STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495246	A. BUILDING _____ B. WING _____	C 02/07/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODMONT CENTER	11 DAIRY LANE FREDERICKSBURG, VA 22405

(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 2/5/19 through 2/7/19. Corrections are required for compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities.	E 000	**Preparation and/or execution of this Plan of Correction does not constitute admission or agreement of the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The Plan of Correction is prepared and/or executed solely because it is required by the provisions of federal and state law.**	
E 037 SS=B	EP Training Program CFR(s): 483.73(d)(1) (1) Training program. The [facility, except CAHs, ASCs, PACE organizations, PRTFs, Hospices, and dialysis facilities] must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected role. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. *[For Hospitals at §482.15(d) and RHCs/FQHCs at §491.12:] (1) Training program. The [Hospital or RHC/FQHC] must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing on-site services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. *[For Hospices at §418.113(d):] (1) Training. The	E 037	1. **The 3 out of 113 employees who had not completed Emergency Preparedness Training (EPP) training will be completed as of 3/1/2019.** 2. **All residents at risk for staff not trained.** 3. **All new employees will receive EPP training during new employee orientation. All current employees will complete the Annual training with our annual corporate compliance training by October 2019.** 4. **Audits of Training log will be monitored monthly by CED. Audits will be reviewed at Quality Assurance and Performance Improvement Committee monthly with QAPI committee responsible for ongoing compliance.** 5. **Date of Compliance: 3/15/2019**	

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Wendy S Nero | TITLE: Regional Executive Director | (X6) DATE: 3/7/19

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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E 037	Continued From page 1 hospice must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing hospice employees, and individuals providing services under arrangement, consistent with their expected roles. (ii) Demonstrate staff knowledge of emergency procedures. (iii) Provide emergency preparedness training at least annually. (iv) Periodically review and rehearse its emergency preparedness plan with hospice employees (including nonemployee staff), with special emphasis placed on carrying out the procedures necessary to protect patients and others. *[For PRTFs at §441.184(d):] (1) Training program. The PRTF must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) After initial training, provide emergency preparedness training at least annually. (iii) Demonstrate staff knowledge of emergency procedures. (iv) Maintain documentation of all emergency preparedness training. *[For PACE at §460.84(d):] (1) The PACE organization must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing on-site services under arrangement, contractors, participants, and volunteers, consistent with their expected roles.	E 037		

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E 037	Continued From page 2 (ii) Provide emergency preparedness training at least annually. (iii) Demonstrate staff knowledge of emergency procedures, including informing participants of what to do, where to go, and whom to contact in case of an emergency. (iv) Maintain documentation of all training. *[For CORFs at §485.68(d):](1) Training. The CORF must do all of the following: (i) Provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. All new personnel must be oriented and assigned specific responsibilities regarding the CORF's emergency plan within 2 weeks of their first workday. The training program must include instruction in the location and use of alarm systems and signals and firefighting equipment. *[For CAHs at §485.625(d):] (1) Training program. The CAH must do all of the following: (i) Initial training in emergency preparedness policies and procedures, including prompt reporting and extinguishing of fires, protection, and where necessary, evacuation of patients, personnel, and guests, fire prevention, and cooperation with firefighting and disaster authorities, to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected	E 037		

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E 037	Continued From page 3 roles. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. *[For CMHCs at §485.920(d):] (1) Training. The CMHC must provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles, and maintain documentation of the training. The CMHC must demonstrate staff knowledge of emergency procedures. Thereafter, the CMHC must provide emergency preparedness training at least annually. This REQUIREMENT is not met as evidenced by: Based on staff interview and facility document review it was determined the facility staff failed to have a complete emergency preparedness plan. The facility staff failed to provide evidence of documentation of the facility's initial emergency preparedness training for three of 113 employees, CNA (certified nursing assistant) #12, CNA #13, and CNA #14. The findings include: On 2/7/19 at 11:12 a.m. a review and interview of the facility's emergency preparedness plan was conducted with other staff member (OSM) #4, the maintenance director. Review of the facility's emergency preparedness plan failed to provide evidence of the intimal training, provided and the	E 037		

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E 037	Continued From page 4 annual emergency preparedness training. OSM #4 stated he would get back with this surveyor. On 2/7/19 at approximately 3:00 p.m. ASM (administrative staff member) #1, the executive director, presented a list of the employees and the dates that they have completed their annual training in emergency preparedness. Of the list of 113 employees, three CNA's were not documented as having the training. CNA #12 was hired on 10/27/18. CNA #13 was hired on 10/27/18. CNA #14 was hired on 8/26/18. These three CNAs did not have documented evidence that they had completed the training on emergency preparedness. An interview was conducted on 2/7/19 at 4:12 p.m. with RN (registered nurse) #5, the nurse practice educator. When asked if she had any other documentation of the three CNAs during their orientation of the emergency preparedness plan, RN #5 stated she looked through the office and could not locate any documentation for the three CNAs. ASM #1, ASM #2, the nurse executive and ASM #3, the clinical quality specialist, were made aware of these findings on 2/7/19 at 3:36 p.m. No further information was provided prior to exit.	E 037		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted from 2/5/19 through 2/7/19. Complaints were 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	F 000	**Preparation and/or execution of this Plan of Correction does not constitute admission or agreement of the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The Plan of Correction is prepared and/or executed solely because it is required by the provisions of federal and state law.**	

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F 000	Continued From page 5 survey/report will follow. The census in this 118 certified bed facility was 103 at the time of the survey. The survey sample consisted of 45 current resident reviews and 10 closed record reviews.	F 000	F550 1. Resident's #74, 13, 34, 62, 500, 36, 59, 49, 48, 55, 33, 24, 8, 40 and 61 staff were corrected at time surveyor presented concern on proper dignified dining process. Resident #8 and 24 staff addressed loud cursing at the time surveyor was present. Resident #40 and 61 staff were corrected at time surveyor presented concern, on proper dignified dining process. 2. All residents are at risk for undignified dining process. 3. 100% of staff will be in-serviced on proper dignified dining process by Center Nurse Executive, Nurse Practice Educator and, ADON. Education included serving residents at the same table and in the same room at the same time, and on ensuring that disruptive behavior during the dining experience will be addressed immediately to prevent disruption to residents dining experience.	
F 550 SS=E	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the	F 550		

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F 550	Continued From page 6 resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, clinical record review, and facility document review, it was determined that the facility staff failed to provide a dignified dining experience for fifteen of 55 residents in the survey sample; Residents #74, #13, #34, #62, #500, #36, #59, #49, #48, #55, #33, #24, #8, #40, and #61. 1. The facility staff failed to provide a dignified dining experience for Residents #74, #13, #34, #62, #500, #36, #59, #49, #48, #55, and #33. Residents were observed sitting at three tables in the small café dining room without food while another resident at the table was served their meal and eating. 2. The facility staff failed to provide a dignified dining experience for Resident #8 and Resident #24. The facility staff failed to address Resident #97's loud cursing at staff for approximately 29 minutes, during which time Resident #8 and #24 both expressed a dislike of Resident #97's cursing. 3. The facility staff failed to serve Resident #40 lunch on 2/5/19 at the same time her roommate received lunch. Resident #40 did not receive	F 550	4. Audit of dining process to be completed 5 times a week for 4 weeks then randomly thereafter, by, Center Nurse Executive, Nurse Practice Educator and ADON or designee. Variances will be corrected immediately and brought to Quality Assurance and Performance Improvement Committee monthly, with QAPI Committee responsible for on-going compliance. 5. Date of Compliance: 3/15/19	

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F 550	Continued From page 7 lunch until at least 16 minutes after her roommate was served. 4. The facility staff failed to assist Resident# 61 with eating on 2/5/19 at the same time her roommate received lunch. Resident #61 did not receive assistance with eating until at least 15 minutes after her roommate was served The findings include: 1. The facility staff failed to provide a dignified dining experience for Residents #74, #13, #34, #62, #500, #36, #59, #49, #48, #55, and #33. Residents were observed sitting at three tables in the small café dining room without food while another resident at the table was served their meal and eating. On 2/5/19 at 12:17 p.m., a dining observation in the small cafe dining room was conducted. There were three (3) tables of residents. Table 1, closest to the door, had 3 (three) residents (#62, #48, and #59). Table 2, closest to the courtyard windows, had 4 (four) residents (#74, #500, #36, and #55). Table 3, closest to the sink and counter area, had 4 (four) residents (#13, #49, #33, and #34). The following was observed on 2/5/19 during the dining observations: Table 1: - At 12:55 p.m., Resident #62 at table 1 was served. The remaining two residents (Residents #48, and #59) at this table were not served at this time. - At 12:56 p.m., Resident 59 at table 1 was	F 550		

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F 550	Continued From page 8 served. The third resident (Resident #48) at this table was still not served at this time. - At 1:02 p.m., Resident #48 at table 1 was served. This was 7 minutes after Resident #62 at the same table was served. Table 2: - At 12:46 p.m., Resident #74 at table 2 was served. The remaining three residents at this table (Residents #500, #36, and #55) were not served at this time. - At 12:55 p.m., Resident #500 at table 2 was served. This was 9 minutes after Resident #74 at the same table was served their meal. The remaining two residents (Residents#36, and #55) at this table were not served. - At 12:56 PM, Resident #36 at table 2 was served. This was 10 minutes after Resident #74 was served at the same table. - At 1:03 p.m., Resident #55 at table 2 was served. This was 17 minutes after the meal for Resident #74 at the same table, was served. Table 3: - At 12:49 p.m., Residents #13 and #34 at table 3 were served. The remaining two residents (Residents #49 and #33) at this table were not served at this time. - At 12:58 p.m., Resident #49 at table 3 was served. This was 9 minutes after Residents #13 and #34 at the same table were served. - At 1:05 p.m., Resident #33 at table 3 was served. This was 16 minutes after Residents #13 and #34 at the same table were served. On 2/7/19 at 10:40 a.m., during an interview conducted with CNA #1 (Certified Nursing Assistant). CNA#1 stated that residents are served depending on when their tray is brought to	F 550		

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F 550	Continued From page 9 the dining room from the kitchen; or when it is brought to the dining from a cart that went out to the unit for residents who are being served in their rooms. CNA #1 stated residents should not be served this way; residents at a table should all be served at the same time, but that this happens all the time. A review of the facility policy, "Dining Service Standards" documented, "Patients/Residents are provided a positive meal experience....Meals are served table by table....Restaurant style dining is encouraged in the primary dining locations...." On 2/7/19 at approximately 2:20 p.m., the Executive Director and Nurse Executive (ASM [Administrative Staff Member] #1 and #2) were made aware of the findings. No further information was provided by the end of the survey. Resident #74 was admitted to the facility on 7/27/18 with the diagnoses of but not limited to chronic obstructive pulmonary disease, high blood pressure, and dementia. The most recent MDS (Minimum Data Set) was a quarterly assessment with an ARD (Assessment Reference Date) of 1/8/19. The resident was coded as being moderately impaired in ability to make daily life decisions. The resident was coded as supervision for eating. Resident #13 was admitted to the facility on 10/31/18 with the diagnoses of but not limited to Alzheimer's disease, high blood pressure, and arthritis. The most recent MDS (Minimum Data Set) was an admission assessment with an ARD (Assessment Reference Date) of 11/7/18. The	F 550		

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F 550	Continued From page 10 resident was coded as severely cognitively impaired in ability to make daily life decisions. The resident was coded as requiring limited assistance for eating. Resident #34 was admitted to the facility on 6/29/17 with the diagnoses of but not limited to renal insufficiency, stroke, high blood pressure, and dementia. The most recent MDS (Minimum Data Set) was a quarterly assessment with an ARD (Assessment Reference Date) of 1/11/19. The resident was coded as being severely impaired in ability to make daily life decisions. The resident was coded as requiring extensive assistance for eating. Resident #62 was admitted to the facility on 1/6/16, acute kidney failure, and bladder cancer. The most recent MDS (Minimum Data Set) was a quarterly assessment with an ARD (Assessment Reference Date) of 1/1/19. The resident was coded as being significantly impaired in ability to make daily life decisions. The resident was coded as requiring total care for eating. Resident #500 was admitted to the facility on 1/17/19 with diagnoses including but not limited to: systemic inflammatory response syndrome, and dementia. The MDS had not yet been completed. The admission nursing assessment dated 1/17/19 documented the resident was alert and oriented to person, place, and time. The assessment form did not include documentation about the resident's level of assistance required to attend to any areas of activities of daily living. Resident #36 was admitted to the facility on 11/26/16 with diagnoses including but not limited to: urinary retention, and encephalopathy. The	F 550		

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F 550	Continued From page 11 most recent MDS (Minimum Data Set) was an annual assessment with an ARD (Assessment Reference Date) of 11/21/18. The resident was coded as being severely impaired in ability to make daily life decisions. The resident was coded as requiring extensive assistance for transfers and eating. Resident #59 was admitted to the facility on 11/24/10 with diagnoses including but not limited to: cerebral palsy, asthma, and mood disorder. The most recent MDS (Minimum Data Set) was a quarterly assessment with an ARD (Assessment Reference Date) of 12/29/18. The resident was coded as being severely impaired in ability to make daily life decisions. The resident was coded as requiring supervision for eating. Resident #49 was admitted to the facility on 9/4/15 with diagnoses including but not limited to: pelvic fracture, wrist fracture, distal radius fracture, frontal scalp hematoma, head injury, and dementia MDS was a quarterly assessment with an ARD (Assessment Reference Date) of 12/12/18. The resident was coded as being severely cognitively impaired in ability to make daily life decisions. The resident required total care for all areas of activities of daily living, including eating. Resident #48 was admitted to the facility on 11/13/18 with diagnoses including but not limited to: with diagnoses that included but are not limited to diabetes, high blood pressure, and stroke. The most recent MDS (Minimum Data Set) was a quarterly assessment with an ARD (Assessment Reference Date) of 12/12/18. The resident was coded as being moderately impaired in ability to make daily life decisions. The	F 550		

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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 550	Continued From page 12 resident was coded as independent for eating. Resident #55 was admitted to the facility on 10/13/14, with diagnoses including but not limited to: renal mass, macular degeneration, frequent falls, and dementia. The most recent MDS (Minimum Data Set) was a quarterly assessment with an ARD (Assessment Reference Date) of 12/19/18. The resident was coded as being severely impaired in ability to make daily life decisions. The resident was coded as requiring limited assistance for eating. Resident #33 was admitted to the facility on 5/5/16 with diagnoses that included but are not limited to hip fracture, Alzheimer's disease, and dysphagia. The most recent MDS (Minimum Data Set) was a quarterly assessment with an ARD (Assessment Reference Date) of 11/10/18. The resident was coded as being severely impaired in ability to make daily life decisions. The resident was coded as requiring extensive assistance for transfers, eating and hygiene. 2. The facility staff failed to provide a dignified dining experience for Resident #8 and Resident #24. The facility staff failed to address Resident #97's loud cursing at staff for approximately 29 minutes, during which time Resident #8 and #24 both expressed a dislike of Resident #97's cursing. Resident #8 was admitted to the facility on 1/15/18 and readmitted on 7/23/18 with diagnoses that included but were not limited to: diabetes, history of falls, anxiety, depression and dementia (1). The most recent MDS (minimum data set), a quarterly assessment, with an ARD (assessment reference date) of 10/23/18 coded the resident as having a 14 out of 15 on the BIMS	F 550		

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F 550	Continued From page 13 (brief interview for mental status), indicating the resident was cognitively intact to make daily decisions. The resident was coded as requiring supervision while eating. The resident was also coded as being on a diabetic therapeutic diet. Resident #24 was admitted to the facility on 11/13/15 and readmitted 1/17/19 with diagnoses that included but were not limited to: diabetes, atrial fibrillation (5) heart failure (6), and cerebral infarction (4). The most recent MDS (minimum data set), an annual day assessment, with an ARD (assessment reference date) of 3/28/18 coded the resident as having a 13 out of 15 on the BIMS (brief interview for mental status), indicating the resident was cognitively intact to make daily decisions. The resident was coded as requiring supervision with eating. The resident was also coded as requiring a diabetic therapeutic diet. Resident #97 was admitted to the facility on 12/23/18 with diagnoses that included but were not limited to: diabetes, high blood pressure, hemiplegia (2) and hemiparesis (3) following cerebral infarction (4). The most recent MDS (minimum data set), a Medicare thirty day assessment, with an ARD (assessment reference date) of 1/18/19 coded the resident as having a 15 out of 15 on the BIMS (brief interview for mental status), indicating the resident was cognitively intact to make daily decisions. The resident was coded as requiring limited assistance with eating. On 02/05/19 at approximately 12:20 p.m., an observation was conducted in the main dining room, where lunch was being served. Resident	F 550		

