STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495324	A. BUILDING _____ B. WING _____	C 01/28/2019

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E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 1/24/19 through 1/28/19. The facility was in substantial compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities. No emergency preparedness complaints were investigated during the survey.	E 000		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 1/24/19 through 1/28/19. One complaint was investigated during the survey. Corrections are required for compliance with the following 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. The census in this 50 certified bed facility was 41 at the time of the survey. The survey sample consisted of 22 resident reviews; 18 current residents and 4 closed record reviews.	F 000		
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible.	F 584		2/15/19

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

Electronically Signed | 02/15/2019

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 584	Continued From page 1 (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility documentation review, and in the course of a complaint investigation, the facility staff failed to provide reasonable care for the protection of residents' property from loss for 1 of 22 residents (Resident #88) in the survey sample. The facility staff disposed of Resident #88's cards that had sentimental value.	F 584	1. Resident #88 no longer resides in the facility. Immediately after the complaint was given to the facility by the resident's caregiver in July 2018 an investigation occurred as to how it happened, the policy was reviewed and revised. 2. Upon discharge, if residents have belongings that are remaining in the	

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F 584	Continued From page 2 The findings included: Resident #88 was originally admitted to the facility on 6/06/18. Diagnoses for Resident #88 included but not limited to Urinary Tract Infection and Altered Mental Status. The current Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 7/2/18 coded Resident #88 with 13 out of possible 15 score for Brief Interview for Mental Status (BIMS) which indicated no cognitive impairment. Based on a complaint investigation, the complainant alleged facility staff threw away Resident #88's most sentimental valuables when he did not return to the facility. An interview was conducted on 1/28/19 at approximately 1:30 P.M. with the facility administration who stated, "Yea, I believe housekeeping went in to clean the room and threw out some cards that were in a drawer. I believe it was a very special card to him." The facility policy titled "Resident's Personal Belongings" effective date 12/24/17 and revised 7/13/18 was reviewed and is documented in part, as follows: Procedure: 1. Upon discharge, if the family has not picked up the belongings, all resident's item will be packed up neatly by housekeeping staff and placed in the office. All residents' items include, but are not limited to notes, papers, tissues, care items, toiletries, cards, clothing, electronics, and any items that do not belong to	F 584	facility, housekeeping will pack them up and place in the office. Housekeeping will ensure no items are thrown in the garbage. The Housekeeping Supervisor or designee shall conduct audits of items that were in a room and compare to items located in the packed bag. 3. The facility policy was revised on 7/13/2018 to add description of all items that should not be disposed of when the resident is discharged from the facility. Facility staff were trained and educated on the policy updates. 4. Housekeeping Supervisor or designee shall conduct audits of items that were in a room and compare to items located in the packed bag. This shall be reported in the QAPI committee. 5. Corrective action has been completed as of 2/15/2019	

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F 584	Continued From page 3 the facility. The facility Administrator was informed of the findings during the pre-exit meeting on 1/28/19 at approximately 7:00 P.M. The facility did not have any further questions or present any further information at that time.	F 584		
F 622 SS=E	Complaint Deficiency. Transfer and Discharge Requirements CFR(s): 483.15(c)(1)(i)(ii)(2)(i)-(iii) §483.15(c) Transfer and discharge- §483.15(c)(1) Facility requirements- (i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless- (A) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility; (B) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility; (C) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident; (D) The health of individuals in the facility would otherwise be endangered; (E) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after	F 622		2/22/19

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F 622	Continued From page 4 admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or (F) The facility ceases to operate. (ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose. §483.15(c)(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider. (i) Documentation in the resident's medical record must include: (A) The basis for the transfer per paragraph (c)(1)(i) of this section. (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	F 622		

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F 622	Continued From page 5 (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 medical record review, staff interviews and facility document review the facility staff failed to ensure that individual plan of care summary was sent with 3 of 22 Residents in the survey sample upon transfer to the hospital, Resident #22, #19, and #88. 1. The facility staff failed to ensure that Resident #22's plan of care summary was sent upon transfer to the hospital on 1/27/19. 2. Facility staff failed to send Resident #19's care plan summary when discharged to the hospital. 3. The facility staff failed to ensure Resident #88 plan of care summary was sent upon transfer to the hospital on 6/23/18 and 6/30/18. The findings included:	F 622	1. Resident #22, 19 and 88 are no longer in the hospital. 1 resident has returned and is currently admitted into our care. 2. Facility reviewed for any residents any residents sent out to the hospital after the survey had the care plan included with the transfer packet that went to the hospital with them. All transfer packets were given to the EMS care team. 3. Facility reviewed and updated the current policy to include, all transfers to another facility will include the baseline or comprehensive care plan along with the patient care summary. A Checklist of all items required to be sent with the resident upon transfer will be included with the transfer packet. The updated policy will be	

