not stored in a plastic bag. The surveyor went back into the resident's room on 1/24/19 at approximately 11 am at which time the surveyor observed the nebulizer mask being stored in a plastic bag. At 4:15 pm on 1/24/19, the surveyor notified the administrative team of the above findings. The director of nursing stated, "That mask should be stored in a plastic bag when not in use by the resident." The surveyor requested a copy of the policy concerning storage of a nebulizer mask when not in use. On 1/25/19 at 11 am, the surveyor was provided a copy of the facility's policy titled "Departmental (Respiratory Therapy) Prevention of Infection. The policy read in part, " ...Store the circuit in plastic bag, marked with date and resident's name, between uses ..." No further findings were provided to the surveyor prior to the exit conference on 1/28/19.	F 695		
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	F 761	Corrective Action(s): The 3 bottles of expired artificial tears identified during the medication cart reviews of side 2 medication cart have been removed and	

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F 761	Continued From page 52 professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility staff failed to discard expired medications on 1 of 3 medication carts inspected. On 1/25/19 at 11:00 AM, the surveyor checked the medication cart on Side 2 for expired medications. The surveyor found 3 containers of artificial tears with expiration date 12/2018. The containers were labeled with the names of 3 unsampled residents. Medication administration records indicated that the 3 residents had received the medications daily in the 24 days after the expiration date. . The nurse was informed of the concern and pulled the eye drops from the cart and went to the supply room for	F 761	discarded. All new bottles were obtained and properly dated when opened and put into use. A Facility Incident & Accident form has been completed for this incident. Identification of Deficient Practices & Corrective Action(s): All other unit medication rooms, medication carts and medication refrigerators used for the storage medications may have been potentially affected. The DON, ADON and/or Unit Manager will conduct a 100% review of the medication rooms medication refrigerators and medication carts to identify any undated, expired or unlabeled medications, equipment or biologicals. Any/all negative findings will be corrected at time of discovery. A Facility Incident and Accident Form will be completed for each incident identified. Systemic Changes(s): Facility policy and procedure for medication and biological storage have been reviewed and no changes are warranted at this time. All licensed nurses will be inserviced by the DON on the	

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F 761	Continued From page 53 replacements. The director of nursing and administrator were notified of the issue on 1/25/19.	F 761	facility policy and procedure for storing medications and biologicals. The nursing staff will also be inserviced on the Medication Administration Policy and Procedure to include weekly inspection of all medication carts, medication rooms and medication rooms and medication refrigerators to remove and discard all undated and expired medications. Monitoring: The DON is responsible for maintaining compliance. The DON and/or unit manager will perform weekly Medication room and medication cart audits to monitor for compliance. All discrepancies found in these audits will be corrected at the time of discovery and disciplinary action taken as appropriate. Results of these audits will be reported to the Quality Assurance Committee for review, analysis and recommendations for change in facility policy, procedure, and/or practice. Completion Date: 3/12/19	
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; (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,	F 842		

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F 842	Continued From page 54 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 staff interview, facility document review, and clinical record review, the facility staff failed to maintain a complete and accurate clinical record for 1 of 29 residents (Resident #117).	F 842	Corrective Action(s): A facility Incident and Accident form was completed for the lack of RN documentation in medical record when the pronouncement of death occurred in the facility. Identification of Deficient Practices & Corrective Action(s): The DON and/or ADON have reviewed all deaths in the last year to identify any negative findings. All negative findings will be reported to the Medical Director at time of discovery. A facility Incident & Accident form will be completed for each negative finding. Systemic Change(s): The facility policy and procedure has been reviewed and no changes are warranted at this time. All licensed nursing staff will be inserviced by the Regional Nurse Consultant on the clinical documentation standards per facility policy and procedure. This training will include the standards for maintaining accurate medical records. This includes the requirement that a Registered	

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F 842	Continued From page 55 The findings included: The facility staff failed to ensure a registered nurse documented when Resident #117 was pronounced dead. The clinical record of Resident #117 was reviewed 1/28/19. Resident #117 was admitted to the facility 8/1/14 and expired 11/29/18. Diagnoses included but were not limited to Alzheimer's disease, heart failure, atrial fibrillation, atherosclerotic heart disease, chronic kidney disease, hypertension, type 2 diabetes mellitus, hyperlipidemia, insomnia, anxiety, major depressive disorder, and gastrointestinal hemorrhage. Resident #117's quarterly minimum data set (MDS) assessment with an assessment reference date (ARD) of 10/10/18 assessed the resident with a brief interview for mental status as 0/15. The departmental note dated 11/29/18 6:34 a.m. read "Upon rounding, resident was observed in bed with no respirations, no apical pulse, no blood pressure, no oxygen saturation. Her skin is cool to touch and model (sic) up to her legs and hands. RN (registered nurse) notified and comfirmed (sic) findings time of death 01613. Notified RP (responsible party) and Dr. (Doctor). RP stated to send body to ____ (name of nursing home omitted). Signed by licensed practical nurse #4." The surveyor was unable to locate documentation by the registered nurse of Resident #117's death in the clinical record.	F 842	Nurse must document the pronouncement of death when a resident expires in the facility according to the acceptable professional standards and practices. Monitoring: The DON and Administrator are responsible for maintaining compliance. The DON, ADON and/or designee will conduct chart audits of all residents that expire in the facility to monitor for proper documentation by a registered nurse. Any/all negative findings will be clarified and corrected at time of discovery and disciplinary action will be taken as needed. The results of this audit will be provided to the Quality Assurance Committee for analysis and recommendations for change in facility policy, procedure, and/or practice. Completion Date: 3/12/19	

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F 842	Continued From page 56 The surveyor informed the director of nursing (DON) of the above issue on 1/28/19 at 11:56 a.m. The DON was unable to locate documentation by the RN of Resident #117's death. The DON stated she would expect staff especially the RN on duty when Resident #117 expired to document their findings. The surveyor requested the facility policy on documentation from the director of nursing on 1/28/19. The surveyor reviewed the facility policy titled "Charting and Documentation" on 1/28/19. The policy read in part "2. The following information is to be documented in the resident medical record: d. Changes in the resident's condition." No further information was provided prior to the e exit conference on 1/28/19.	F 842		

Jeremiah Fish Administrator 2-13-19