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F 550	Continued From page 14 #97 was observed cursing loudly and continuously at staff. He was also observed complaining to other residents in the dining hall about the food and service in the lunchroom. On 02/05/19 at approximately 12:22 p.m., Resident #8 was heard and observed telling Resident #97, "Can you please stop using that language." Resident #8 then turned to this surveyor and said, "He always does this, and they (the facility staff) need to do something." On 02/05/19 at approximately 12:32 p.m., Resident #24 was heard and observed telling Resident #97, "Watch your language please." However, Resident #97 continued cursing loudly. On 02/05/19 at approximately 12:49 p.m., (29 minutes after the initial observation of Resident #97 cursing in the dining room), Resident #97 was told by CNA (certified nursing assistant) #1, "Mr. (name of Resident #97) you can't use that type of language in the dining room." On 02/05/19 at approximately 12:45 p.m., an interview was conducted with Resident #24. When asked about a dignified dining experience, Resident #24 stated, "No, the language that some people use in here should not be allowed." On 02/06/19 at approximately 1:47 p.m., an interview was conducted with CNA #1. CNA #1 was asked if Resident #97 had a habit of cursing in the dining room, CNA #1 replied, "Yes, he is known for cursing we have told him in the past to stop but sometimes he does not listen." CNA #1 was asked if the dining room experience for the other residents in the dining room was dignified, with Resident #97 cursing. CNA #1 stated, "I don't	F 550		

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F 550	Continued From page 15 think so." On 02/05/19 at approximately 3:53 p.m., an interview was conducted with Resident #8. Resident #8 was asked if she is treated with dignity and respect by the facility. Resident #8 replied, "The dining room has been a problem. There is a person that curses in there constantly. I have told the staff to do something about it, but nothing gets done. I'm not use to that type of language." Review of Resident #97's comprehensive care plan initiated on 12/24/18 and revised on 1/8/19 failed to document the residents' behavior of cursing in the dining room. Review of the facility's document titled, "Residents Rights Under Federal Law" dated 11/28/16 documented, "The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility." On 02/07/19 at approximately 5:45 p.m., ASM (administrative staff member) #1, the Executive Director and ASM #2, the Nurse Executive, and ASM #3, Clinical Quality Specialist, were made aware of the findings. No further information was provided prior to exit. 1. A loss of brain function that occurs with certain diseases. It affects memory, thinking, language, judgment, and behavior. This information was obtained from the website: https://medlineplus.gov/ency/article/000739.htm. 2. Also called: Hemiplegia, Palsy, Paraplegia, and	F 550		

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F 550	Continued From page 16 Quadriplegia. Paralysis is the loss of muscle function in part of your body. It happens when something goes wrong with the way messages pass between your brain and muscles. Paralysis can be complete or partial. It can occur on one or both sides of your body. It can also occur in just one area, or it can be widespread. This information was obtained from the website: https://medlineplus.gov/paralysis.html. 3. Paralysis is the loss of muscle function in part of your body. This information was obtained from the website: https://medlineplus.gov/paralysis.html. 4. A stroke. When blood flow to a part of the brain stops. A stroke is sometimes called a "brain attack." If blood flow is cut off for longer than a few seconds, the brain cannot get nutrients and oxygen. Brain cells can die, causing lasting damage. This information was obtained from the website: https://medlineplus.gov/ency/article/000726.htm. 5. An arrhythmia is a problem with the speed or rhythm of the heartbeat. Atrial fibrillation (AF) is the most common type of arrhythmia. The cause is a disorder in the heart's electrical system. This information was obtained from the website:https://vsearch.nlm.nih.gov/vivisimo/cgi-bin/query-meta?v%3Aproject=medlineplus&v%3Asources=medlineplus-bundle&query=atrial+fibrillation 3. The facility staff failed to serve Resident #40 lunch on 2/5/19 at the same time her roommate received lunch. Resident #40 did not receive lunch until at least 16 minutes after her roommate was served.	F 550		

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F 550	Continued From page 17 Resident #40 was admitted to the facility on 4/21/14. Resident #40's diagnoses included but were not limited to diabetes, major depressive disorder and retention of urine. Resident #40's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 12/4/18, coded the resident as being cognitively intact. Section G coded Resident #40 as requiring supervision/set up help only with eating. Resident #40's comprehensive care plan dated 12/11/17 failed to document information regarding a dignified dining experience. On 2/5/19 at 12:58 p.m., Resident #40 was observed sitting up in bed with no lunch tray. The resident's roommate was observed sitting up in the room and eating lunch. On 2/5/19 at 1:08 p.m., LPN (licensed practical nurse) #1 was observed entering and exiting the room. On 2/5/19 at 1:11 p.m., this surveyor attempted to interview Resident #40 regarding lunch but the resident refused to talk. On 2/5/19 at 1:14 p.m., RN (registered nurse) #1 entered the room and served Resident #40 a meal tray. An interview was conducted with RN #1 and RN #2 in the hall, immediately after RN #1 served Resident #40's meal tray. RN #1 confirmed Resident #40's meal tray was not on the food cart used to serve meal trays in resident rooms. RN #1 stated she went to the dining room to obtain the resident's meal tray. RN #2 stated Resident #40 usually eats in the dining room. On 2/6/19 at 3:02 p.m., an interview was conducted with CNA (certified nursing assistant) #2. CNA #2 was asked if both residents in a room are supposed to be served their meal trays at the same time. CNA #2 stated, "They should be served at the same time." CNA #2 stated	F 550		

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F 550	Continued From page 18 serving residents who reside in the same room at the same time has been an issue because of the way the meal trays are organized in the food carts. CNA #2 stated the meal trays are not organized in the food carts in order of the rooms. CNA #2 stated a resident's meal tray might be in one place in the food cart while the roommate's tray may be placed somewhere else in the food cart. CNA #2 was asked how she would feel if she had not been served her meal while her roommate was eating. CNA #2 stated she would be hurt and embarrassed. On 2/6/19 at 5:39 p.m., ASM (administrative staff member) #1 (the executive director), ASM #2 (the nurse executive) and ASM #3 (the clinical quality specialist) were made aware of the above concern. The facility policy titled, "Treatment: Considerate and Respectful" documented, "(Name of company) Centers will promote care for patients in a manner and in an environment that maintains or enhances each patient's dignity and respect in full recognition of his or her individuality." No further information was presented prior to exit. 4. The facility staff failed to assist Resident# 61 with eating on 2/5/19 at the same time her roommate received lunch. Resident #61 did not receive assistance with eating until at least 15 minutes after her roommate was served. Resident #61 was admitted to the facility on 12/18/18. Resident #61's diagnoses included but were not limited to dementia, repeated falls and high cholesterol. Resident #61's most recent MDS (minimum data set), a 14 day Medicare	F 550		

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F 550	Continued From page 19 assessment with an ARD (assessment reference date) of 1/29/19, coded the resident's cognition as severely impaired. Section G coded Resident #61 as requiring extensive assistance of one staff with eating. Resident #61's care plan dated 12/29/18 failed to document information regarding a dignified dining experience. On 2/5/19 at 1:25 p.m., Resident #61 was observed sitting in a wheelchair beside her bed. The resident's meal tray was on a table positioned over the bed. Resident #61's roommate was sitting up and eating lunch. On 2/5/19 at 1:28 p.m., a male and a female visitor entered Resident #61's room and were observed talking to the resident. On 2/5/19 at 1:31 p.m., OSM (other staff member) #8 (a speech therapist) entered Resident #61's room, spoke to the resident's roommate and exited the room. On 2/5/19 at 1:40 p.m., an interview was conducted with CNA (certified nursing assistant) #3 in the hall outside of Resident #61's room. CNA #3 confirmed Resident #61 required assistance with eating. When asked if the resident had eaten lunch, CNA #3 stated, "We feed her if her family isn't here. We just finished serving trays." CNA #3 looked into Resident #61's room and stated family was present in the room. At this time, CNA #3 entered Resident #61's room. The resident's meal tray remained on the table over the bed. CNA #3 asked the resident's visitors if they were feeding her (Resident #61). The female visitor stated, "No." This surveyor asked the female visitor if she or the male visitor was family; she stated they were Resident #61's friends. This surveyor asked the female visitor if she or the male visitor ever assists Resident #61 with eating; the female visitor stated they never had. CNA #3 stated she was obtaining meal trays for a	F 550		

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F 550	Continued From page 20 few other residents who did not receive a tray then she would assist Resident #61 with eating (note- after this interview, Resident #61 was observed receiving assistance with eating). On 2/6/19 at 3:02 p.m., an interview was conducted with CNA (certified nursing assistant) #2. CNA #2 was asked if both residents in a room are supposed to be served their meal trays at the same time. CNA #2 stated, "They should be served at the same time." CNA #2 stated serving residents who reside in the same room at the same time has been an issue because of the way the meal trays are organized in the food carts. CNA #2 stated the meal trays are not organized in the food carts in order of the rooms. CNA #2 stated a resident's meal tray might be in one place in the food cart while the roommate's tray may be placed somewhere else in the food cart. CNA #2 was asked if a meal tray should be left beside a resident who requires assistance while the roommate is eating. CNA #2 stated, "No." CNA #2 was asked how she would feel if she had not been served her meal while her roommate was eating. CNA #2 stated she would be hurt and embarrassed. On 2/6/19 at 5:39 p.m., ASM (administrative staff member) #1 (the executive director), ASM #2 (the nurse executive) and ASM #3 (the clinical quality specialist) were made aware of the above concern. No further information was presented prior to exit.	F 550		
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive	F 558		

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F 558	Continued From page 21 services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, resident interview and clinical record review, it was determined that the facility staff failed to provide accommodation of resident needs for one of 55 residents in the survey sample, Resident # 7. The facility staff failed to ensure Resident #7's call bell (a device with a button that can be pushed to alert staff when assistance is needed), was within the resident's reach. The findings include: Resident # 7 was admitted to the facility on 10/12/17 with diagnoses that included but were not limited to lack of coordination, rheumatoid arthritis (1), Alzheimer's disease (2), gastroesophageal reflux disease (3) and hypertension (4). Resident # 7's most recent MDS (minimum data set), an annual assessment with an ARD (assessment reference date) of 10/20/18, coded Resident # 7 as scoring an eight on the brief interview for mental status (BIMS) of a score of 0 - 15, eight - being moderately impaired of cognition for making daily decisions. Resident # 7 was coded as requiring extensive assistance of one staff member for activities of daily living. Section G0400 "Functional Limitation in Range of Motion" coded Resident # 7 as being impaired on both sides of her upper extremities (shoulder,	F 558	F558 1. Resident #7's call bell, pancake paddle was corrected with the surveyor present. 2. All residents are at risk for call bell being placed inappropriately. 100% audit was completed by management staff to ensure that all residents have call bells in place to meet their individual needs. 3. Nurse Practice Educator, ADON or designee to in-service 100% of licensed staff on proper call bell placement. 4. Audit of ten random residents call bell placement to be completed 5 times a week for 4 weeks by ADON or designee. Variances will be corrected immediately and brought to Quality Assurance and Performance Improvement Committee monthly, with QAPI Committee responsible for ongoing compliance. 5. Date of Compliance: 3/15/19	

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F 558	Continued From page 22 elbow, wrist, hand). On 02/05/19 at 11:08 a.m., an observation of Resident # 7 revealed she was lying in bed, awake, neat and clean, watching television. The head of the bed was slightly raised and a pillow was under the upper part of Resident # 7's back. Further observation of Resident # 7 revealed she was leaning toward her left side. Observation of the call bell revealed it was a flat pressure switch. Observation of the call bell's placement revealed it was lying on top of the mattress in the upper right corner, behind Resident # 7's head. When asked if she could locate the call bell Resident # 7 moved her head slightly to the right and left and struggled to remove her right arm from under the blanket covering her. Resident # 7 stated, "I don't know where it is." Observation of Resident # 7's movements revealed there was decreased range of motion. On 02/05/19 at 3:22 p.m., an observation of Resident # 7 revealed she was lying in bed, awake, neat and clean, watching television. The head of the bed was slightly raised and a pillow was under the upper part of Resident # 7's back. Further observation of Resident # 7 revealed she was leaning slightly to her left side. Observation of the call bell's placement revealed it was hanging off the side of the mattress in the upper right corner, behind Resident # 7's head. When asked if she could locate the call bell Resident # 7 stated, "I don't know where it is." On 02/06/19 at 8:01 a.m., an observation of Resident # 7 was lying in bed, watching television. The head of the bed was slightly raised and a pillow was under the upper part of Resident # 7's back. Further observation of	F 558		

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F 558	Continued From page 23 Resident # 7 revealed she was leaning slightly to her left side. Observation of the call bell's placement revealed it was lying on the bed, on Resident # 7's right side just below her shoulder. When asked if she could locate the call bell Resident # 7 stated, "I don't know where it is." On 02/07/19 at 8:15 a.m., an observation of Resident # 7 was lying in bed, watching television. The head of the bed was slightly raised and a pillow was under the upper part of Resident # 7's back. Further observation of Resident # 7 revealed she was leaning slightly to her left side. Observation of the call bell's placement revealed it was lying on the bed, on Resident # 7's right side just below her shoulder. When asked if she could locate the call bell Resident # 7 stated, "No." The comprehensive care plan for Resident # 7 dated 10/25/2017, with a revision date of 12/12/2018 documented, "Focus. Resident is at risk for falls related to cognitive impairment, lack of safety awareness and impaired mobility. Date initiated 10/25/2017. Revision date: 12/12/2018." Under "Interventions", it documented Place call light within reach while in bed or close proximity to the bed. Date initiated: 10/25/2017." On 02/07/19 at 8:15 a.m., an observation of Resident # 7's call bell placement was conducted with CNA (certified nursing assistant) # 2. When asked if the call bell was placed in, a position that Resident # 7 could reach and activate, CNA #2 sated, "It's not in reach, she has limited range of motion." When asked to describe the procedure for the placement of a cell bell for a resident, CNA # 2 stated, "They should be placed in reach. It should have been placed on her gown where she	F 558		

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F 558	Continued From page 24 can reach it." When asked why it was important for a resident to have access to their call bell, CNA # 2 stated, "In case they have an accident, if they are in pain to get a hold of the staff for assistance, to have their needs met." When asked how often the placement of the call bell should be checked, CNA # 2 stated, (At least every two hour during rounds and when you go into the room." On 02/07/19 at 8:30 a.m., an observation of Resident # 7's call bell placement was conducted with RN (registered nurse) # 8, unit manager. When asked if the call bell was placed in a position that Resident # 7 could reach and activate, RN # 8 sated, "No" and immediately repositioned the call bell within reach of Resident # 7's right hand. When asked to describe the procedure for the placement of a cell bell for a resident, RN # 8 stated, "Should be in reach within the resident's ability." When asked why it was important for a resident to have access to their call bell, RN # 8 stated, "For dignity, to be able to get a hold of staff for assistance and help." When asked how often the placement of the call bell should be checked, RN # 8 stated, "Every time we (staff) go into the resident's room." On 02/07/19 at approximately 3:45 p.m., ASM (administrative staff member) #1, the executive director, and ASM #2, executive nurse, were made aware of the above findings. No further information was provided prior to exit. References: (1) A long-term disease. It leads to inflammation of the joints and surrounding tissues. It can also	F 558		

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F 558	Continued From page 25 affect other organs. This information was obtained from the website: https://medlineplus.gov/ency/article/000431.htm. (2) A swallowing disorder. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/swallowingdisorders.html. (3) Fear. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/anxiety.html#summary. (4) High blood pressure. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/highbloodpressure.html.	F 558		
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse	F 578	F578 1. Resident #26 code status was corrected immediately upon surveyor bringing it to staff's attention on 2/6/2019, by ADON. 2. All residents in the facility are at risk for failure to have clarification on MD order in regards to code status. 100 % audit of all current residents was completed by Center Nurse Executive, ADON and or	

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F 578	Continued From page 26 medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State Law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, it was determined that the facility staff failed to clarify a physician's order for code status for one of 55 residents in the survey sample, Resident #26. The facility staff failed to ensure Resident #26's current active physician's order form signed by the physician on 2/5/19 contained the resident's code status (whether or not to perform cardiopulmonary resuscitation in the event of cardiac arrest). The findings include:	F 578	designee to ensure that Code Status was correctly identified on Physician's orders. 3. Nurse Practice Educator, ADON or designee to in-service 100% of licensed nursing staff on proper procedure in regards to MD order for code status. 4. Social Service Director and/or Director of Nursing will audit all new admissions for appropriate documentation of Code Status 5 X week for four weeks then weekly thereafter. Social Services to address code status in Quarterly Care Plan Meetings and ensure appropriate orders in place. 5. Date of Compliance: 3/15/19	

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F 578	Continued From page 27 Resident #26 was admitted to the facility on 10/30/18. Resident #26's diagnoses included but were not limited to fractured vertebra, acute kidney failure and urinary tract infection. Resident #26's most recent MDS (minimum data set), a 30 day Medicare assessment with an ARD (assessment reference date) of 11/25/18, coded the resident's cognition as severely impaired. Review of Resident #26's clinical record revealed a Virginia Department of Health Durable Do Not Resuscitate Order form dated 2/5/18. Resident #26's comprehensive care plan dated 10/31/18 documented, "Resident has established advanced directive and/or DNR (do not resuscitate) order in place...DO NOT RESUSCITATE (DNR)..." Review of Resident #26's current active physician's order form (a listing of all active physician's orders), signed by the physician on 2/5/19 failed to reveal documentation of the resident's code status. On 2/6/19 at 4:05 p.m., an interview was conducted with LPN (licensed practical nurse) #3. LPN #3 was asked where nurses reference a resident's code status. LPN #3 stated, "Sometimes in the computer or in the chart under the admissions records or the advance directives." When asked if a resident should have a physician's order for his or her code status, LPN #3 stated, "Well yeah." Resident #26's current active physician's order form signed by the physician on 2/5/19 was reviewed with LPN #3. LPN #3 stated the form should reflect the resident's current active physician's orders. When asked to confirm that the form did not contain a current active order reflecting Resident #26's code status, LPN #3 stated, "According to this no."	F 578		

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F 578	Continued From page 28 On 2/6/19 at 5:39 p.m., ASM (administrative staff member) #1 (the executive director), ASM #2 (the nurse executive) and ASM #3 (the clinical quality specialist) were made aware of the above concern. No further information was presented prior to exit.	F 578		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any,	F 580	F580 1. Resident #71 Physician notified of Advair not being administered for dates during November 2018 and January 2019. Resident #35 ADON notified physician on 2/6/19 of late administration of medication on 8/30/18 and 10/3/18. 2. All residents are at risk for Physician not being notified of medication not being administered and late administration. 100% audit of current residents Medication Administration Records for the last 30 days were audited by Center Nurse Executive, ADON and or Designee, to ensure that any missed or late medication administration was notified to the physician.	