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F 622	Continued From page 6 1. Resident #22 was a 97 year old admitted to the facility on 11/12/18 with diagnoses to include but not limited to Diabetes Mellitus, Congestive Heart Failure, and Peripheral Vascular Disease. The most recent comprehensive Minimum Data Set (MDS) assessment was a 60 day with an assessment reference date (ARD) of 1/10/19. Resident #22's Brief Interview for Mental Status (BIMS) was a 10 out of a possible 15 which indicated that the resident had moderate cognitive impairment but capable of daily decision making most days. Resident #22's most recent Minimum Data Set (MDS) assessment was a Discharge Assessment with assessment reference date (ARD) of 1/27/19. Resident #22's Comprehensive Care Plan was reviewed and revealed the following facility identified problems for the resident: Nutrition, Allergies, Diabetes, Foley Catheter, Gastro-Esophageal Reflux Disease, Psychotropic -Anxiety, Skin Integrity, Potential for Urinary Tract Infection, Vision, Pneumonia, Constipation, Risk for Dehydration, Congestive Heart Failure, Activities of Daily Living, Pain Management, Risk for falls, Psychotropic-Antipsychotic, Dementia, and Social Services. Resident #22's Skilled Assessment Note dated 1/27/19 at 6:45 AM was reviewed and is documented in part, as follows: Patient had combative behaviors this am. She spit out all her medications, she threw her prostat and Miralax on this nurse. She tried to hit this	F 622	reviewed with all staff to ensure they are understanding of the importance of item. 4. Chart audits will be conducted with each transfer to the hospital that will include documentation of notices/information sent with the resident upon transfer. Audits will be reviewed by the QAPI committee. 5. All actions noted above will be completed by 2/22/2019	

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F 622	Continued From page 7	F 622		

nurse in the face with a water pitcher. She was crying out Mommy at times. Her daughter was in this shift as this nurse was calling the oncall to inform of behaviors and temperature of 101.2- then recheck was 100.5. Daughter stated she was trying to hit her several times and yelling at her. Clinching teeth. NP (Nurse Practitioner) was requested about maybe extending antibiotic for UTI (urinary tract infection), since today was last day for Keflex. NP only wanted STAT labs as they were done this am anyway and vital signs every 4 hours. Informed daughter of NP orders she stated no, she wanted her mother to be checked in the ER (emergency room) d/t (due to) increasing behaviors and wanting her urine rechecked as well as medicated for behaviors since she was seeing how combative her mother was. Called 911 after calling NP oncall back and telling them of her daughter request to send out. Called 911 and gate house to inform them of calling, called (Hospital Name) ER at 12:45 P.M. and spoke to RN (Registered Nurse) on duty to give them report. Called at 4:15 pm to check on patient being admitted or not, she was still being evaluated. She left facility via Stretcher at 12:50 PM.

The facility Model Transfer Form: Nursing Facility to Emergency Department/Hospital for Resident #22 was reviewed and is documented in part, as follows:

Date: 1/27/19
Time of Transfer: 12:50 PM
Reason for Transfer/Actions Taken Prior to transfer: Last day of UTI medications, increased behaviors noted-severe combativeness this am-refused all meds. this am. Needs Eval. Verbal Communication to ED (emergency

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F 622	Continued From page 8 department) staff: (Name) Time: 12:45 PM On 1/28/19 at approximately 1:30 P.M. an interview was conducted with the Director of Nursing regarding Resident #22's hospital transfer on 1/27/19. The Director of Nursing was asked if the facility had send an individual plan of care summary with Resident #22 when she was transferred to the hospital on 1/27/19. The Director of Nursing stated, "We send the transfer form with them but not the care plan." On 1/28/19 at 7:00 P.M. a pre-exit de-briefing was conducted with the Administrator and the Director of Nursing where the above information was shared. Prior to exit no further information was provided. 2. The facility staff failed to send Resident #19's care plan summary when discharged to the hospital. Resident #19 was admitted to the facility on 01/03/2019. Diagnosis included but were not limited to, Aphasia and Encephalopathy. The Admission Minimum Data Set (an assessment protocol) with an Assessment Reference Date of 01/10/2019 coded Resident #19 with a BIMS (Brief Interview for Mental Status) score of zero (0) indicating severe cognitive impairment. In addition, the Minimum Data Set coded Resident #19 as requiring extensive assistance with Activities of Daily Living. On 01/28/2019 at approximately 6:10 p.m., an interview was conducted with the Director of Nursing (DON). The DON was asked, "When was Resident #19 discharged from the facility?" The	F 622		

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F 622	Continued From page 9	F 622		

DON provided copy of a nurse note stating that Resident #19's caretaker signed Resident #19 out of the facility on 12/24/2018 and took him to the hospital. Resident #19 was admitted to the hospital with a diagnosis of sepsis. The DON was asked, "Was a care plan summary sent to the hospital?" The DON could not produce any evidence that the care plan was sent.