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F 580	Continued From page 29 when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview, facility document review and clinical record review, it was determined that the facility staff failed to notify and consult with the physician regarding a possible need to alter treatment for two of 55 residents in the survey sample, Resident #71, and #35. 1. The facility staff failed to notify Resident #71's physician when the resident's medication Advair was not administered on multiple dates in November 2018 and January 2019. 2. The facility staff failed to evidence the physician was notified, consulted regarding, the need to administer prescribed medications to Resident #35 late, when the resident returned to	F 580	3. Nurse Practice Educator or, ADON or designee to in-service 100% of licensed nursing staff on proper physician notification when medications are not administered or administered late. 4. Audit of 10 random MARS/Tars to be complete by ADON or designee 5 X week for 4 weeks, and randomly thereafter, to review for omitted medications or medications delivered late to ensure that Physician was notified appropriately. Variances will be corrected immediately and brought to Quality Assurance and Performance Improvement Committee monthly, with QAPI Committee responsible for ongoing compliance. 5. Date of Compliance: 3/15/19	

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F 580	Continued From page 30 the facility late, over an hour past the scheduled time for the 8:00 p.m., administration of two medications on 8/30/18 and 10/3/18. The findings include: 1. Resident #71 was admitted to the facility on 10/1/18. Resident #71's diagnoses included but were not limited to chronic obstructive pulmonary disease (2), low back pain and anxiety disorder. Resident #71's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 1/8/19, coded the resident as being cognitively intact. Review of Resident #71's clinical record revealed a physician's order dated 10/17/18, for, Advair 500 mcg (micrograms)/50 mcg and to inhale one puff every 12 hours. Review of Resident #71's November 2018 and January 2019 MARs (medication administration records) failed to reveal Advair was administered to the resident (as evidenced by blank spaces with no documented nurses' initials) on the following dates and times: - 11/1/18 at 9:00 p.m., - 11/3/18 at 9:00 a.m., - 11/30/18 at 9:00 p.m., - 1/9/19 at 9:00 p.m., - 1/23/19 at 9:00 p.m. Nurses' notes for those dates failed to reveal the medication was administered. Further review of Resident #71's January 2019 MAR revealed Advair was not administered to the resident on the following dates and times: -1/6/19 at 9:00 a.m. and 9:00 p.m., -1/18/19 at 9:00 a.m. and 9:00 p.m.,	F 580		

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F 580	Continued From page 31 -1/19/19 at 9:00 a.m. and - 1/29/19 at 9:00 a.m. On these dates above, the nurses circled their initials and documented the medication was not available on the back of the MAR. Resident #71's comprehensive care plan dated 10/2/18 documented, "Resident exhibits or is at risk for respiratory complications related to Asthma, COPD...Medicate as ordered and monitor for effectiveness and observe for signs/symptoms of side effects. Report to physician as indicated." On 2/5/19 at 12:20 p.m., an interview was conducted with Resident #71. The resident stated he was not getting his Advair as he was supposed to "for a while" but that had "straightened itself out." On 2/6/19 at 4:05 p.m., an interview was conducted with LPN (licensed practical nurse) #3. LPN #3 was asked how nurses evidence the medications and treatments they administer. LPN #3 stated, "They sign off on the MAR (medication administration record) and TAR." When asked what is meant if there are blank, spaces on the MAR or TAR and the nurses did not sign off, LPN #3 stated, "In reality it means that they didn't do it." LPN #3 was asked what is meant if nurses sign and circle their initials on the MAR. LPN #3 stated, "Usually if signed and circled, either they held it, or couldn't give it, they are supposed to explain on the back of the MAR." LPN #3 was asked if Advair is contained in the facility STAT (immediate) box (a box containing various medications that can be accessed for any resident if needed). LPN #3 stated Advair is contained in the facility omnicell (a machine	F 580		

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F 580	Continued From page 32 provided by that pharmacy, containing many various medications that can be accessed for each resident). LPN #3 was asked about the facility process for ensuring Advair is available for administration, if not in the medication cart. LPN #3 stated, "They can check the omnicell. If it's the right dose, the omnicell will let you pull it. If not, let the physician know it's not here, let the patient know, call the pharmacy and ask to send (the medication) from backup (a backup pharmacy) and let the rp (responsible party) know that you didn't give it." When asked why the physician should be notified, LPN #3 stated, "Cause it's a med (medication) they ordered and they need to know if they got it or not. Complications could happen so they need to be aware." On 2/6/19 at 5:39 p.m., ASM (administrative staff member) #1 (the executive director), ASM #2 (the nurse executive) and ASM #3 (the clinical quality specialist) were made aware of the above concern. The facility policy titled, "Medication Administration: General" documented, "A licensed nurse, Med Tech, or medication aide, per state regulations, will administer medications to patients...If discrepancies, including medication not available, notify physician/advanced practice provider (APP) and/or pharmacy as indicated..." No further information was obtained prior to exit. (1) Advair is used to treat difficulty breathing, wheezing, shortness of breath, coughing, and chest tightness caused by asthma. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a699063.h	F 580		

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F 580	Continued From page 33 tml (2) "COPD (chronic obstructive pulmonary disease) makes it hard for you to breathe. The two main types are chronic bronchitis and emphysema. The main cause of COPD is long-term exposure to substances that irritate and damage the lungs. This is usually cigarette smoke. Air pollution, chemical fumes, or dust can also cause it." This information was obtained from the website: https://vsearch.nlm.nih.gov/vivisimo/cgi-bin/query-meta?v%3Aproject=medlineplus&v%3Asources=medlineplus-bundle&query=copd&_ga=2.95971676.178186840.1550160688-1667741437.1550160688 2. The facility staff failed to evidence the physician was notified, consulted regarding, the need to administer prescribed medications to Resident #35 late, when the resident returned to the facility late, over an hour past the scheduled time for the 8:00 p.m., administration of two medications on 8/30/18 and 10/3/18. Resident #35 was admitted to the facility on 5/22/18 with the diagnoses of but not limited to hip fracture, atrial fibrillation, high blood pressure, falls, inguinal hernia, and cardiomyopathy. The most recent MDS (Minimum Data Set) was a quarterly assessment with an ARD (Assessment Reference Date) of 11/23/18. The resident was coded as being cognitively intact in ability to make daily life decisions. The resident was coded as being independent for transfers, locomotion, dressing, eating, and toileting and as requiring supervision for hygiene. A review of the clinical record revealed a physician's order dated 8/22/18 that documented	F 580		

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F 580	Continued From page 34 the resident may go on LOA [leave of absence] for 4 hours daily. A review of the nurse's notes revealed the following: A nurse's note dated 8/30/18 documented, "Resident signed out at 1:30pm, today and stated that he was going to (name of bank) and not going to church tonight. Cousin and friend were contacted at 10pm today because resident was not back at facility. Unit manager on call was contacted. Resident made contact with facility soon after and was reported to unit manager on call. Unit manager will pick up resident from Firestone off of (location)...." A nurse's note dated 8/31/18 documented, "Late entry: This RN was contacted by nursing staff of residents (Sic.) failure to return to the facility following his departure for the bank earlier in the afternoon. Nursing staff was advised to make contact with RP to see if they knew where resident was located. This RN was advised that contact was made with residents (Sic.) cousin and friend, neither of which knew of his whereabouts. DON was notified of incident. Nursing staff was advised to call the sheriffs (Sic.) office non emergency number to report the residents (Sic.) failure to return. At approximately 10:30pm, this RN was notified by staff that (resident) had called the facility and stated he was at the Firestone and was unable to get back due to not having enough money for the cab ride. This writer went to pick up resident shortly after. Resident was found in front of the Firestone (location) sitting on the ground. Resident stated he left his bank card (Sic.) back at the facility and was unable to get a ride back. Resident returned	F 580		

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F 580	Continued From page 35	F 580		

to facility. This RN stressed the importance to the resident of returning in a timely manner and the need to be able to take his evening medicine. Resident expressed understanding. Resident was asked where he usually goes when he leaves the facility so if another incident occurs we know where to look. Resident stated that he goes to the (name of bank) on (location) and is usually in the shopping center above or below the hospital. Resident returned to facility at approximately 11:30pm."

A nurse's note dated 10/3/18 documented, "Patient left facility at 2:10 p.m., for LOA was supposed to return by 6:10 p.m. Patient called facility at 7:50 p.m., to say he was at the Bus Station in (location) with no way back. Patient returned at 9:30PM He stated, "Someone from the Bus Station gave me a ride back." Patient education given on Safety and if Patient is going out alone he must have money for Cab fare both ways and he must return back on time."

A review of the clinical record revealed an order dated 5/23/18 for Cal-Gest {1}, 1 tab (tablet) twice daily for calcium supplement; and a Metoprolol {2} 50 mg (milligrams) twice daily for high blood pressure.

A review of the August 2018 MAR (Medication Administration Record) documented that the resident was to receive the above medications at 8:00 p.m. On 8/30/18, these medications were documented as administered at 8:00 p.m., when the resident was documented in nurses' notes, as not present in the building between 1:30 p.m., and 11:30 p.m. There was no evidence that the physician was notified, consulted for orders to administer the medications late.

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F 580	Continued From page 36 A review of the October 2018 MAR documented that the resident was to receive the same two medications above at 8:00 p.m. On 10/3/18, these medications were documented as administered at 8:00 p.m., when the resident was documented in nurses' notes as not being in the building between 2:10 p.m. and 9:30 p.m. There was no evidence that the physician was notified, consulted for orders to administer the medications late. On 2/7/19 at 1:24 p.m., in an interview with LPN #4, was asked about the process staff follows when a resident is out on leave long enough to miss medications. LPN #4 stated the physician should be called to verify if the medications can be given or not. On 2/7/19 at 2:20 p.m., in an interview with the Executive Director (ASM [administrative staff member] #1) and Nurse Executive, ASM #2. When asked about the resident's unsupervised outings into the community and issues he had of returning to the facility timely, ASM #1 stated that he was alert and oriented, his BIMS (Brief Interview for Mental Status exam) was a 15 (cognitively intact). She stated the physician was aware of the resident's outings and that it was his right to go out if he wanted to. When asked about the resident's missed medications when he was late returning to the facility, ASM #1 stated that the doctor should have been notified and direction provided whether or not to administer them (medications) late. A review of the facility policy, "Leave of Absence/Therapeutic Leave" did not include direction on procedures if the resident was out	F 580		

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F 580	Continued From page 37 past a medication time and missed medications. A review of the facility policy, "Leave of Absence, Resident Discharge with Medication or Other Change of Status" documented, "When a Facility physician/prescriber provides an order for the resident to take a leave of absence, the physician/prescriber should specify the medications the resident is to take with them while on leave....If the resident is taking a leave of absence for less than 24 hours, consider a change in the time for administration of a medication, if appropriate, to avoid the need to send that dose of medication with the resident...." The policy did not address what the procedure should be if the resident's leave was to be brief, but the resident missed the medications due to a late return. No further information was provided. {1} Cal-Gest Antacid - "Calcium carbonate is a dietary supplement used when the amount of calcium taken in the diet is not enough. Calcium is needed by the body for healthy bones, muscles, nervous system, and heart. Calcium carbonate also is used as an antacid to relieve heartburn, acid indigestion, and upset stomach. It is available with or without a prescription." Information obtained from https://medlineplus.gov/druginfo/meds/a601032.html {2} Metoprolol - "Metoprolol is used alone or in combination with other medications to treat high blood pressure. It also is used to prevent angina (chest pain) and to improve survival after a heart attack. Metoprolol also is used in combination with other medications to treat heart failure.	F 580		

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F 580	Continued From page 38 Metoprolol is in a class of medications called beta blockers. It works by relaxing blood vessels and slowing heart rate to improve blood flow and decrease blood pressure." Information obtained from https://medlineplus.gov/druginfo/meds/a682864.html	F 580		
F 583 SS=D	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws.	F 583	F583 1. Resident #50 mail was opened before arriving to him. Resident # 50 is currently opening packages in front of staff due to risk of what he is receiving in the mail, this has been added to his care plan to have packages opened in the presence of staff for his safety. 2. All residents receiving mail are at risk. Social Services/ Activities Director will interview	

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F 583	Continued From page 39 (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview, facility policy review and clinical record review, it was determined the facility staff failed to ensure resident mail was received unopened for one of 55 residents in the survey sample, Resident #50. The facility staff failed to ensure Resident #50 received unopened mail. The findings include: Resident #50 was admitted to the facility on 8/20/17. Diagnosis included but were not limited to: high blood pressure, depression, chronic obstructive pulmonary disease (1) and obstructive sleep apnea (2). The most recent MDS (minimum data set), an annual assessment, with an assessment reference date of 7/24/18, coded the resident as having a score of 15 of 15 on the BIMS (brief interview for mental status) indicating the resident was cognitively intact to make daily decisions. On 02/05/19 at approximately 11:09 a.m., an interview was conducted with Resident #50. Resident #50 was asked if he felt the facility offered him privacy. Resident #50 replied, "For the most part. A couple of months ago I was supposed to get a package in the mail, but when it got to me, someone had opened it. I was pretty-mad about that, and I let the administration know	F 583	100% of current residents who are alert and oriented to ensure that they are receiving their mail unopened by 3/8/19. 3. Business office and Recreation Staff were inserviced on Delivering mail and packages to patients unopened on 1/10/19. 4. Activities to audit 10 random residents receiving mail weekly to ensure mail is unopened when delivered. Variances will be corrected immediately and brought to Quality Assurance and Performance Improvement Committee monthly, with QAPI Committee responsible for ongoing compliance. 5. Date of compliance: 3/15/19	

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F 583	Continued From page 40 about it (Sic). I had ordered some batons from Amazon. They (the facility administration) thought it was a weapon. I have a 'bum' shoulder, and I was going to use them to stretch my arms. After I complained about this, they said they would ask me before they opened my packages." The social worker note dated 8/21/18 at 3:07 p.m., documented "(name of Resident #50) has a rotator cuff pain and goals will focus on improving his flexibility and pain level. (Name of Resident #50) continues to order equipment from Amazon that might not be appropriate for our facility (i.e. gym equipment, karate gear, etc.). He is aware that anything he wants to order should be reviewed first so that he does not bring anything inappropriate to the facility." On 02/07/19 at approximately 8:43 a.m., an interview was conducted with OSM (other staff member) #2, Activities director. OSM #2 was asked how residents are supposed to receive their mail, OSM #2 replied, "We usually receive mail every day, and try to give it to the residents. We have a mail day on Saturday." OSM #2 was asked if residents were supposed to get their mail unopened, OSM #2 replied "Yes." OSM #2 was asked if any resident had complained about receiving opened mail, OSM #2 replied "Yes, (name of the Resident #50), I don't know who opened it. I remember asking around about it but no one said they opened it. But I, the activities assistant and the receptionist all were educated that a resident's mail was supposed to be unopened." On 02/07/19 at approximately 8:52 a.m., an interview was conducted with ASM (administrative staff member) #1, the Executive Director. ASM #1	F 583		