The facility does not have a policy regarding issuing a care plan at time of transfer or discharge.

On 01/28/2019 at approximately 7:15 p.m., at pre-exit meeting the Administrator and the Director of nursing was informed of the findings. The facility did not present any further information about the findings.

3. The facility staff failed to ensure Resident #88 plan of care summary was sent upon transfer to the hospital on 6/23/18 and 6/30/18.

Resident #88 was originally admitted to the facility on 6/06/18. Diagnosis for Resident #88 included but not limited to Urinary Tract Infection and Altered Mental Status. A closed record review was conducted.

The most recent Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 7/2/18 coded the Resident #88 with 13 out of possible 15 score for Brief Interview for Mental Status (BIMS) indicating minimal cognitive impairment.

The clinical note dated 6/23/18 at 6:48 P.M. revealed the following: received resident in bed. a&o x4. Thirty minutes later unable to speak. Out of bed up in wc bedside, refused to eat any dinner. Found with his chin in his chest drooling.

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F 622	Continued From page 10 BS 0815 230. Manual BP 90/45. This nurse call for assistance getting him into bed. Observed he is cold clammy and still unable to speak. Opened his eyes and looked when his name was spoken. Hand grasps average strength equal. Smile unable to be checked. 95% o2 sat on ra, no sob noted. On call md notified. 911 called. Supervisor notified and family made aware. Manual bp 140/70 lying flat in Trendelenburg. EMT responds and resident unable to verbalize. Transported to (Hospital Name), family made aware. Admission confirmed with hospital and family. Oof (out of facility) to hospital 0900. The clinical note dated 6/30/18 at 4:26 P.M. revealed the following: Called to room approximately 12:45 pm. Patient had just had a small amount of emesis noted right after lunch. This emesis was not observed via this nurse. MDS nurse was in room and Social Worker was bringing a v/s machine. Resident had a b/p of 149/66, heart rate 58, POX 97% on room air. Noted to be diaphoretic, BS was checked and noted 194. Patient was lethargic, but able to be aroused. He then had noted to have a very thick white emesis (large amount). It was projectile. Patient was then in and out of responsiveness. Sternum rub performed several times. Social worker called on-call, no return call. 911 was called, patients' blood pressure was noted to be 87/37, still in and out of consciousness. Left facility at 1:20 pm to (Hospital Name) ER. An interview was conducted with the facility Director of Nursing on 1/28/19 at 1:30 P.M. who stated, "We send out a patient summary that includes face sheet, meds, treatments, but not a care plan."	F 622		

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F 622	Continued From page 11 The facility policy titled "Required Documentation for a Planned Discharge" with issued date 4/2002 and revised date 2/2018 was reviewed and is documented in part, as follows: Purpose: To ensure that all residents upon discharge receive the information required for a safe discharge. Procedure: 3. Complete discharge paperwork is resident is going home. If the resident is being transferred to another facility, you are required to complete a transfer summary and provide discharge paperwork. Facility could not provide policy or procedure specific to care plan included with resident transfer. The facility Administrator was informed of the findings during the pre-exit meeting on 1/28/19 at approximately 7:00 P.M. The facility did not have any further questions or present any further information at that time.	F 622		
F 625 SS=E	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility;	F 625		2/22/19

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F 625	Continued From page 12 (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on medical record review, staff interviews and facility document review the facility staff failed to ensure that a written notice of the Bed-Hold Policy was sent with 3 of 22 Residents in the survey sample upon transfer to the hospital, Resident #22, #19 and #88. 1. The facility staff failed to ensure that Resident #22 received a written notice of the Bed-Hold Policy upon transfer to the hospital on 1/27/19. 2. The facility staff failed to provide Resident #19 and/or Resident Representative a written Bed Hold Notice upon transfer to the hospital on 12/24/18. 3. The facility staff failed to provide Resident #88 or resident representative with a written notice of the bed hold policy upon transfer to the hospital on 6/23/18 and 6/30/18.	F 625	1. Resident #22, 19 and 88 are no longer in the hospital. 1 resident has returned and is currently admitted into our care. 2. Facility conducted a review on all residents that were sent out to the hospital after the survey to ensure the bed hold policy had been given to the resident and, if applicable, the resident representative at time of transfer to the hospital. All residents and/or personal representatives were found to have received a copy at time of transfer. 3. Facility reviewed and updated the current policy to include, when a resident is transferred out to the hospital, the facility staff will give them a copy of the bed hold policy at the time of transfer. The resident representative, if applicable, will be informed and a copy of the bed	