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F 583	Continued From page 41 was asked if any residents had complained of getting opened mail. ASM #1 replied, "Yes (name of Resident #50), told me while I made a tour, that a while back before I got here, he had received an opened package. The resident had a history of getting weapons in the mail, so the previous administrator opened his package. However when I found out about this I educated the staff on not opening a residents mail. We also told him that he can't have any weapons here. And now staff are not to open any of his package unless he consents and they open it in his presence." On 02/07/19 at approximately 11:00 a.m., the facility provided this surveyor with a document titled "Recreation Staff Education" dated 1/8/19, which documented, "Resident mail will be delivered unopened." The document was signed by OSM #12, activities assistant, OSM #13, activities, and OSM #2, activities assistant. The comprehensive care plan dated February 2019 failed to mention how Resident #50's mail should be delivered. On 02/07/19 at approximately 5:45 p.m., ASM #1, the Executive Director and ASM #2, the Nurse Executive, and ASM #3, Clinical Quality Specialist, were made aware of the findings. The facility policy titled "Privacy Rights: Patient" with a most recent revision date of 11/28/16, documented, "Personal privacy includes accommodations, medical treatment, written, telephone and electronic communication." No further information was obtained prior to exit.	F 583		

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F 583	Continued From page 42 1. Disease that makes it difficult to breath that can lead to shortness of breath). The two main types are chronic bronchitis and emphysema. The main cause of COPD is long-term exposure to substances that irritate and damage the lungs. This is usually cigarette smoke. Air pollution, chemical fumes, or dust can also cause it. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/copd.html. 2. Obstructive sleep apnea (OSA) is a problem in which your breathing pauses during sleep. This occurs because of narrowed or blocked airways. This information was obtained from the website: https://medlineplus.gov/ency/article/000811.htm.	F 583		
F 607 SS=D	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(3) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, it was determined that the facility staff failed to implement the facility abuse policy for three of 55 residents in the survey sample, Residents #3, #261 and #262.	F 607	F607 1. Resident #3, 261 and 262 facility failed to implement facility abuse policy. 2. All residents in the facility are at risk. 3. NPE and or designee in-serviced 100% of staff on Abuse Policy with attention to required 2 hour time frame. 4. Further abuse allegations will be reviewed by the Administrator, CNE or designee immediately. Variances will be corrected immediately and reviewed at QAPI monthly. 5. Date of Compliance: 3/15/19	

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F 607	Continued From page 43 1. The facility staff failed to implement the facility abuse policy for reporting Resident #3's allegation of abuse to the state agency within the required two-hour timeframe. 2. The facility staff failed to implement the facility abuse policy for reporting Resident #261's and Resident #262's allegations of abuse to the SA (state agency) within the required two-hour timeframe. On 9/23/18, Resident #261 reported an allegation of abuse to RN (registered nurse) #11. The allegation was not reported to the SA until 9/24/18. On 9/22/18, Resident #262 reported an allegation of abuse to CNA (certified nursing assistant) #9. The allegation was not reported to the SA until 9/24/18. Both allegations were submitted to the SA in one FRI (facility reported incident) on 9/24/18. The findings include: 1. The facility staff failed to implement the facility abuse policy for reporting Resident #3's allegation of abuse to the state agency within the required two hour timeframe. Resident #3 was admitted to the facility on 9/2/16. Resident #3's diagnoses included but were not limited to diabetes, major depressive disorder and end stage kidney disease. Resident #3's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 10/5/18, coded the resident's cognition as severely impaired. The facility policy titled, "Abuse Prohibition" documented, "6. Upon receiving information concerning a report of suspected or alleged abuse, mistreatment, or neglect, the CED (center	F 607		

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executive director) or designee will perform the following: 6.1 Enter allegation into the Risk Management System (RMS). 6.2 Report allegations involving abuse (physical, verbal, sexual, mental) not later than two hours after the allegation is made..."

A FRI (facility reported incident) submitted to the state agency (Office of Licensure and Certification) on 1/18/19 documented, "Incident Date: 1/17/2019. Report date: 1/18/2019. Residents involved: (name of Resident #3). Injuries: (an X beside No). Incident type: (an X beside Allegation of abuse/mistreat)." No further information regarding the incident was documented on the FRI. The final report dated 1/23/19 documented, "On 1/17/19 (name of Resident #3) reported that 'a CNA (certified nursing assistant) with red hair was rough when putting me back to bed, they picked me up around my breast and threw me into bed' this statement was made to the resident's son (name) when he came to visit...(Name of Resident #3's son) later than evening arrived to the facility to visit with (name of Resident #3) at this time the resident reported rough care to her son. The charge nurse returned to the resident's room with (name of son) to interview the resident. (Name of Resident #3) stated the CNA threw her into bed. An investigation was initiated and it was found to be a lack of education with transfers..." A witness statement dated 1/17/19 and signed by the nurse caring for Resident #3 during the evening shift of 1/17/19 documented, "Around 6:45 p.m. resident son arrived to the building to visit his mom. He reported to this nurse that (name of Resident #3) told him a CNA with red hair grabbed her and threw her in bed. When asked the resident what happened in front of the son resident stated that:

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F 607	Continued From page 45 a CNA grab (sic) me and throw (sic) me in bed. Supervisor 3-11 shift made aware and told me to call the DON (director of nursing). DON unable to reach. Call placed to the unit manager and informed about incident and she stated she will call the DON to follow up on this matter. A note was left at the unit manager office to follow up." A witness statement signed by the on-call manager on 1/17/19 documented, "As on call mgr (manager) I received call from facility (name of nurse caring for Resident #3) at 7:02 p.m. concerning resident in room (number) had fallen on the floor with no injuries at about 3:20 p.m. Also patient stated that aid with red hair had grabbed her and threw her on the bed. I placed call to (name of ASM [administrative staff member] #2 [nurse executive- also known as director of nursing]) and after talking with (ASM #2) we decided to interview patient in morning concerning her transfer from wheelchair to bed." The nurse who cared for Resident #3 during the evening shift on 1/17/19, and was made aware of the allegation by Resident #3's son was not available for interview during the survey. On 2/6/19 at 4:32 p.m., an interview was conducted with RN (registered nurse) #10. RN #10 was asked what nurses should do if an allegation of resident abuse is reported to them. RN #10 stated she would ensure the patient's safety, separate the staff member and notify her direct supervisor. RN #10 stated she would contact the director of nursing then the executive director if her direct supervisor was not available. On 2/6/19 at 5:39 p.m., ASM #1 (the executive director), ASM #2 and ASM #3 (the clinical quality specialist) were made aware of the above	F 607		

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F 607	Continued From page 46 concern. ASM #2 was asked the facility process for reporting allegations of abuse to the state agency. ASM #2 stated allegations of abuse should be reported to the state agency within two hours. ASM #2 stated training had recently been completed with staff and they have been told to report allegations of abuse to her and ASM #1. ASM #2 stated that ASM #1 was the abuse coordinator and ultimately needed to know about any allegations. (Note- not all staff had recently been provided abuse training). No further information was presented prior to exit. 2. The facility staff failed to implement the facility abuse policy for reporting Resident #261's and Resident #262's allegations of abuse to the SA (state agency) within the required two-hour timeframe. On 9/23/18, Resident #261 reported an allegation of abuse to RN (registered nurse) #11. The allegation was not reported to the SA until 9/24/18. On 9/22/18, Resident #262 reported an allegation of abuse to CNA (certified nursing assistant) #9. The allegation was not reported to the SA until 9/24/18. Both allegations were submitted to the SA in one FRI (facility reported incident) on 9/24/18. Resident #261 was admitted to the facility on 8/24/18. Resident #261's diagnoses included but were not limited to arthritis, high blood pressure and morbid obesity. Resident #261's most recent MDS (minimum data set) (prior to discharge) a 60 day Medicare assessment with an ARD (assessment reference date) of 10/19/18, coded the resident as being cognitively intact. Resident #262 was admitted to the facility on 12/11/11. Resident #262's diagnoses included	F 607		

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F 607	Continued From page 47 but were not limited to paralysis, major depressive disorder and diabetes. Resident #262's most recent MDS (minimum data set) (prior to discharge), a 14 day Medicare assessment with an ARD (assessment reference date) of 12/18/18, coded the resident's cognition as moderately impaired. The facility policy titled, "Abuse Prohibition" documented, "6. Upon receiving information concerning a report of suspected or alleged abuse, mistreatment, or neglect, the CED (center executive director) or designee will perform the following: 6.1 Enter allegation into the Risk Management System (RMS). 6.2 Report allegations involving abuse (physical, verbal, sexual, mental) not later than two hours after the allegation is made..." A FRI (facility reported incident) submitted to the state agency (Office of Licensure and Certification) on 9/24/18 documented, "Report date: September 24, 2018. Incident date: 9/20/18 and 9/22/18. Residents involved: (name of Resident #261 [9/20/18] and name of Resident #262 [9/23/18]). Injuries: None. Incident type: (a check mark beside Allegation of abuse/mistreat). Describe incident, including location and action taken: (name of Resident #261) reported that she asked the aide on 11-7 shift 9/20/18 to put her on the bedpan. She stated she advised the aide she was not positioned correctly on the bedpan and was left to 'soil all over herself and the bed' due to the bedpan not positioned correctly. She also stated that she was 'rough' while positioning her on the bedpan, pushing her hard to get her on the bedpan since patient was unable to assist. She advised the CNA that she was unable to assist with positioning and that she was uncomfortable	F 607		

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during the process. On the same date, (name of Resident #262) advised nursing supervisor that the 11-7 aide on 9/22/18 used 'force' when changing her diaper. Patient stated the aide was 'pushing and pulling me so hard and rough.' She asked the aide to stop due to the aide hurting her and the aide rolled her eyes and continued to provide care. (Name of Resident #262) went on to state the aide grabbed her right leg while getting her comfortable in bed which caused her pain due to that being her 'bad leg.'"

A witness statement signed by CNA #9 on 9/23/18 documented, "To Whom It may concerned (sic). On Saturday September 22, 2018 at 3:30 p.m. when I went into (Resident #262's room) she reported to me that the 11-7 cna who had given care to her was very rude and abusive to her. She throw (sic) the diapers on the other bed, calling her names and was upset because she was unable to reached (sic) the call bell and had wet on herself. So I reported the incident to the charged (sic) nurse (name of RN #11) who told me she could not deal with the situation. So I then reported it to (name of RN #10) Sunday morning on the 7-3 shift."

A witness statement signed by RN #11 on 9/23/18 documented, "To whom this may concern, (name of CNA #9) told me about an encounter related to her by a resident (name of Resident #262). (Name of CNA #9) stated that I told her I could not deal with it right now and that she should tell the supervisor. I had seen the resident several times during the shift later on but I had forgotten about the incident and did not ask the resident or anyone else about it."

A witness statement documented by RN #10 on

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9/23/18, documented, "At the start of my 7am shift on Sunday 9/23/2018, (name of CNA #9) reported to me that she was told last night (3-11 9/22/2018) by (name of Resident #262) in Room (number) that the CNA the night before (Friday night 11-7 9/21/2018) was being very rude and rough with her, the most abusive person shes (sic) ever had to deal with. (Name of CNA #9) said she reported it to me this morning because she said she tried to notify (name of RN #11) on 3-11 Saturday when the patient reported it to her, but (name of RN #11's) response back to (name of CNA #9) was 'Im (sic) too busy and don't have time to deal with that.' Upon interviewing patient, she gave a recollection of her account of events from the night of the concern. I forwarded her statement to the Unit Manager, ADON (assistant director of nursing) for her assigned unit. I was the charge nurse on 11-7, the night of patients (sic) admission. I rounded multiple times throughout the shift, for the most part, patient was sleeping peacefully so I did not wake her. There were no concerns reported to me throughout the shift I was assigned to work with her, nor did the CNA report any issues to me."

A statement verbally obtained from Resident #262 by RN #10 on 9/23/18 documented, "I came here Friday night and the CNA in the middle of the night was very rough with me. I knew she was pissed off because she came in with an attitude and slammed the closet door. She also used force when she was changing my diaper. She was pushing and pulling me so hard and rough. I asked her to stop because it was hurting me and she rolled her eyes and kept doing it until she was done. Her attitude and body language was cold and scary. Please don't make me have to deal with her again, I am scared to be around

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her. She grabbed my right leg while getting me comfortable in bed and it was so painful because it is my bad leg. She isn't a nice or gentle person. She threw a pack of my diapers across the room to the empty bed on the other side of the room. She didn't speak or talk to me much, Real grumpy and quiet. Didn't seem to acknowledge anything I said. I finally decided to report what happened to one of the girls last night because I need to help keep the other people here safe too."

A patient statement obtained from Resident #261 by RN #10 on 9/23/19 documented, "Patient reported to this nurse that a CNA she had a few nights ago was very rude and hurtful for her. She said she reported it to her nurse around 6am that same shift and asked the nurse that the CNA in question doesn't go back in the room again, and the nurse told her she would make sure that CNA doesn't go back to her room. Patient said the CNA came in with a nasty attitude and seemed like she didn't really like her job. Also stated that she seemed very angry and was throwing things, anything she picked up and needed to place somewhere or put down, she threw it and was very rough and abrupt. Patient stated she was put on a bedpan by CNA and told her it wasn't positioned right, but she left patient that way and she was forced to soil all over herself and the bed because the bedpan was not positioned correctly. Patient also stated that she was very rough with her while positioning her on the bedpan. She told CNA that the side she was laying on restricted her movement and she couldn't help the CNA with repositioning her, however she pushed patient really hard to get her in the position she wanted to, and it wasn't comfortable during the whole process. Patient asked to never have the CNA in

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F 607	Continued From page 51 her room ever again. She described the CNA as (name), an agency CNA. She described her nurse as the one she has every night almost, but couldn't remember her name." A final report sent to the SA on 9/27/18 documented, "Resident (name of Resident #261) reported that she asked the aide on 11-7 shift 9/20/18 to put her on the bedpan. She stated she advised the aide she was not positioned correctly on the bedpan and was left to 'soil all over herself and the bed' due to the bedpan not positioned correctly. She also stated that she was 'rough' while positioning her on the bedpan, pushing her hard to get her on the bedpan since patient was unable to assist. She advised the CNA that she was unable to assist with positioning and that she was uncomfortable during the process. On the same date, (name of Resident #262) advised nursing supervisor that the 11-7 aide on 9/22/18 used 'force' when changing her diaper. Patient stated the aide was 'pushing and pulling me so hard and rough.' She asked the aide to stop due to the aide hurting her and the aide rolled her eyes and continued to provide care. (Name of Resident #262) went on to state the aide grabbed her right leg while getting her comfortable in bed which caused her pain due to that being her 'bad leg.'" CONCLUSION: Unable to Substantiate allegation of abuse. Allegations to be unsubstantial due to interviewed Staff, alert and orient (sic) residents in the care of alleged perpetrator with no allegations of roughness during ADL (activities of daily living) care. Accused employee denies allegations. Per accused employee states she was not aware of residents (sic) concern and voicing she was rough. She states she forgot her hearing aids the day of the incident. CNA is contract agency and	F 607		

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F 607	Continued From page 52 is no longer working at Facility. Staff in service on the 'Abuse policy and Abuse Prohibition' with the Center Nursing Executive. Current Status of Resident: Stable." On 2/6/19 at 3:37 p.m., an interview was conducted with CNA #9. When asked what a CNA should do if a resident verbalizes an allegation of abuse, CNA #9 stated, "I am supposed to report it to the charge nurse." When asked if she does anything after she reports the allegation to the charge nurse, CNA #9 stated, "I follow up to see if she does anything about it. If not, I report to the supervisor above her." CNA #9 stated she would follow up the next day if the allegation occurred on her 3:00 p.m. to 11:00 a.m. shift. CNA #9 was asked to explain the situation regarding Resident #262's allegation of abuse. CNA #9 stated on 9/22/18 she went into Resident #262's room and the resident did not look happy. CNA #9 stated she asked Resident #262 what was wrong, and the resident explained the 11:00 p.m. to 7:00 a.m. shift CNA had thrown a diaper and said verbal things to her that was out of place. CNA #9 stated she went straight to RN #11 and told RN #11 the information reported to her by Resident #262. CNA #9 stated RN #11 told her to tell the supervisor but the supervisor was not in the building so she told RN #10 when she came to the facility. On 2/6/19 at 4:32 p.m., an interview was conducted with RN (registered nurse) #10. RN #10 was asked what nurses should do if an allegation of resident abuse is reported to them. RN #10 stated she would ensure the patient's safety, separate the staff member and notify her direct supervisor. RN #10 stated she would contact the director of nursing then the executive	F 607		