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F 625	Continued From page 13 The findings included: 1. Resident #22 was a 97 year old admitted to the facility on 11/12/18 with diagnoses to include but not limited to *Diabetes Mellitus, *Congestive Heart Failure, and * Peripheral Vascular Disease. The most recent comprehensive Minimum Data Set (MDS) assessment was a 60 day with an assessment reference date (ARD) of 1/10/19. Resident #22's Brief Interview for Mental Status (BIMS) was a 10 out of a possible 15 which indicated that the resident was cognitively intact and capable of daily decision making most days. Resident #22's most recent Minimum Data Set (MDS) assessment was a Discharge Assessment with assessment reference date (ARD) of 1/27/19. Resident #22's Skilled Assessment Note dated 1/27/19 at 6:45 AM was reviewed and is documented in part, as follows: Patient had combative behaviors this am. She spit out all her medications, she threw her prostat and Miralax on this nurse. She tried to hit this nurse in the face with a water pitcher. She was crying out Mommy at times. Her daughter was in this shift as this nurse was calling the oncall to inform of behaviors and temperature of 101.2- then recheck was 100.5. Daughter stated she was trying to hit her several times and yelling at her. Clinching teeth. NP (Nurse Practitioner) was requested about maybe extending antibiotic for UTI (urinary tract infection), since today was last day for Keflex. NP only wanted STAT labs as they were done this am anyway and vital signs	F 625	hold policy will be emailed to them if we are unable to provide a copy in person. Documentation of this will be placed in the resident record. 4. Chart audits will be conducted with each transfer to the hospital that will include documentation of notices/information sent with the resident upon transfer. Audits will be reviewed by the QAPI committee. 5. All actions noted above will be completed by 2/22/2019	

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F 625	Continued From page 14 every 4 hours. Informed daughter of NP orders she stated no, she wanted her mother to be checked in the ER (emergency room) d/t (due to) increasing behaviors and wanting her urine rechecked as well as medicated for behaviors since she was seeing how combative her mother was. Called 911 after calling NP oncall back and telling them of her daughter request to send out. Called 911 and gate house to inform them of calling, called (Hospital Name) ER at 12:45 P.M. and spoke to RN (Registered Nurse) on duty to give them report. Called at 4:15 pm to check on patient being admitted or not, she was still being evaluated. She left facility via Stretcher at 12:50 PM. The facility Model Transfer Form: Nursing Facility to Emergency Department/Hospital for Resident #22 was reviewed and is documented in part, as follows: Date: 1/27/19 Time of Transfer: 12:50 PM Reason for Transfer/Actions Taken Prior to transfer: Last day of UTI medications, increased behaviors noted-severe combativeness this am-refused all meds. this am. Needs Eval. Verbal Communication to ED (emergency department) staff: (Name) Time: 12:45 PM On 1/28/19 at approximately 1:30 P.M. an interview was conducted with the Admissions Coordinator regarding the Resident #22's hospital transfer on 1/27/19. The Admissions Coordinator was asked if the facility had sent a written notice of the Bed-Hold Policy upon Resident #22's transfer to the hospital on 1/27/19. The Admissions Coordinator stated, "When a resident is sent out, we get a computer alert and find out	F 625		

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F 625	Continued From page 15	F 625		

they are admitted to the hospital. I call the family the next day to ask them if they want to hold the bed. If they want to hold the bed I get them to come in and sign the bed-hold agreement. No bed-hold goes out when resident leaves."

On 1/28/19 at 7:00 P.M. a pre-exit de-briefing was conducted with the Administrator and the Director of Nursing where the above information was shared. The Administrator was asked if she was aware of the new regulation for bed-holds upon transfer to out of the facility. The Administrator stated, "Yes, I must have misinterpreted the new bed-hold policy." Prior to exit no further information was provided.

2. The facility staff failed to provide Resident #19 and/or Resident Representative a written Bed Hold Notice upon transfer to the hospital on 12/24/18.

Resident #19 was discharged to the hospital on 12/24/2018. Resident #19 was re-admitted to the facility on 01/03/2019. Diagnosis included but were not limited to Aphasia and Encephalopathy. Resident #19's Admission Minimum Data Set (an assessment protocol) with an Assessment Reference Date of 01/10/2019 coded Resident #19 with a BIMS (Brief Interview for Mental Status) score of zero (0) indicating severe cognitive impairment. In addition, the Minimum Data Set coded Resident #19 as requiring extensive assistance with Activities of Daily Living.