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F 607	Continued From page 53 director if her direct supervisor was not available. RN #10 was asked to explain the situation regarding Resident #262's allegation. RN #10 stated she made sure Resident #262 was okay, interviewed the resident, interviewed staff and contacted the ADON (assistant director of nursing) as soon as she was made aware of the allegation. On 2/6/19 at 5:39 p.m., ASM #1 (the executive director), ASM #2 and ASM #3 (the clinical quality specialist) were made aware of the above concern. (Note- ASM #1 and ASM #2 were not employed at the facility in September 2018). ASM #2 was asked the facility process for reporting allegations of abuse to the state agency. ASM #2 stated allegations of abuse should be reported to the state agency within two hours. ASM #2 stated training had recently been completed with staff and they have been told to report allegations of abuse to her and ASM #1. ASM #2 stated that ASM #1 was the abuse coordinator and ultimately needed to know about any allegations. (Note- not all staff had recently been provided abuse training). On 2/7/19 at 9:22 a.m., an interview was conducted with RN #11. RN #11 was asked what should be done if she is made aware of a resident's allegation of abuse. RN #11 stated, "Right away you are supposed to tell your supervisor and the supervisor must tell the manager." When asked about the period of time this should be done, RN #11 stated it must be done, timely within 24 hours but the allegation should be reported to the supervisor right away. RN #11 was asked to explain the situation regarding Resident #262's allegation. RN #11 stated a CNA came to her and stated Resident	F 607		

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F 607	Continued From page 54 #262 reported an allegation but the alleged event did not occur on her shift so she told the CNA to tell the supervisor. No further information was presented prior to exit.	F 607		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by:	F 609	F609 1. Resident #3, 261 and 262 facility failed to implement facility abuse policy. Abuse allegations were submitted upon Administration notification. 2. All residents in the facility are at risk. 100% of current residents who are alert and oriented were interviewed by management staff regarding potential abuse to ensure that all allegations have been reported and investigated accordingly. 3. Nurse Practice Educator and or designee in-serviced 100% of staff on Abuse Policy, to include requirement to report abuse immediately to senior management. Policy reviewed to ensure that staff understand that the regulation is to report all allegations to the state within two hours.	

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F 609	Continued From page 55 Based on staff interview, facility document review and clinical record review, it was determined that the facility staff failed to report allegations of abuse to the SA (state agency) within a timely manner for three of 55 residents in the survey sample, Residents #3, #261 and #262. 1. The facility staff failed to report Resident #3's allegation of abuse to the SA within the two-hour timeframe. Resident #3's allegation of abuse was reported to staff on 1/17/19 and was not reported to the SA until 1/18/19. 2. The facility staff failed to report Resident #261's and Resident #262's allegations of abuse to the SA within the two-hour timeframe. Resident #261's allegation of abuse was reported to staff on 9/23/18 and was not reported to the SA until 9/24/18. Resident #262's allegation of abuse was reported to staff on 9/22/18 and was not reported to the SA until 9/24/18. Both allegations were submitted to the SA in one FRI (facility reported incident) on 9/24/18. The findings include: 1. The facility staff failed to report Resident #3's allegation of abuse to the SA within the two-hour timeframe. Resident #3's allegation of abuse was reported to staff on 1/17/19 and was not reported to the SA until 1/18/19. Resident #3 was admitted to the facility on 9/2/16. Resident #3's diagnoses included but were not limited to diabetes, major depressive disorder and end stage kidney disease. Resident #3's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 10/5/18, coded the resident's cognition	F 609	4. Resident Council will meet weekly x 4 weeks with emphasis on appropriate treatment and resident abuse. Social Services and /or Activities Director will interview 10 residents weekly for four weeks and randomly thereafter to ensure appropriate treatment and freedom from abuse/mistreatment. Further abuse allegations will be reviewed by the Administrator, Director of Nursing, or designee immediately. Variances will be corrected immediately and reviewed at Quality Assurance and Performance Improvement 5. Date of compliance: 3/15/19	

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F 609	Continued From page 56 as severely impaired. A FRI (facility reported incident) submitted to the state agency (Office of Licensure and Certification) on 1/18/19 documented, "Incident Date: 1/17/2019. Report date: 1/18/2019. Residents involved: (name of Resident #3). Injuries: (an X beside No). Incident type: (an X beside Allegation of abuse/mistreat)." No further information regarding the incident was documented on the FRI. The final report dated 1/23/19, documented, "On 1/17/19 (name of Resident #3) reported that 'a CNA (certified nursing assistant) with red hair was rough when putting me back to bed, they picked me up around my breast and threw me into bed' this statement was made to the resident's son (name) when he came to visit...(Name of Resident #3's son) later than evening arrived to the facility to visit with (name of Resident #3) at this time the resident reported rough care to her son. The charge nurse returned to the resident's room with (name of son) to interview the resident. (Name of Resident #3) stated the CNA threw her into bed. An investigation was initiated and it was found to be a lack of education with transfers..." A witness statement dated 1/17/19 and signed by the nurse caring for Resident #3 during the evening shift of 1/17/19 documented, "Around 6:45 p.m. resident son arrived to the building to visit his mom. He reported to this nurse that (name of Resident #3) told him a CNA with red hair grabbed her and threw her in bed. When asked the resident what happened in front of the son resident stated that: a CNA grab (sic) me and throw (sic) me in bed. Supervisor 3-11 shift made aware and told me to call the DON (director of nursing). DON unable to reach. Call placed to the unit manager and informed about incident and she stated she will	F 609		

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call the DON to follow up on this matter. A note was left at the unit manager office to follow up." A witness statement signed by the on-call manager on 1/17/19 documented, "As on call mgr (manager) I received call from facility (name of nurse caring for Resident #3) at 7:02 p.m. concerning resident in room (number) had fallen on the floor with no injuries at about 3:20 p.m. Also patient stated that aid with red hair had grabbed her and threw her on the bed. I placed call to (name of ASM [administrative staff member] #2 [nurse executive- also known as director of nursing]) and after talking with (ASM #2) we decided to interview patient in morning concerning her transfer from wheelchair to bed."

The nurse who cared for Resident #3 during the evening shift on 1/17/19, and was made aware of the allegation by Resident #3's son was not available for interview during the survey.

On 2/6/19 at 4:32 p.m., an interview was conducted with RN (registered nurse) #10. RN #10 was asked what nurses should do if an allegation of resident abuse is reported to them. RN #10 stated she would ensure the patient's safety, separate the staff member and notify her direct supervisor. RN #10 stated she would contact the director of nursing then the executive director if her direct supervisor was not available.

On 2/6/19 at 5:39 p.m., ASM #1 (the executive director), ASM #2 and ASM #3 (the clinical quality specialist) were made aware of the above concern. ASM #2 was asked the facility process for reporting allegations of abuse to the state agency. ASM #2 stated allegations of abuse should be reported to the state agency within two hours. ASM #2 stated training had recently been

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F 609	Continued From page 58 completed with staff and they have been told to report allegations of abuse to her and ASM #1. ASM #2 stated that ASM #1 was the abuse coordinator and ultimately needed to know about any allegations. (Note- not all staff had recently been provided abuse training). The facility policy titled, "Abuse Prohibition" documented, "6. Upon receiving information concerning a report of suspected or alleged abuse, mistreatment, or neglect, the CED (center executive director) or designee will perform the following: 6.1 Enter allegation into the Risk Management System (RMS). 6.2 Report allegations involving abuse (physical, verbal, sexual, mental) not later than two hours after the allegation is made..." No further information was presented prior to exit. 2. The facility staff failed to report Resident #261's and Resident #262's allegations of abuse to the SA within the two-hour timeframe. Resident #261's allegation of abuse was reported to staff on 9/23/18 and was not reported to the SA until 9/24/18. Resident #262's allegation of abuse was reported to staff on 9/22/18 and was not reported to the SA until 9/24/18. Both allegations were submitted to the SA in one FRI (facility reported incident) on 9/24/18. Resident #261 was admitted to the facility on 8/24/18. Resident #261's diagnoses included but were not limited to arthritis, high blood pressure and morbid obesity. Resident #261's most recent MDS (minimum data set) (prior to discharge) a 60 day Medicare assessment with an ARD (assessment reference date) of 10/19/18, coded the resident as being cognitively intact.	F 609		

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F 609	Continued From page 59 Resident #262 was admitted to the facility on 12/11/11. Resident #262's diagnoses included but were not limited to paralysis, major depressive disorder and diabetes. Resident #262's most recent MDS (minimum data set) (prior to discharge), a 14 day Medicare assessment with an ARD (assessment reference date) of 12/18/18, coded the resident's cognition as moderately impaired. A FRI (facility reported incident) submitted to the state agency (Office of Licensure and Certification) on 9/24/18 documented, "Report date: September 24, 2018. Incident date: 9/20/18 and 9/22/18. Residents involved: (name of Resident #261 [9/20/18] and name of Resident #262 [9/23/18]). Injuries: None. Incident type: (a check mark beside Allegation of abuse/mistreat). Describe incident, including location and action taken: (name of Resident #261) reported that she asked the aide on 11-7 shift 9/20/18 to put her on the bedpan. She stated she advised the aide she was not positioned correctly on the bedpan and was left to 'soil all over herself and the bed' due to the bedpan not positioned correctly. She also stated that she was 'rough' while positioning her on the bedpan, pushing her hard to get her on the bedpan since patient was unable to assist. She advised the CNA that she was unable to assist with positioning and that she was uncomfortable during the process. On the same date, (name of Resident #262) advised nursing supervisor that the 11-7 aide on 9/22/18 used 'force' when changing her diaper. Patient stated the aide was 'pushing and pulling me so hard and rough.' She asked the aide to stop due to the aide hurting her and the aide rolled her eyes and continued to provide care. (Name of Resident #262) went on	F 609		

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F 609	Continued From page 60	F 609		

to state the aide grabbed her right leg while getting her comfortable in bed which caused her pain due to that being her 'bad leg.'"

A witness statement signed by CNA #9 on 9/23/18 documented, "To Whom It may concerned (sic). On Saturday September 22, 2018 at 3:30 p.m. when I went into (Resident #262's room) she reported to me that the 11-7 cna who had given care to her was very rude and abusive to her. She throw (sic) the diapers on the other bed, calling her names and was upset because she was unable to reached (sic) the call bell and had wet on herself. So I reported the incident to the charged (sic) nurse (name of RN #11) who told me she could not deal with the situation. So I then reported it to (name of RN #10) Sunday morning on the 7-3 shift."

A witness statement signed by RN #11 on 9/23/18 documented, "To whom this may concern, (name of CNA #9) told me about an encounter related to her by a resident (name of Resident #262). (Name of CNA #9) stated that I told her I could not deal with it right now and that she should tell the supervisor. I had seen the resident several times during the shift later on but I had forgotten about the incident and did not ask the resident or anyone else about it."

A witness statement documented by RN #10 on 9/23/18, documented, "At the start of my 7am shift on Sunday 9/23/2018, (name of CNA #9) reported to me that she was told last night (3-11 9/22/2018) by (name of Resident #262) in Room (number) that the CNA the night before (Friday night 11-7 9/21/2018) was being very rude and rough with her, the most abusive person shes (sic) ever had to deal with. (Name of CNA #9)

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said she reported it to me this morning because she said she tried to notify (name of RN #11) on 3-11 Saturday when the patient reported it to her, but (name of RN #11's) response back to (name of CNA #9) was 'Im (sic) too busy and don't have time to deal with that.' Upon interviewing patient, she gave a recollection of her account of events from the night of the concern. I forwarded her statement to the Unit Manager, ADON (assistant director of nursing) for her assigned unit. I was the charge nurse on 11-7, the night of patients (sic) admission. I rounded multiple times throughout the shift, for the most part, patient was sleeping peacefully so I did not wake her. There were no concerns reported to me throughout the shift I was assigned to work with her, nor did the CNA report any issues to me."

A statement verbally obtained from Resident #262 by RN #10 on 9/23/18 documented, "I came here Friday night and the CNA in the middle of the night was very rough with me. I knew she was pissed off because she came in with an attitude and slammed the closet door. She also used force when she was changing my diaper. She was pushing and pulling me so hard and rough. I asked her to stop because it was hurting me and she rolled her eyes and kept doing it until she was done. Her attitude and body language was cold and scary. Please don't make me have to deal with her again, I am scared to be around her. She grabbed my right leg while getting me comfortable in bed and it was so painful because it is my bad leg. She isn't a nice or gentle person. She threw a pack of my diapers across the room to the empty bed on the other side of the room. She didn't speak or talk to me much, Real grumpy and quiet. Didn't seem to acknowledge anything I said. I finally decided to report what

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F 609	Continued From page 62 happened to one of the girls last night because I need to help keep the other people here safe too." A patient statement obtained from Resident #261 by RN #10 on 9/23/19 documented, "Patient reported to this nurse that a CNA she had a few nights ago was very rude and hurtful for her. She said she reported it to her nurse around 6am that same shift and asked the nurse that the CNA in question doesn't go back in the room again, and the nurse told her she would make sure that CNA doesn't go back to her room. Patient said the CNA came in with a nasty attitude and seemed like she didn't really like her job. Also stated that she seemed very angry and was throwing things, anything she picked up and needed to place somewhere or put down, she threw it and was very rough and abrupt. Patient stated she was put on a bedpan by CNA and told her it wasn't positioned right, but she left patient that way and she was forced to soil all over herself and the bed because the bedpan was not positioned correctly. Patient also stated that she was very rough with her while positioning her on the bedpan. She told CNA that the side she was laying on restricted her movement and she couldn't help the CNA with repositioning her, however she pushed patient really hard to get her in the position she wanted to, and it wasn't comfortable during the whole process. Patient asked to never have the CNA in her room ever again. She described the CNA as (name), an agency CNA. She described her nurse as the one she has every night almost, but couldn't remember her name." A final report sent to the SA on 9/27/18 documented, "Resident (name of Resident #261) reported that she asked the aide on 11-7 shift	F 609		

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F 609	Continued From page 63 9/20/18 to put her on the bedpan. She stated she advised the aide she was not positioned correctly on the bedpan and was left to 'soil all over herself and the bed' due to the bedpan not positioned correctly. She also stated that she was 'rough' while positioning her on the bedpan, pushing her hard to get her on the bedpan since patient was unable to assist. She advised the CNA that she was unable to assist with positioning and that she was uncomfortable during the process. On the same date, (name of Resident #262) advised nursing supervisor that the 11-7 aide on 9/22/18 used 'force' when changing her diaper. Patient stated the aide was 'pushing and pulling me so hard and rough.' She asked the aide to stop due to the aide hurting her and the aide rolled her eyes and continued to provide care. (Name of Resident #262) went on to state the aide grabbed her right leg while getting her comfortable in bed which caused her pain due to that being her 'bad leg.'" CONCLUSION: Unable to Substantiate allegation of abuse. Allegations to be unsubstantial due to interviewed Staff, alert and orient (sic) residents in the care of alleged perpetrator with no allegations of roughness during ADL (activities of daily living) care. Accused employee denies allegations. Per accused employee states she was not aware of residents (sic) concern and voicing she was rough. She states she forgot her hearing aids the day of the incident. CNA is contract agency and is no longer working at Facility. Staff in service on the 'Abuse policy and Abuse Prohibition' with the Center Nursing Executive. Current Status of Resident: Stable." On 2/6/19 at 3:37 p.m., an interview was conducted with CNA #9. When asked what a CNA should do if a resident verbalizes an	F 609		