An interview was held with the Administrator and Director of Nursing by another surveyor on 01/28/19 at 1:30 p.m. They stated, "When a resident is sent out, we get a computer alert and find out they are admitted to the hospital. I call the

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family the next day to ask them if they want to hold the bed. If they want to hold the bed I get them to come in and sign the bed hold agreement." (are bed holds given out when resident leaves facility) "No. No bed hold goes out when resident leaves."

On 01/28/2019 at approximately 6:00 p.m., an interview was conducted with the Administrator. The Administrator was asked, "Was a Bed Hold Notice issued to the resident or the resident's representative?" The Administrator stated, "The Admissions Coordinator called the resident's representative but did not issue the notice." The Administrator was unable to provide any evidence that Bed Hold Notice was provided.

On 01/28/2019 at approximately 7:15 p.m., at the pre-exit meeting the Administrator and the Director of Nursing was informed of the findings. The facility did not present any further information about the findings. The facility staff failed to issue a bed hold notice at time of transfer and discharge to the local hospital for three residents. 3. The facility staff failed to provide Resident #88 or resident representative with a written notice of the bed hold policy upon transfer to the hospital on 6/23/18 and 6/30/18.

Resident #88 was originally admitted to the facility on 6/06/18. Diagnosis for Resident #88 included but not limited to Urinary Tract Infection and Altered Mental Status.

The current Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 7/2/18 coded the Resident #88 with 13 out of possible 15 score for Brief Interview for Mental Status (BIMS) indicating minimal cognitive impairment.

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The clinical note dated 6/23/18 at 6:48 P.M. included the following: received resident in bed. a&o x4. Thirty minutes later unable to speak. Out of bed up in wc bedside, refused to eat any dinner. Found with his chin in his chest drooling. BS 0815 230. Manual BP 90/45. This nurse call for assistance getting him into bed. Observed he is cold clammy and still unable to speak. Opened his eyes and looked when his name was spoken. Hand grasps average strength equal. Smile unable to be checked. 95% o2 sat on ra, no sob noted. On call md notified. 911 called. Supervisor notified and family made aware. Manual bp 140/70 lying flat in Trendelenburg. EMT responds and resident unable to verbalize. Transported to (Hospital Name), family made aware. Admission confirmed with hospital and family. Oof (out of facility) to hospital 0900.

The clinical note dated 6/30/18 at 4:26 P.M. revealed the following: Called to room approximately 12:45 pm. Patient had just had a small amount of emesis noted right after lunch. This emesis was not observed via this nurse. MDS nurse was in room and Social Worker was bringing a v/s machine. Resident had a b/p of 149/66, heart rate 58, POX 97% on room air. Noted to be diaphoretic, BS was checked and noted 194. Patient was lethargic, but able to be aroused. He then had noted to have a very thick white emesis (large amount). It was projectile. Patient was then in and out of responsiveness. Sternum rub performed several times. Social worker called on-call, no return call. 911 was called, patients' blood pressure was noted to be 87/37, still in and out of consciousness. Left facility at 1:20 pm to (Hospital Name) ER.

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F 625	Continued From page 18 An interview was conducted with the facility Admission Coordinator on 1/28/19 at 1:30 P.M. who stated, "When a resident is sent out, we get a computer alert and find out they are admitted to the hospital. I call the family the next day to ask them if they want to hold the bed. If they want to hold the bed I get them to come in and sign the bed hold agreement." When asked are bed hold notifications provided when resident leaves the facility the Admission Coordinator stated, "No. No bed hold goes out when resident leaves." The facility policy titled "Notice of Bed Hold" effective date 12/15/11 was reviewed and is documented in part, as follows: General Information. When transferring nursing facility residents to the hospital, it is important that the resident and their family or legal representative receive timely notification of the facility's bed hold practices while the resident is in the hospital. The facility Administrator was informed of the findings during the pre-exit meeting on 1/28/19 at approximately 7:00 P.M. The facility did not have any further questions or present any further information at that time.	F 625		
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.	F 690		2/22/19

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F 690	Continued From page 19 §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 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 staff interview, facility documentation review, and in the course of a complaint investigation, the facility staff failed to provide appropriate indwelling Foley catheter care for 1 of 22 residents (Resident #88) in the survey sample. 1. The facility staff failed to provide appropriate indwelling Foley catheter care for Resident #88 daily for 5 days in June 2018.	F 690	1. Resident #88 no longer resides in the facility. 2. An audit of all residents currently in the facility with a urinary catheter was conducted by the Director of Nursing to ensure documentation / TAR assists were included in the resident's record and that documentation of care was being completed.	

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F 690	Continued From page 20 The findings included: Resident #88 was originally admitted to the facility on 6/06/18. Diagnosis for Resident #88 included but not limited to Urinary Tract Infection and Altered Mental Status. Resident #88 no longer resided in the facility. The most recent Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 7/2/18 coded Resident #88 with 13 out of possible 15 score for Brief Interview for Mental Status (BIMS) indicating minimal cognitive impairment. Based on a complaint, the complainant alleged facility staff did not provide catheter hygiene. The review of resident's Physician Orders and Care Plan revealed the following: Perform appropriate cleaning of entry point of catheter tubing as well as the tip of the penis. A review of the resident's Treatment Administration Record (TAR) Assist report dated 6/6/18 through 6/23/18 revealed no daily catheter care was provided on 6/10/18, 6/11/18, 6/16/18, 6/17/18, and 6/20/18. An interview was conducted on 1/28/19 at approximately 1:30 P.M. with the facility administration who stated, "It looks like the resident did not get catheter care for 5 different days while he was here in our facility. The expectation is Foleys are cleaned and cared for daily." The facility policy titled "Catheter Care, Urinary" with issue date 2/2018 was reviewed and is	F 690	3. All staff, to include CNA's and nurses, will be educated on proper catheter care and must demonstrate competency on rendering care as well as documenting it. 4. All charts will be audited, no less than monthly to ensure proper documentation is occurring. All staff will demonstrate competency of catheter care no less than annually. Random audits on direct patient care will be conducted by the Unit Manager or Director of Nursing. Audits will be reviewed by the QAPI committee. 5. All actions noted above will be completed by 2/22/19	

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F 690	Continued From page 21 documented in part, as follows: Purpose: The purpose of this procedure is to prevent infection of the resident's urinary tract. The facility Administrator was informed of the findings during the pre-exit meeting on 1/28/19 at approximately 7:00 P.M. The facility did not have any further questions or present any further information at that time.	F 690		
F 755 SS=D	Complaint Deficiency. Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility.	F 755		2/22/19

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F 755	Continued From page 22 §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on the observation of 2 medication carts and 1 medication room; the facility staff failed to dispose of medications on a discharged Resident # 191. The facility staff failed to dispose of an expired controlled medication (Fentanyl patch) and unidentified medications for Resident #191. The findings include: Resident # 191 was admitted to the facility 09/29/18 from an acute care facility with diagnoses that included but not limited to Diabetes mellitus, hyperlipidemia, and chronic pain. Resident # 191 Admission assessment with an assessment reference date (ARD) of 10/06/18 coded the resident as being able to complete the Brief Interview of Mental Status (BIMS). On 01/25/19 at approximately 11:27 AM an inspection was being conducted in the medication room. There was a locked box located on the wall in the medication room, consisting of two locks. Licensed Practical Nurse # 4 was asked what was inside of the box and she stated that she	F 755	1. At the time of inspection all medications were destroyed and documented on med destruction form as per facility policy. 2. Director of Nursing and /or Unit Manger will conduct an audit of the medication carts to ensure there are no medications from residents in the cart that are not in proper packaging or that there is no order/prescription for. The audit will also look to ensure there are no expired medications or any that belong to residents that have discharged from the facility left in the cart. 3. The facility policy on Medication Destruction was reviewed and updated. To comply with 18VAC110-20-530. a. Drug destruction at the facility shall be witnessed by the director of nursing or, if there is no director, then by the facility administrator and by a pharmacist providing pharmacy services to the facility or by another employee authorized to administer medication. b. The facility shall destroy discontinued or unused drugs or return them to the pharmacy within 30 days of the date the	