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F 609	Continued From page 64 allegation of abuse, CNA #9 stated, "I am supposed to report it to the charge nurse." When asked if she does anything after she reports the allegation to the charge nurse, CNA #9 stated, "I follow up to see if she does anything about it. If not, I report to the supervisor above her." CNA #9 stated she would follow up the next day if the allegation occurred on her 3:00 p.m. to 11:00 a.m. shift. CNA #9 was asked to explain the situation regarding Resident #262's allegation of abuse. CNA #9 stated on 9/22/18 she went into Resident #262's room and the resident did not look happy. CNA #9 stated she asked Resident #262 what was wrong, and the resident explained the 11:00 p.m. to 7:00 a.m. shift CNA had thrown a diaper and said verbal things to her that was out of place. CNA #9 stated she went straight to RN #11 and told RN #11 the information reported to her by Resident #262. CNA #9 stated RN #11 told her to tell the supervisor but the supervisor was not in the building so she told RN #10 when she came to the facility. On 2/6/19 at 4:32 p.m., an interview was conducted with RN (registered nurse) #10. RN #10 was asked what nurses should do if an allegation of resident abuse is reported to them. RN #10 stated she would ensure the patient's safety, separate the staff member and notify her direct supervisor. RN #10 stated she would contact the director of nursing then the executive director if her direct supervisor was not available. RN #10 was asked to explain the situation regarding Resident #262's allegation. RN #10 stated she made sure Resident #262 was okay, interviewed the resident, interviewed staff and contacted the ADON (assistant director of nursing) as soon as she was made aware of the allegation.	F 609		

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F 609	Continued From page 65 On 2/6/19 at 5:39 p.m., ASM #1 (the executive director), ASM #2 and ASM #3 (the clinical quality specialist) were made aware of the above concern. (Note- ASM #1 and ASM #2 were not employed at the facility in September 2018). ASM #2 was asked the facility process for reporting allegations of abuse to the state agency. ASM #2 stated allegations of abuse should be reported to the state agency within two hours. ASM #2 stated training had recently been completed with staff and they have been told to report allegations of abuse to her and ASM #1. ASM #2 stated that ASM #1 was the abuse coordinator and ultimately needed to know about any allegations. (Note- not all staff had recently been provided abuse training). On 2/7/19 at 9:22 a.m., an interview was conducted with RN #11. RN #11 was asked what should be done if she is made aware of a resident's allegation of abuse. RN #11 stated, "Right away you are supposed to tell your supervisor and the supervisor must tell the manager." When asked about the time period this should be done, RN #11 stated it must be done timely within 24 hours but the allegation should be reported to the supervisor right away. RN #11 was asked to explain the situation regarding Resident #262's allegation. RN #11 stated a CNA came to her and stated Resident #262 reported an allegation but the alleged event did not occur on her shift so she told the CNA to tell the supervisor. No further information was presented prior to exit.	F 609		
F 622 SS=D	Transfer and Discharge Requirements CFR(s): 483.15(c)(1)(i)(ii)(2)(i)-(iii)	F 622		

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F 622	Continued From page 66 §483.15(c) Transfer and discharge- §483.15(c)(1) Facility requirements- (i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless- (A) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility; (B) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility; (C) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident; (D) The health of individuals in the facility would otherwise be endangered; (E) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; 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	F 622	F622 1. Resident 208, 90, and 51 were transferred to the hospital without required documentation. 2. All residents being transferred to the hospital are at risk. Facility has not been sending documentation according to regulation to hospital on transfers. 3. Nurse Practice Educator, ADON or designee to in-service licensed nursing staff on documentation that is required when sending a resident to the hospital. 4. ADON or designee to audit discharged residents' charts 5 X week for 4 weeks, then weekly thereafter, to ensure proper documentation is sent. Variances will be corrected and brought to Quality Assurance and Performance Improvement Committee monthly, with the QAPI Committee responsible for ongoing compliance. 5. Date of Compliance: 3/15/19	

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F 622	Continued From page 67 or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose. §483.15(c)(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider. (i) Documentation in the resident's medical record must include: (A) The basis for the transfer per paragraph (c)(1)(i) of this section. (B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s). (ii) The documentation required by paragraph (c)(2)(i) of this section must be made by- (A) The resident's physician when transfer or discharge is necessary under paragraph (c) (1) (A) or (B) of this section; and (B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of 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	F 622		

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F 622	Continued From page 68 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, clinical record review, and facility documentation review, the facility staff failed to evidence that required documentation was sent with residents to the Hospital at the time of transfer, for three of 55 residents, Residents #208, #90, and #51. 1. The facility staff failed to evidence that Resident #208's comprehensive care plan goals were sent with the resident to the hospital at the time of the facility-initiated transfer on 05/25/2018. 2. The facility staff failed provide required documentation to a receiving provider for Resident #90's facility initiated hospital transfer dated 11/28/18 and 1/5/18. 3. The facility staff failed to provide evidence that all required information (including physician contact information, resident representative contact information, special instructions for ongoing care, advance directives and comprehensive care plan goals) was provided to the hospital staff when Resident #51 was transferred to the hospital on 1/24/19. The Findings Included: 1. The facility staff failed to evidence that	F 622		

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F 622	Continued From page 69 Resident #208's comprehensive care plan goals were sent with the resident to the hospital at the time of the facility-initiated transfer on 05/25/2018. Resident #208 was reviewed as a closed record. Resident #208 was admitted to the facility on 05/04/2018. Her diagnoses included right hip fracture, muscle weakness, hyperlipidemia (high levels of fat/cholesterol in the blood), and hypertension (high blood pressure). Her most recent Minimum Data Set (MDS) Assessment was a Medicare 14 Day Assessment with and Assessment Reference Date (ARD) of 05/16/2018. Resident #208 was scored as a six (6) on the Brief Interview for Mental Status (BIMS), indicating severe impairment. Resident #208 was coded as requiring extensive assistance of two or more people for transfers and bed mobility; and extensive assistance of one person for ambulation, dressing, eating, hygiene, and toileting. A review of Resident #208's closed record revealed that Resident #208 was transferred to the hospital on 05/25/2018. According to the nurse's note dated 05/25/2018 8:59 p.m., Resident #208 was discovered on the floor of her room at 5:45 p.m. Resident #208 complained of pain to her right hip at that time. Facility staff notified the Provider, who ordered a mobile x ray of the right hip. However, according to the nurse's note, Resident #208's daughter, upon being informed of the fall, stated she wished for her mother to be sent to the ER (emergency room) immediately. A review of the Physician's Orders revealed an order dated 05/25/2018 reading "Send Resident to [HOSPITAL] ER for Tx (treatment) and Eval (evaluation) per family	F 622		

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F 622	Continued From page 70 request." A review of the nurse's notes for 05/25/2019 revealed no description of what documentation, if any, was sent to the hospital with Resident #208. At the End of Day Meeting on 02/06/2019, ASM (Administrative Staff Member) #1, the Executive Director, and ASM #2, the Center Nurse Executive, were informed of the concerns regarding Resident #208's transfer, and were asked to provide documentation of what was sent with her to the hospital. ASM #2 replied, "We usually give a face sheet with the resident's demographics, history and physical and also some labs [laboratory tests results]. We also have a transfer form with a list of required documents that we started to use a couple of months ago, however, nursing is not using it consistently." ASM #2 was asked if the facility had evidence that Resident #208's comprehensive care plan goals were provided to the hospital for the facility initiated hospital transfer on 05/25/18. ASM #2 replied, "No." No further information was provided prior to exit. 2. The facility staff failed provide required documentation to a receiving provider for Resident #90's facility initiated hospital transfer dated 11/28/18 and 1/5/18. Resident #90 was admitted to the facility on 10/23/18 with a most recent readmission date of 1/10/19. Diagnoses included but were not limited to: syncope and collapse (1), depression, urinary tract infection and bradycardia (2). The most recent MDS (minimum data set), a Medicare fourteen day assessment, with an ARD (assessment reference date) of 1/24/19 coded	F 622		

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the resident as having a score of five on the BIMS (brief interview for mental status), indicating the resident had severe cognitive impairment.

Resident #90's clinical record revealed that she was sent to the hospital on 11/28/18. A nurse's note dated 11/28/18 at 3:31 p.m., documented "(name of resident) had an unplanned transfer. Contact person notified of transfer."

Resident #90's clinical record revealed that she was sent to the hospital on 1/5/19. Nurse's note dated 1/5/19 at 7:18 p.m., documented "This writer F/U (followed up) with (name of hospital) on pt. (patient) status and noted resident admitted with diagnosis of AMS (altered mental status) and acute cystitis (urinary tract infection)."

There was no evidence in the clinical record that the required information was provided to the hospital for Resident #90's facility initiated hospital transfers dated 11/28/18 and 1/5/18.

On 02/07/19 at approximately 11:18 a.m., an interview was conducted with ASM (administrative staff member) #2, the Nurse Executive. ASM #2 was asked what documents the facility provides to receiving providers when a resident is transferred to the hospital. ASM #2 replied, "We usually give a face sheet with the resident's demographics, history and physical and also some labs [laboratory tests results]. We also have a transfer form with a list of required documents that we started to use a couple of months ago, however, nursing is not using it consistently." ASM #2 was asked if the facility had evidence that the required documentation such as but not limited to: Contact information of the residents, resident representative information

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F 622	Continued From page 72 including contact information, Advance Directive, all special instructions or precautions for ongoing care and comprehensive care plan goals, was provided for Resident #90's hospital transfer dated 11/28/18 and 1/5/18. ASM #2 replied, "No." On 02/07/19 at approximately 5:45 p.m., ASM #1, the Executive Director and ASM #2, the Nurse Executive, and ASM #3, Clinical Quality Specialist, were made aware of the findings. The facility policy titled "Discharge and Transfer" with a most recent revision date of 11/28/16 documented, "5.3 Patient's advance directives and/or health care instructions will be sent to the hospital with the resident." No further information was provided prior to exit. 1. Fainting is a temporary loss of consciousness. If you're about to faint, you'll feel dizzy, lightheaded, or nauseous. Your field of vision may "white out" or "black out." Your skin may be cold and clammy. You lose muscle control at the same time, and may fall down. This information was obtained from the website: https://vsearch.nlm.nih.gov/vivisimo/cgi-bin/query-meta?v%3Aproject=medlineplus&v%3Asources=medlineplus-bundle&query=syncope. 3. The facility staff failed to provide evidence that all required information (including physician contact information, resident representative contact information, special instructions for ongoing care, advance directives and comprehensive care plan goals) was provided to the hospital staff when Resident #51 was transferred to the hospital on 1/24/19.	F 622		

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F 622	Continued From page 73 Resident #51 was admitted to the facility on 6/28/18. Resident #51's diagnoses included but were not limited to diabetes, high blood pressure and pneumonia. Resident #51's most recent MDS (minimum data set), a 14 day Medicare assessment with an ARD (assessment reference date) of 12/13/18, coded the resident's cognition as severely impaired. Review of Resident #51's clinical record revealed the resident was transferred to the hospital on 1/24/19 due to a fall. Further review of Resident #51's clinical record (including nurses' notes) failed to reveal evidence that the facility staff provided the required information to hospital staff when the resident was transferred. On 2/6/19 at 4:05 p.m., an interview was conducted with LPN (licensed practical nurse) #3. LPN #3 was asked to describe the information that is provided to hospital staff when a resident is transferred to the hospital. LPN #3 stated, "Their name, I usually go by their name, date of birth, the reasoning as to why we are sending them, their history, code status, last set of vitals, last time seen normal, face sheet, labs [laboratory tests], medication list, H&P (history and physical)." When asked if the resident representative's contact information, physician's contact information and special instructions for care are provided, LPN #3 stated that information is documented on an eInteract form. LPN #3 stated the eInteract form is sometimes but not always provided to the hospital staff. LPN #3 stated that information is provided via phone if the eInteract form is not sent to the hospital. When asked if residents' comprehensive care plan goals are provided to hospital staff, LPN #3 stated, "No." LPN #3 was asked how nurses	F 622		

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F 622	Continued From page 74 evidence the information that is provided to hospital staff. LPN #3 stated, "We know that stuff goes but are not able to evidence. They started off with a form that we check off with, with an envelope but it's new and I'm not sure everyone is using it." Further review of Resident #51's clinical record failed to reveal an eInteract form or check off list containing all the required information. On 2/6/19 at 5:39 p.m., ASM (administrative staff member) #1 (the executive director), ASM #2 (the nurse executive) and ASM #3 (the clinical quality specialist) were made aware of the above concern. No further information was presented prior to exit.	F 622		
F 656 SS=E	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not	F 656	F656 1. Resident #50 care plan developed to address mail delivery, Resident #52 care plan was corrected to include oxygen while surveyor was present, Resident #97 care plan was developed to address resident behavior of cursing, Resident #7 care plan for call bell placement was not followed, Resident #99 care plan was developed to address feeding and tracheostomy tube, Resident #309 care plan was developed to address oxygen, Resident #71 care plan for respiratory medication was implemented, Resident #29 care plan for pressure injury treatment was implemented.	

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F 656	Continued From page 75 provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview, facility document review, and clinical record review, it was determined that the facility staff failed to develop and implement the comprehensive care plan for eight of 55 residents in the survey sample, Resident #50, #52, #97, #7, #99, #309, #71, and #29. 1. The facility staff failed to develop a comprehensive care plan regarding Resident #50's mail delivery. 2. The facility staff failed to implement the comprehensive care plan for the administration of	F 656	2. All residents in the facility requiring mail delivery, administration of oxygen, displaying behaviors of cursing, requiring proper call bell placement, requiring tube feed and tracheostomy care, requiring respiratory medication and requiring pressure injury treatment are at risk. Care Plans for current residents with oxygen, behaviors, tube feeding, tracheostomy and respiratory medications were reviewed and updated accordingly. Residents with specific / special call bell needs have had their care plans updated accordingly. No other residents have been identified as having concerns with the mail that they receive as being dangerous/hazardous. 3. Nurse Practice Educator, ADON or designee to in-service licensed nursing staff on care plan development and implementation.	

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F 656	Continued From page 76 oxygen for Resident #52. 3. The facility staff failed to develop a behavior care plan for Resident #97 to address the residents cursing. 4. The facility staff failed to follow Resident # 7's comprehensive care plan for the placement of the call bell. 5. The facility staff failed to develop a comprehensive care plan for Resident # 99's tube feeding and tracheostomy care. 6. The facility staff failed to develop a comprehensive care plan for Resident # 309's oxygen. 7. The facility staff failed to implement Resident #71's care plan for respiratory medication administration. 8. The facility staff failed to implement Resident #29's care plan for pressure injury treatment. The findings include: 1. Resident #50 was admitted to the facility on 8/20/17. Diagnosis included but were not limited to: high blood pressure, depression, chronic obstructive pulmonary disease (1) and obstructive sleep apnea (2). The most recent MDS (minimum data set), an annual assessment, with an assessment reference date of 7/24/18, coded the resident as having a score of 15 of 15 on the BIMS (brief interview for mental status) indicating the resident	F 656	4. ADON, Nurse Practice Educator and or designee to audit 10 random care plans weekly for 4 weeks, then randomly thereafter to ensure development and implementation occur. Variances will be corrected immediately and brought to Quality Assurance and Performance Improvement Committee monthly, with QAPI Committee responsible for ongoing compliance. 5. Date of Compliance: 3/15/19	

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F 656	Continued From page 77 was cognitively intact to make daily decisions. On 02/05/19 at approximately 11:09 a.m., an interview was conducted with Resident #50. Resident # 50 was asked if he felt the facility offered him privacy. Resident #50 replied "For the most part. A couple of months ago I was supposed to get a package in the mail but when it got to me, someone had opened it. I was pretty mad about that and I let the administration know about it (Sic)." Resident #50 was asked what was in the package. Resident #50 replied "Some batons that I ordered from Amazon. They (the facility administration) thought it was a weapon. I have a 'bum' shoulder, and I was going to use them to stretch my arms. After I complained about this, they said they would ask me before they opened my packages." The social worker note dated 8/21/18 at 3:07 p.m., documented "(name of Resident #50) has a rotator cuff pain and goals will focus on improving his flexibility and pain level. (Name of Resident #50) continues to order equipment of (sic) amazon that might not be appropriate for our facility (i.e. gym equipment, karate gear, etc.). He is aware that anything he wants to order should be reviewed first so that he does not bring anything inappropriate to the facility." The comprehensive care plan dated February 2019, failed to address how Resident #50's history of ordering in appropriate items and how his mail should be delivered. On 2/6/19 at approximately 1:47 p.m., an interview was conducted with CNA (certified nursing assistant) #1. CNA #1 was asked what the purpose of a care plan is. CNA #1 replied, "It	F 656		

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F 656	Continued From page 78 contains all the basic information about how to care for a resident." On 02/07/19 at approximately 8:52 a.m., an interview was conducted with ASM (administrative staff member) #1, the Executive Director. ASM #1 was asked if any residents had complained of getting opened mail. ASM #1 replied, "Yes (name of Resident #50), told me while I made a tour, that a while back before I got here, he had received an opened package. The resident had a history of getting weapons in the mail, so the previous administrator opened his package. However when I found out about this I educated the staff on not opening a residents mail. We also told him that he can't have any weapons here. And now staff are not to open any of his package unless he consents and they open it in his presence." On 2/7/19 at approximately 11:27 a.m., an interview was conducted with RN (registered nurse) #5, Nurse Practice Educator. RN #5 was asked if Resident #50's care plan documented how his mail should be delivered. RN #5 replied, "No." RN #5 was asked if Resident #50's care plan should include his history of ordering inappropriate items, and if it should address how to handle his mail. RN #5 replied, "Yes." On 2/7/18 at approximately 5:45 p.m., ASM (administrative staff member) #1, the Executive Director and ASM #2, the Nurse Executive, and ASM #3, Clinical Quality Specialist, were made aware of the findings. No further information was obtained prior to exit.	F 656		

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F 656	Continued From page 79 1. Disease that makes it difficult to breath that can lead to shortness of breath). The two main types are chronic bronchitis and emphysema. The main cause of COPD is long-term exposure to substances that irritate and damage the lungs. This is usually cigarette smoke. Air pollution, chemical fumes, or dust can also cause it. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/copd.html. 2. Obstructive sleep apnea (OSA) is a problem in which your breathing pauses during sleep. This occurs because of narrowed or blocked airways. This information was obtained from the website: https://medlineplus.gov/ency/article/000811.htm. 2. The facility staff failed to implement Resident #52's comprehensive care plan for the administration of oxygen. Resident #52 was admitted to the facility on 2/7/2013. Diagnoses included but were not limited to: chronic obstructive pulmonary disease (COPD) (1), myelodysplastic syndrome (2), anemia (3), depression, and shortness of breath. The most recent MDS (minimum data set), an annual assessment, with an ARD (assessment reference date) of 12/15/18, coded the resident as having a score of 14 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was cognitively intact to make daily decisions. Section O-Special Treatments, documented that Resident #52 receives oxygen therapy. The physician order sheet dated January 2019	F 656		

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F 656	Continued From page 80	F 656		

documented "Oxygen at 2 liters per minute via nasal cannula (a plastic tube with two prongs that inserts in the nose) continuously."