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F 755	Continued From page 23 didn't know but thought it might be empty. She then stated that the Director of Nursing (DON) was the only person with the keys to open it. Registered Nurse # 1 was also asked if she knew what was in the box, she stated that she was new to the facility and didn't know what was in the locked box. A brief interview was conducted with LPN # 2 (Licensed Practical Nurse) on 01/25/19 at approximately 11:35 AM concerning the locked medication box on the wall in the medication room. She stated that she will get the DON (Director of Nursing) to open the locked box, because she was the only person with access. On 1/25/19 at approximately 11:45 AM, The DON entered the medication room with the keys to the wall mounted medication box. Once she unlocked the box she removed 2 unopened fentanyl 25 mcg/HR patches with an expiration date of January 2017. Attached with the fentanyl patches was a controlled medication utilization record dated 09/29/18 with 2 nursing signatures. She also pulled out 2 zip locked bags of loose pills. One bag had 4 round, white pills and the other bag had 36 round, white pills. There were no medication records found. The DON (Director Of Nursing) stated that the locked box was mostly for keeping discharged patient medications, jewelry or other valuable items. She stated that the pills were brought from home by the resident's family and that she just forgot to waste the pills. On 1/28/19 at approximately 11:00 AM, the DON stated that she and LPN # 1, had destroyed the expired fentanyl patches and two zip locked bags of pills that were brought in by the resident's	F 755	drug was discontinued. All staff will be trained on the policy of receiving medications from an outside pharmacy/family and the policy on medication destruction. 4. The lock box will be opened on the first of every month to ensure there are no medications remaining in there. Routine audits will be conducted on the medication carts to ensure compliance with the policy. Results will be reported to the QAPI committee. 5. All actions noted above will be completed by 2/22/19	

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F 755	Continued From page 24 family. She presented the Controlled Medication Utilization Record which stated that the above medications were destroyed on 01/25/19 at 12 noon. A brief interview was held with License Practical Nurse # 3 on 1/28/19 at approximately 3:35 PM. She was asked what should be done if a Resident brought in medication from home to the facility. She stated that she would lock up the medication in her medication cart if the Director Of Nursing wasn't available. She also stated that if the medication was a narcotic that she would count it with another license nurse and put the information on the medication inventory sheet. On 1/28/19 at approximately 3:40 PM an interview was held with License Practical Nurse # 1 concerning her receiving medications brought in from the resident's family on 09/29/18. She stated that a nurses aide caring for the resident informed her that Resident #191 had a bag of pills in her room that her family brought in for her. LPN #1 stated that she took the medications from the resident and locked them in her cart until the DON (Director Of Nursing) was available. She was asked if she had documented the incident in her nursing notes but stated that she didn't. She was also asked if she tried to contact the resident's family to pick up the medication, but stated that she never contacted anyone to pick up the medications. On 1/25/19 at approximately 12:56 PM The facility's policy was provided by the DON and reviewed. Policy: Titled Disposal Of Medications. PURPOSE: To ensure safely, legally and properly dispose of all outdated or discontinued	F 755		

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F 755	Continued From page 25	F 755		

medications. To ensure that controlled substances are not diverted. To comply with state and federal DEA regulations. RESPONSIBLE PERSONNEL: Licensed Nursing.

PROCEDURE: For Narcotics and Liquid Medication Destruction: All narcotics and liquid medications must be hand delivered to the Director Of Nursing for destruction. Two people must witness the crushing of the narcotic and/ or liquid medication and placing it into a sharp's container for destruction. PRIVATE RESIDENTS LTC-If family is requesting for medications not to be disposed of: (1.) If family is requesting for us not to dispose of the medications because the doctor may prescribe again they must pick up within 72 hours of med. Being discontinued. (2.) Until family picks up medication nursing staff must place all discontinued medications into plastic bag labeled D/C meds. With name date and time and person contacted and pick up. (3.) If family does not pick up within 72 hours, medication will be disposed of per current policy.

On 1/28/19 at approximately 12:50 PM a phone call was made to the facility Pharmacist #4 with concerns involving the facility's medication disposal procedures. She stated that she would like to talk in person concerning the matter.

A brief interview was held on 1/28/19 at approximately, 1:26 PM with the facility Pharmacist # 4 and Pharmacist # 5 concerning procedures involving medications brought in to the facility by residents. Pharmacy # 4 stated that the nursing staff should try to send the medications home within the required time frame. The Pharmacist agreed they are not involved in the destruction of narcotics, but the Director of

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F 755	Continued From page 26 Nursing should destroy the meds. Pharmacist # 5 stated that if the resident brought in other medications such as inhalers, eye drops etc. they would have licensed staff list medications on the count sheet so they would be aware of what the resident is taking. Pharmacist # 4 stated that the medication was placed in a secure double locked box which was important. On 1/28/19 at approximately 3:00 PM a debriefing was held with the DON (Director Of Nursing) and facility Administrator concerning the medication incident. The DON stated that the nurse gave her the medication because the resident was "self-medicating." She said that she should have put the incident in her nursing note, contacted a family member to pick up the medications, and/or destroyed the medication if family member hadn't showed up in 72 hours. The administration had no comment at this time. On 1/28/19 at approximately 4:36 PM, received policy from facility administrator titled Proper Medication Disposal. Policy: The facility adheres to all federal, state and local regulations regarding, drug destruction when discarding medication and medical waste. Purpose: (1.)To safely, legally and properly dispose of all outdated or unwanted controlled substances. (2.) To ensure that controlled substances are not diverted. (3.) To comply with state and federal DEA regulations. Procedure: If the medication is supplied in a bubble pack or prescription bottle from another pharmacy, you must do the following: Have another staff witness the destruction, document the amount of pills being destroyed, crush all pills and put in sharps container, crush all pills and place in a sharps container to make sure both staff members	F 755		

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F 755	Continued From page 27 witness the destruction and sign the medication destruction form. On 1/28/19 at approximately 7 PM a pre-exit interview was conducted. The Director Of Nursing (DON) and the Administrator were present. The DON stated that she rarely uses the lock box, and that the medications should have been destructed in 72 hours. On 1/28/19 the facility Administrator handed surveyor a copy of the following: Title 21 of the Code of Federal Regulations (CFR), 21 CFR 1307.21 (Disposal of Unused or Unwanted Medications). 18VAC110-20-211. Disposal of Drugs by Authorized Collectors. She stated this is what the facility follows.	F 755		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional	F 812		2/22/19

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F 812	Continued From page 28 standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and facility document review, the facility staff failed to store and label food in accordance with food service safety guidelines. The findings included: On 1/24/19 at approximately 2:30 P.M. on the way to the main kitchen staff members were observed in the Seaside Grill kitchen area with the refrigerator open. The Seaside Grill is the main dining room for the facility residents. The area has a kitchenette with 2 refrigerators. The first refrigerator had 4 doors on it. The Director of Health Care Food Services was also in the kitchenette. The refrigerator was inspected with the following observations noted: 1. 2 full chocolate cheese cakes covered but not labeled with date. 2. Half a chicken salad sandwich on a plate wrapped but not labeled with date. 3. 1 small fruit cup covered but not labeled with date. The Director of Health Care Food Services was asked about the unlabeled items and stated, "These came over today from the kitchen and would be served tonight." Surveyor asked if they should be labeled when they were prepared and if so why. She stated, "Definitely, to make sure they are safe for the resident's." On 01/24/19 2:45 PM the Initial Kitchen Inspection was completed with the Head Chef.	F 812	1. The Food and Beverage Director, Executive Chef, and F&B Manager of Healthcare conducted an inspection and corrected all deficiencies while the survey was in progress. 2. An audit of all storage areas was completed and the FDA guideline dating form that is used throughout the facility was reviewed. 3. The current facility "Food Labeling" policy was reviewed and updated. The updates include: a. Food items, such as desserts, shall be labeled before meal service.(the wording of after "day of services" was removed. b. Items that are taken out of the original packing without dating on the individual package will be marked by receive date. Appropriate staff were educated on the updated "Food Labeling" policy and apprised of the audits that will be conducted by management. 4. An audit of storage locations will be performed daily and as needed. This will be performed by the supervisor or designee. Routine inspections shall be conducted by the Registered Dietician to ensure compliance. Compliance reporting results shall be presented to the QAPI committee.	

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F 812	Continued From page 29 In the Dry Storage Room the following observations were made: 1. One bottle of regular and one bottle of white balsamic vinegar opened but not labeled with date opened or use by date. 2. Half a bag of whole pecans opened but not labeled with date opened or use by date. 3. One Box of Penne Pasta opened but not labeled with date opened or use by date. In the open kitchen area there were 3-25 gallon closed bins noted, 2 bins contained flour and 1 bin contained sugar. There was no label as to when the dry ingredients were added or a use by date on the 3 bins. On 1/24/19 at approximately 3:15 P.M. the Head Chef was asked if the open items in the dry storage room should have been labeled when opened/use by dates and if so why. The Head Chef stated, "Yes everything that is opened should be labeled so that we will know when is expires and to protect the resident from any food born illnesses. I agree we have a labeling issue with opened items we will get right on it." The facility policy titled "Food Labels" revised June 2018 was reviewed and is documented in part, as follows: POLICY: To establish a system for handling food items while in storage. Procedure: 1. All prepared and leftover food intended for storage will be covered, labeled, and dated according to posted FDA Guidelines and	F 812	5. All actions noted above will be completed by 2/22/19	

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F 812	Continued From page 30 department standard. Dating charts are available in each area. 2. Day item is opened or prepared is considered day one. 3. Item is to placed in proper refrigerator, freezer or dry storage. On 1/28/19 at 7:00 P.M. a pre-exit de-briefing was conducted with the Administrator and the Director of Nursing where the above information was shared. The Administrator was asked what where her expectations regarding the labeling and storage of foods in the facility kitchens. The Administrator stated, "I expect that if foods are opened for then to be labeled with the date they were made or opened and the use by date as well." Prior to exit no further information was shared.	F 812		