The comprehensive care plan dated 7/13/18 documented, "O2 (oxygen) as ordered."

On 2/5/19 at approximately 8:34 a.m., an observation was made of Resident #52. Resident #52 was observed receiving oxygen via a nasal cannula connect to an oxygen concentrator. Observation of the flow meter on Resident #52's oxygen concentrator revealed the oxygen flow rate was set with the ball between the 2.0L/min (liters per minute) and 2.5L/min lines.

On 2/5/19 at approximately 3:30 p.m., a second observation was made of Resident #52's oxygen concentrator. Observation of the flow meter on Resident #52's oxygen concentrator revealed the oxygen flow rate was set with the ball between the 2.0L/min (liters per minute) and 2.5L/min lines.

On 2/5/19 at approximately 3:40 p.m., a third observation was made with of Resident 52's oxygen concentrator flow meter with LPN (licensed practical nurse) #1. LPN #1 was asked to read the flow meter on Resident #52's oxygen concentrator. After observing Resident #52's oxygen concentrator flow meter, LPN #1 stated, "its set at 2.5L (liters)."

On 2/5/19 at approximately 3:41 p.m., an interview was conducted with LPN #1. When asked was asked how an oxygen flow meter is read, LPN #1 replied, "The top of the ball is supposed to be on the line."

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F 656	Continued From page 81 On 2/5/19 at approximately 3:45 p.m., an interview was conducted with RN (registered nurse) #2. RN #2 was asked how the rate on an oxygen flow meter is set. RN #2 replied, "You turn the dial until the line is in the middle of the ball." On 2/6/19 at approximately 1:47 p.m., an interview was conducted with CNA (certified nursing assistant) #1, regarding the purpose of a care plan. CNA #1 replied, "It's all the basic information about how to care for a resident." CNA #1 was asked residents' care plans should be followed. CNA #1 replied, "Yes." On 2/6/19 at approximately 2:17 p.m., an interview was conducted with LPN (licensed practical nurse) #2. LPN #2 was asked the purpose of resident care plans. LPN #2 replied, "It has all the information you need so you can care for a particular resident." LPN #2 was asked if Resident #52's care plan in regards to oxygen administration be followed. LPN #2 replied, "Yes." On 2/7/19 at approximately 5:45 p.m., ASM (administrative staff member) #1, the Executive Director and ASM #2, the Nurse Executive, and ASM #3, Clinical Quality Specialist, were made aware of the findings. No further information was provided prior to exit. 1. A disease that makes it difficult to breath that can lead to shortness of breath. The two main types are chronic bronchitis and emphysema. The main cause of COPD is long-term exposure to substances that irritate and damage the lungs. This is usually cigarette smoke. Air pollution, chemical fumes, or dust can also cause it. This information was obtained from the website:	F 656		

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F 656	Continued From page 82 https://www.nlm.nih.gov/medlineplus/copd.html. 2. Your bone marrow is the spongy tissue inside some of your bones, such as your hip and thigh bones. It contains immature cells, called stem cells. The stem cells can develop into the red blood cells that carry oxygen through your body, the white blood cells that fight infections, and the platelets that help with blood clotting. If you have a myelodysplastic syndrome, the stem cells do not mature into healthy blood cells. Many of them die in the bone marrow. This means that you do not have enough healthy cells, which can lead to infection, anemia, or easy bleeding. This information was obtained from the website: https://medlineplus.gov/myelodysplasticsyndromes.html 3. If you have anemia, your blood does not carry enough oxygen to the rest of your body. The most common cause of anemia is not having enough iron. Your body needs iron to make hemoglobin. Hemoglobin is an iron-rich protein that gives the red color to blood. It carries oxygen from the lungs to the rest of the body. This information was obtained from the website: https://vsearch.nlm.nih.gov/vivisimo/cgi-bin/query-meta?v%3Aproject=medlineplus&v%3Asources=medlineplus-bundle&query=anemia&_ga=2.71282640.1704263304.1542638661-1154288035.1542638661 3. The facility staff failed to develop a behavior care plan for Resident #97 to address the residents cursing. Resident #97 was admitted to the facility on 12/23/18 with diagnoses that included but were	F 656		

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F 656	Continued From page 83 not limited to: diabetes, high blood pressure, hemiplegia (1) and hemiparesis (2) following cerebral infarction (3). The most recent MDS (minimum data set), a Medicare thirty day assessment, with an ARD (assessment reference date) of 1/18/19 coded the resident as having scored a 15 out of 15 on the BIMS (brief interview for mental status) indicating the resident was cognitively intact to make daily decisions. The resident was coded as requiring limited assistance with eating. On 02/05/19 at approximately 12:20 p.m., an observation was conducted in the main dining room, where lunch was being served. Resident #97 was observed cursing loudly and continuously at staff. He was also observed complaining to other residents in the dining hall about the food and service in the lunchroom. On 02/05/19 at approximately 12:22 p.m., Resident #8 told Resident #97, "Can you please stop using that language." Resident #8 then turned to this surveyor and stated, "He always does this, and they (the facility staff) need to do something." On 02/05/19 at approximately 12:32 p.m., Resident #24 told Resident #97, "Watch your language please." However, Resident #97 continued cursing loudly. On 02/05/19 at approximately 12:49 p.m., (29 minutes after the initial observation of cursing in the dining room), an observation was conducted in the main dining room, where lunch was being served. Resident #97 was told by CNA (certified nursing assistant) #1, "Mr. (name of resident) you	F 656		

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F 656	Continued From page 84 can't use that type of language in the dining room." On 02/06/19 at approximately 1:47 p.m., an interview was conducted with CNA #1. CNA #1 was asked if Resident #97 had a habit of cursing in the dining room. CNA #1 replied, "Yes, he is known for cursing we have told him in the past to stop but sometimes he does not listen." CNA #1 was asked about the purpose of resident care plans. CNA #1 replied, "It contains all the basic information about how to care for a resident." CNA #1 was asked if Resident #97's behavior of cursing in the dining room was addressed in his care plan, CNA #1 replied "No." CNA #1 was asked how all staff would know how to care for Resident #97 in regards to his behavior, if they were not familiar with him. CNA #1 replied, "If something else is not written down anywhere else in his chart, I don't know." On 02/07/19 at approximately 11:27 a.m., an interview was conducted with RN (registered nurse) #5, Nurse Practice Educator. RN #5 was asked about the purpose of residents' care plans, RN #5 replied, "It communicates with all staff about how to care for a specific resident's needs." RN #5 was asked if a resident has behaviors; should that be a part of the residents care plan, RN #5 replied, "Yes." Review of Resident #97's care plan initiated on 12/24/18 and revised on 1/8/19 failed to document the residents' behavior of cursing in the dining room. On 02/07/19 at approximately 5:45 p.m., ASM (administrative staff member) #1, the Executive Director and ASM #2, the Nurse Executive, and	F 656		

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F 656	Continued From page 85 ASM #3, Clinical Quality Specialist, were made aware of the findings. No further information was given to surveyor prior to exit. 1. Also called: Hemiplegia, Palsy, Paraplegia, and Quadriplegia. Paralysis is the loss of muscle function in part of your body. It happens when something goes wrong with the way messages pass between your brain and muscles. Paralysis can be complete or partial. It can occur on one or both sides of your body. It can also occur in just one area, or it can be widespread. This information was obtained from the website: https://medlineplus.gov/paralysis.html. 2. Paralysis is the loss of muscle function in part of your body. This information was obtained from the website: https://medlineplus.gov/paralysis.html. 3. A stroke. When blood flow to a part of the brain stops. A stroke is sometimes called a "brain attack." If blood flow is cut off for longer than a few seconds, the brain cannot get nutrients and oxygen. Brain cells can die, causing lasting damage. This information was obtained from the website: https://medlineplus.gov/ency/article/000726.htm. 2. Bradycardia is a slower than normal heart rate. The hearts of adults at rest usually beat between 60 and 100 times a minute. If you have bradycardia (brad-e-KAHR-dee-uh), your heart beats fewer than 60 times a minute. Bradycardia can be a serious problem if the heart doesn't pump enough oxygen-rich blood to the body. For some people, however, bradycardia doesn't	F 656		

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F 656	Continued From page 86 cause symptoms or complications. This information was obtained from the website: https://www.mayoclinic.org/diseases-conditions/bradycardia/symptoms-causes/syc-20355474?p=1 4. The facility staff failed to follow Resident # 7's comprehensive care plan for the placement of the call bell. Resident # 7 was admitted to the facility on 10/12/17 with diagnoses that included but were not limited to lack of coordination, rheumatoid arthritis (1), Alzheimer's disease (2), gastroesophageal reflux disease (3) and hypertension (4). Resident # 7's most recent MDS (minimum data set), an annual assessment with an ARD (assessment reference date) of 10/20/18, coded Resident # 7 as scoring an eight on the brief interview for mental status (BIMS) of a score of 0 - 15, eight - being moderately impaired of cognition for making daily decisions. Resident # 7 was coded as requiring extensive assistance of one staff member for activities of daily living. Section G0400 "Functional Limitation in Range of Motion" coded Resident # 7 as being impaired on both sides of her upper extremities (shoulder, elbow, wrist, hand). On 02/05/19 at 11:08 a.m., an observation of Resident # 7 revealed she was lying in bed, awake, neat and clean, watching television. The head of the bed was slightly raised and a pillow was under the upper part of Resident # 7's back. Further observation of Resident # 7 revealed she was leaning toward her left side. Observation of the call bell revealed it was a flat pressure switch. Observation of the call bell's placement revealed	F 656		

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F 656	Continued From page 87 it was lying on top of the mattress in the upper right corner, behind Resident # 7's head. When asked if she could locate the call bell Resident # 7 moved her head slightly to the right and then left and struggled to remove her right arm from under the blanket covering her. Resident # 7 stated, "I don't know where it is." Observation of Resident # 7's movements revealed there was decreased range of motion. On 02/05/19 at 3:22 p.m., an observation of Resident # 7 revealed she was lying in bed, awake, neat and clean, watching television. The head of the bed was slightly raised and a pillow was under the upper part of Resident # 7's back. Further observation of Resident # 7 revealed she was leaning slightly to her left side. Observation of the call bell's placement revealed it was hanging off the side of the mattress in the upper right corner, behind Resident # 7's head. When asked if she could locate the call bell Resident # 7 stated, "I don't know where it is." On 02/06/19 at 8:01 a.m., an observation of Resident # 7 was lying in bed, awake, neat and clean, watching television. The head of the bed was slightly raised and a pillow was under the upper part of Resident # 7's back. Further observation of Resident # 7 revealed she was leaning slightly to her left side. Observation of the call bell's placement revealed it was lying on the bed, on Resident # 7's right side just below her shoulder. When asked if she could locate the call bell Resident # 7 stated, "I don't know where it is." On 02/07/19 at 8:15 a.m., an observation of Resident # 7 was lying in bed, awake, neat and clean, watching television. The head of the bed was slightly raised and a pillow was under the	F 656		

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F 656	Continued From page 88 upper part of Resident # 7's back. Further observation of Resident # 7 revealed she was leaning slightly to her left side. Observation of the call bell's placement revealed it was lying on the bed, on Resident # 7's right side just below her shoulder. When asked if she could locate the call bell Resident # 7 stated, "No." The comprehensive care plan for Resident # 7 dated 10/25/2017 with a revision date of 12/12/2018 documented, "Focus. Resident is at risk for falls related to cognitive impairment, lack of safety awareness and impaired mobility. Date initiated 10/25/2017. Revision date: 12/12/2018." Under "Interventions", it documented Place call light within reach while in bed or close proximity to the bed. Date initiated: 10/25/2017." On 02/06/19 at 1:47 p.m., an interview was conducted with CNA (certified nursing assistant) # 1 " When asked to describe the purpose of the care plan, CNA # 1 stated, "All the basic information about how to care for a resident." When asked if they had access to the resident's care plans, CNA # 1 stated, "Yes, it's on our tablet." On 02/06/19 at 2:17 p.m., an interview was conducted with LPN, (licensed practical nurse) # 2. When asked to describe the purpose of the care plan, LPN # 2 stated, "It has all you need so you know what to do for a particular resident." On 02/07/19 at 8:15 a.m., an observation of Resident # 7's call bell placement was conducted with CNA (certified nursing assistant) # 2. When asked if the call bell was placed in a position that Resident # 7 could reach and activate, CNA #2 sated, "It's not in reach, and she has limited	F 656		

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F 656	Continued From page 89 range of motion." On 02/07/19 at 8:30 a.m., an observation of Resident # 7's call bell placement was conducted with RN (registered nurse) # 8, unit manager. When asked if the call bell was placed in a position that Resident # 7 could reach and activate, RN # 8 sated, "No" and immediately repositioned the call bell within reach of Resident # 7's right hand. On 02/07/19 at 11:27 a.m., an interview was conducted with RN (registered nurse) # 5. When asked to describe the purpose of the care plan, RN # 5 stated, "Communicate with all staff about the needs of a resident, its updated constantly as the residents needs change." On 02/07/19 at approximately 3:45 p.m., ASM (administrative staff member) #1, the executive director, and ASM #2, executive nurse, were made aware of the above findings. No further information was provided prior to exit. References: (1) A long-term disease. It leads to inflammation of the joints and surrounding tissues. It can also affect other organs. This information was obtained from the website: https://medlineplus.gov/ency/article/000431.htm. (2) Gastroesophageal reflux disease (GERD) happens when your stomach contents come back up into your esophagus causing heartburn (also called acid reflux). This information was obtained from the website: https://www.niddk.nih.gov/health-information/digestive-diseases/acid-reflux-ger-gerd-adults	F 656		

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F 656	Continued From page 90 (3) Alzheimer's disease is an irreversible, progressive brain disorder that slowly destroys memory and thinking skills and, eventually, the ability to carry out the simplest tasks. It is the most common cause of dementia in older adults. While dementia is more common as people grow older, it is not a normal part of aging. This information was obtained from the website: https://www.nia.nih.gov/health/alzheimers/basics. (4) High blood pressure. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/highbloodpressure.html. 5. The facility staff failed to develop a comprehensive care plan for Resident # 99's tube feeding and tracheostomy care. Resident # 99 was admitted to the facility on 01/09/19 with diagnoses that included but were not limited to aphasia (1), tracheostomy status (2), hemiplegia (3) and cerebral vascular disease (4). Resident # 99's most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 01/216/19, coded Resident # 99 as scoring a three on the brief interview for mental status (BIMS) of a score of 0 - 15, three - being severely impaired of cognition for making daily decisions. Resident # 99 was coded as being totally dependent of two staff members for activities of daily living. Section K "Swallowing/Nutritional Status" coded Resident # 99 as having a feeding tube. Under section "O. Special Treatment, Procedures and Programs", Resident # 99 was coded as requiring	F 656		

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F 656	Continued From page 91 tracheostomy care. On 02/05/19 at 9:56 a.m., an observation of Resident # 99 revealed she was lying in bed, with the head of the bed slightly raised and her television playing. Further observation revealed Resident # 99 had a tracheostomy and was receiving humidification by a tube, a tube feeding was infusing at 55milliliters per hour with an automatic flush and a suctioning machine was on bedside table. The POS (physician order sheet) for Resident # 99 dated 02/01/19 documented, "Diagnosis: TUBE FEEDING, TRACH (tracheostomy)." Under "Enteral Protocols" it documented, "Nutren (5) 1.5 at 55ML/HR (milliliter per hour) x (times 24 HRS (hours) continuously." Under "Treatments" it documented, "Change trach collar every day." Review of the comprehensive care plan for Resident # 99 dated 01/10/2019 and a revision date of 01/29/2019 failed to evidence documentation for tracheostomy care and tube feeding. On 02/06/19 at 1:47 p.m., an interview was conducted with CNA (certified nursing assistant) # 1 " When asked to describe the purpose of the care plan, CNA # 1 stated, "All the basic information about how to care for a resident." When asked if they had access to the resident's care plans CNA # 1 stated, "Yes, it's on our tablet." On 02/06/19 at 2:17 p.m., an interview was conducted with LPN, (licensed practical nurse) # 2. When asked to describe the purpose of the care plan, LPN # 2 stated, "It has all you need so	F 656		

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F 656	Continued From page 92 you know what to do for a particular resident." On 02/06/19 at 2:53 p.m., an interview was conducted with RN (registered nurse) # 6, MDS coordinator and LPN (licensed practical nurse) # 6, MDS nurse. After Reviewing Resident # 99's care plan for tracheostomy and tube feeding, RN # 6 and LPN # 6 stated, "It's not there." When asked to describe the process for the care plan, RN # 6 stated, "When a resident is admitted we look at diagnosis then that ends up on the interim care plan. When the MDS is completed we look at the CAA (care area assessment) triggers we make sure that those areas are on the care plan. When I do the updates I look at the CAA and whatever is triggered I add to the care plan." On 02/07/19 at 11:27 a.m., an interview was conducted with RN (registered nurse) # 5. When asked to describe the purpose of the care plan, RN # 5 stated, "Communicate with all staff about the needs of a resident, its updated constantly as the residents needs change." On 02/07/19 at approximately 3:45 p.m., ASM (administrative staff member) #1, the executive director, and ASM #2, executive nurse, were made aware of the above findings. No further information was provided prior to exit. References: (1) A disorder caused by damage to the parts of the brain that control language. It can make it hard for you to read, write, and say what you mean to say) This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/aphasia.html	F 656		

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F 656	Continued From page 93 (2) A surgical procedure to create an opening through the neck into the trachea (windpipe). A tube is most often placed through this opening to provide an airway and to remove secretions from the lungs. This tube is called a tracheostomy tube or trach tube. This information was obtained from the website: https://medlineplus.gov/ency/article/002955.htm. (3) Also called: Hemiplegia, Palsy, Paraplegia, Quadriplegia. Paralysis is the loss of muscle function in part of your body. It happens when something goes wrong with the way messages pass between your brain and muscles. Paralysis can be complete or partial. It can occur on one or both sides of your body. It can also occur in just one area, or it can be widespread. This information was obtained from the website: https://medlineplus.gov/paralysis.html. (4) A stroke. When blood flow to a part of the brain stops. A stroke is sometimes called a "brain attack." If blood flow is cut off for longer than a few seconds, the brain cannot get nutrients and oxygen. Brain cells can die, causing lasting damage. This information was obtained from the website: https://medlineplus.gov/ency/article/000726.htm . (5) Calorically-dense, nutritionally complete, tube-feeding formula for increased energy requirements and/or restricted fluid volume. This information was obtained from the website: https://www.nestlehealthscience.us/brands/nutren/nutren-1-5-hcp. 6. The facility staff failed to develop a comprehensive care plan for Resident # 309's	F 656		

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F 656	Continued From page 94 oxygen. Resident # 309 was admitted to the facility on 01/23/2019 with diagnoses that included but were not limited to: edema (1), respiratory failure (2), hypertension (3) and anxiety (4). Resident # 309's most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 01/30/19, coded Resident # 309 as scoring a 15 on the brief interview for mental status (BIMS) of a score of 0 - 15, 15 - being cognitively intact for making daily decisions. Resident # 309 was coded as requiring limited assistance of one staff member for activities of daily living. Under section "O. Special Treatment, Procedures and Programs" Resident # 309 was coded for "C. Oxygen therapy." On 02/05/19 at 9:45 a.m., an observation of Resident 309 revealed she was lying in her bed receiving oxygen by nasal cannula connected to an oxygen concentrator that was running. Observation of the flow meter on the oxygen concentrator revealed an oxygen flow rate between three-and-a-half liters and four liters per minute. The POS (physician's order sheet) for Resident # 309 dated "01/23 2019"documented, "O2 (oxygen) at 2/L (two liters) via (by) N/C (nasal cannula) continuous." The comprehensive care plan for Resident # 309 dated 01/25/2019 failed to evidence documentation for oxygen use. On 02/06/19 at 1:47 p.m., an interview was	F 656		

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F 656	Continued From page 95 conducted with CNA (certified nursing assistant) # 1 " When asked to describe the purpose of the care plan, CNA # 1 stated, "All the basic information about how to care for a resident." When asked if they had access to the resident's care plans, CNA # 1 stated, "Yes, it's on our tablet." On 02/06/19 at 2:17 p.m., an interview was conducted with LPN, (licensed practical nurse) # 2. When asked to describe the purpose of the care plan, LPN # 2 stated, "It has all you need so you know what to do for a particular resident." On 02/06/19 at 2:53 p.m., an interview was conducted with RN (registered nurse) # 6, MDS coordinator and LPN (licensed practical nurse) # 6, MDS nurse. After Reviewing Resident # 309's care plan for oxygen, RN # 6 and LPN # 6 stated, "It's not there." When asked to describe the process for the care plan, RN # 6 stated, "When a resident is admitted we look at diagnosis then that ends up on the interim care plan. When the MDS is completed, we look at the CAA (care area assessment) triggers we make sure that those areas are on the care plan. When I do the updates I look at the CAA and whatever is triggered I add to the care plan." On 02/07/19 at 11:27 a.m., an interview was conducted with RN (registered nurse) # 5. When asked to describe the purpose of the care plan, RN # 5 stated, "Communicate with all staff about the needs of a resident, its updated constantly as the residents needs change." On 02/06/19 at approximately 5:50 p.m., ASM (administrative staff member) #1, the executive director, and ASM #2, executive nurse, were	F 656		

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F 656	Continued From page 96 made aware of the above findings. No further information was provided prior to exit. Reference: (1) A swelling caused by fluid in your body's tissues. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/edema.html. (2) When not enough oxygen passes from your lungs into your blood. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/respiratoryfailure.html. (3) High blood pressure. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/highbloodpressure.html. (4) Fear. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/anxiety.html#summary. 7. The facility staff failed to implement Resident #71's care plan for respiratory medication administration. Resident #71 was admitted to the facility on 10/1/18. Resident #71's diagnoses included but were not limited to chronic obstructive pulmonary disease (2), low back pain and anxiety disorder. Resident #71's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 1/8/19, coded the resident as being cognitively intact.	F 656		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODMONT CENTER	11 DAIRY LANE FREDERICKSBURG, VA 22405

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F 656	Continued From page 97 Review of Resident #71's clinical record revealed a physician's order dated 10/17/18, for Advair 500 mcg (micrograms)/50 mcg and to inhale one puff every 12 hours. Review of Resident #71's November 2018 and January 2019 MARs (medication administration records) failed to reveal Advair was administered to the resident (as evidenced by blank spaces with no documented nurses' initials) on the following dates and times: - 11/1/18 at 9:00 p.m., - 11/3/18 at 9:00 a.m., - 11/30/18 at 9:00 p.m., - 1/9/19 at 9:00 p.m., - 1/23/19 at 9:00 p.m. Nurses' notes for those dates failed to reveal the medication was administered. Further review of Resident #71's January 2019 MAR revealed Advair was not administered to the resident on the following dates and times: -1/6/19 at 9:00 a.m. and 9:00 p.m., -1/18/19 at 9:00 a.m. and 9:00 p.m., -1/19/19 at 9:00 a.m. and - 1/29/19 at 9:00 a.m. On these dates above, the nurses circled their initials and documented the medication was not available on the back of the MAR. Resident #71's comprehensive care plan dated 10/2/18 documented, "Resident exhibits or is at risk for respiratory complications related to Asthma, COPD...Medicate as ordered..." On 2/5/19 at 12:20 p.m., an interview was conducted with Resident #71. The resident stated he was not getting his Advair as he was	F 656		

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F 656	Continued From page 98	F 656		

supposed to "for a while" but that had "straightened itself out."

On 2/6/19 at 4:05 p.m., an interview was conducted with LPN (licensed practical nurse) #3. LPN #3 was asked the purpose of a care plan. LPN #3 stated, "So the nursing staff can know how to really care for the resident and if they require any equipment or anything really." When asked how nurses ensure they implement residents' care plans, LPN #3 stated, "Usually most, they honestly go by the orders; the physician orders, and their MARs (medication administration records) and stuff." LPN #3 confirmed residents' care plans are available if nurses need to review them. LPN #3 was asked how nurses evidence the medications and treatments they administer. LPN #3 stated, "They sign off on the MAR (medication administration record) and TAR." When asked what is meant if there are blank spaces on the MAR, or TAR and the nurses did not sign off, LPN #3 stated, "In reality it means that they didn't do it." LPN #3 was asked what is meant if nurses sign and circle their initials on the MAR. LPN #3 stated, "Usually if signed and circled, either they held it, or couldn't give it, they are supposed to explain on the back of the MAR." LPN #3 was asked if Advair is contained in the facility STAT (Immediate) box (a box containing various medications that can be accessed for any resident if needed). LPN #3 stated Advair is contained in the facility omnicell (a machine provided by that pharmacy, containing many various medications that can be accessed for each resident). LPN #3 was asked the facility process for ensuring Advair is available for administration, if not in the medication cart. LPN #3 stated, "They can check the omnicell. If it's

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F 656	Continued From page 99 the right dose, the omnicell will let you pull it. If not, let the physician know it's not here, let the patient know, call the pharmacy and ask to send (the medication) from backup (a backup pharmacy) and let the rp (responsible party) know that you didn't give it." When asked if Resident #71 missed doses of his Advair, LPN #3 stated, "Yes. He would tell us he got it (the disk) and it was empty; then I further investigated." LPN #3 was asked if the Advair disk displays how many doses are left in the device. LPN #3 confirmed it did. LPN #3 was asked if nurses should have addressed a pharmacy refill for the medication before the medication ran out and stated nurses should have addressed the refill when there were four doses left. On 2/6/19 at 5:39 p.m., ASM (administrative staff member) #1 (the executive director), ASM #2 (the nurse executive) and ASM #3 (the clinical quality specialist) were made aware of the above concern. No further information was obtained prior to exit. 8. The facility staff failed to implement Resident #29's care plan for pressure injury treatment. Resident #29 was admitted to the facility on 8/11/18. Resident #29's diagnoses included but were not limited to urinary tract infection, arthritis and abnormal posture. Resident #29's most recent MDS (minimum data set), a 30 day Medicare assessment with an ARD (assessment reference date) of 11/21/18, coded the resident's cognition as moderately impaired. Section G coded Resident #29 as requiring extensive assistance of one staff with bed mobility, toilet	F 656		

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F 656	Continued From page 100	F 656		

use and personal hygiene. Section M coded Resident #29 as having one stage three-pressure injury (1) that was present upon admission.

Review of a skin integrity report dated 10/29/18 revealed Resident #29 presented with a stage three-pressure injury. A physician's order dated 10/29/18 documented, "Cleanse open area L (left) buttock (with) NS (normal saline), apply skin prep to wound edges, santyl (2) to wound bed & cover (with) dry dressing QD (every day) & PRN (as needed) (illegible word)."

Review of Resident #29's October 2018 and November 2018 TARs (treatment administration records) failed to reveal evidence that the treatment ordered on 10/29/18 was provided for Resident #29 on 10/30/18, 11/4/18, 11/10/18, 11/11/18, 11/12/18, 11/24/18, 11/25/18, 11/26/18, 11/27/18, 11/28/18, 11/29/18 and 11/30/18. This was evidenced by blank spaces on the TARs. No nurses' initials were signed off to indicate the treatment had been performed. Review of nurses' notes for the above dates failed to reveal Resident #29's pressure injury treatment was administered except for a note dated 11/4/18 that documented treatments were administered as ordered.

Resident #29's comprehensive care plan dated 11/8/18 documented, "Resident has actual skin breakdown related to limited mobility, stage 3 pressure wound to left buttock...Provide wound treatment as ordered..."

On 2/6/19 at 4:05 p.m., an interview was conducted with LPN (licensed practical nurse) #3. LPN #3 was asked the purpose of a care plan. LPN #3 stated, "So the nursing staff can know

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F 656	Continued From page 101	F 656		

how to really care for the resident and if they require any equipment or anything really." When asked how nurses ensure they implement residents' care plans, LPN #3 stated, "Usually most, they honestly go by the orders; the physician orders, and their MARs (medication administration records) and stuff." LPN #3 confirmed residents' care plans are available if nurses need to review them. LPN #3 was asked how nurses evidence the medications and treatments they administer. LPN #3 stated, "They sign off on the MAR and TAR." When asked what is meant if there are blank spaces on the MAR, or TAR and the nurses did not sign off, LPN #3 stated, "In reality it means that they didn't do it."

On 2/6/19 at 5:39 p.m., ASM (administrative staff member) #1 (the executive director), ASM #2 (the nurse executive) and ASM #3 (the clinical quality specialist) were made aware of the above concern.

No further information was presented prior to exit.

(1) "Pressure Injury:
A pressure injury is localized damage to the skin and underlying soft tissue usually over a bony prominence or related to a medical or other device. The injury can present as intact skin or an open ulcer and may be painful. The injury occurs as a result of intense and/or prolonged pressure or pressure in combination with shear. The tolerance of soft tissue for pressure and shear may also be affected by microclimate, nutrition, perfusion, co-morbidities and condition of the soft tissue.
Stage 3 Pressure Injury: Full-thickness skin loss
Full-thickness loss of skin, in which adipose (fat)

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F 656	Continued From page 102 is visible in the ulcer and granulation tissue and epibole (rolled wound edges) are often present. Slough and/or eschar may be visible. The depth of tissue damage varies by anatomical location; areas of significant adiposity can develop deep wounds. Undermining and tunneling may occur. Fascia, muscle, tendon, ligament, cartilage and/or bone are not exposed. If slough or eschar obscures the extent of tissue loss this is an Unstageable Pressure Injury." This information was obtained from the website: http://www.npuap.org/resources/educational-and-clinical-resources/npuap-pressure-injury-stages/ (2) "SANTYL Ointment is an FDA-approved prescription medicine that removes dead tissue from wounds so they can start to heal." This information was obtained from the website: https://www.santyl.com/	F 656		
F 657 SS=E	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's	F 657	F657 1. Resident's #39, 31, 15, 1, 35 and 309 care plans were reviewed and revised accordingly.	

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F 657	Continued From page 103 medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, and clinical record review, it was determined that the facility staff failed to review and/or revise the comprehensive care plan for six out of 55 residents in the survey sample; Residents #39, #31, #15, #35, #1, and #309. 1. The facility staff failed to evidence that Resident #39's comprehensive care plan was reviewed and/or revised after a fall on 11/8/18, 12/24/18, 1/1/19, 1/6/19, and 2/3/19. 2. The facility staff failed to evidence that Resident #31's comprehensive care plan was reviewed and/or revised after a fall on 1/18/19. 3. The facility staff failed to evidence that Resident #15's comprehensive care plan was reviewed and/or revised after a fall on 1/28/19. 4. The facility staff failed to evidence that Resident #35's comprehensive care plan was updated to include the resident's behaviors of going on leave of absences from the facility unsupervised, and his non-compliance with returning within the specified 4-hour window as	F 657	2. All residents in the facility that have falls, oxygen therapy, Foley catheter, and go for unsupervised leave of absence visits are at risk. 100% of current residents with orders for Oxygen were reviewed to ensure care plan is updated accordingly. 100% review of all current resident who have had an Indwelling catheter discontinued in the last 30 days were reviewed to ensure that the care plan was updated accordingly. All current residents that sign themselves out on Leaves of Absence were reviewed to ensure that their care plan addresses this accordingly.	