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	495375	A. BUILDING _____ B. WING _____	C 01/16/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMPORIA MANOR LLC	200 WEAVER AVENUE EMPORIA, VA 23847

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F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid abbreviated standard survey was conducted 1/15/2019 through 1/16/2019. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care Requirements. One complaint was investigated during the survey. The census in this 120 certified bed facility was 95 at the time of the survey. The survey sample consisted of 2 resident reviews.	F 000		
F 600 SS=D	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on staff interview, facility documentation review, and clinical record review, and in the course of a complaint investigation, facility staff failed to ensure one resident (Resident # 2) of 2 residents in the survey sample was free from abuse.	F 600	F 600 SS=D Free from Abuse and Neglect CFR(s)/: 483012(a)(1) This plan of correction constitutes the facilities written allegation of compliance for the deficiencies cited. However,	2/28/19

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

Electronically Signed | 02/07/2019

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F 600	Continued From page 1 1. For Resident #2, facility staff failed to protect him from a sexual abuse/assault. Staff found Resident # 2, a moderate cognitively impaired resident being touched orally in the genital area by a severe cognitively impaired resident (Resident # 1). The findings included: Resident # 2 was admitted to the facility on 3/20/2014 and readmitted on 9/28/2018. Diagnoses included but were not limited to: Idiopathic Normal Pressure Hydrocephalus, Right ventriculoperitoneal Shunt, Hypertension, Parkinson's Disease, Psychosis and Gait Instability. Resident # 2 was discharged from the facility by the family on 1/11/2019. The most recent minimum data set (MDS) assessment was a quarterly assessment with an assessment reference date of 12/20/2018. Resident # 2 was coded with a Brief Interview of Mental Status score of "11" out of a possible 15, indicating moderate cognitive impairment. Resident # 2 required extensive to total assistance of one staff member with activities of daily living. Resident # 2 was coded as requiring supervision with ambulation on both on and off units. The resident was coded as being always incontinent of bowel and bladder. Review of the closed clinical record for Resident # 2 was conducted on 1/15/2019. Review of the nurses notes revealed documentation on 1/4/2019 at 3:45 AM that another Resident (Resident # 1) was observed to be sexually inappropriate towards Resident # 2 by performing oral sex on him.	F 600	submission of this plan of correction is not an admission that deficiencies exist of that one was cited correctly. The plan of correction is submitted to meet requirements established by federal and state law. With regard to the alleged deficient practice, the facility has taken the following action: 1. Corrective actions(s) accomplished for those residents found to have been affected by the alleged deficient practice. Resident #2 was transferred to a local hospital for evaluation on 1-4-19. Upon discharge from the hospital family made the decision to take the resident home. Resident #2 was subsequently discharged from the facility on 1-11-19 Resident #1 was discharged from the facility on 1-4-19. 2. Identify other residents who have the potential to be affected by the same deficient practice and what corrective action was taken. The facility has identified all residents as having the potential to be affected by abuse, neglect, misappropriation of resident property and exploitation. All residents were interviewed by the Social Service Director/Director of Nursing/Risk Manager/ and asked if they had experienced or witnessed any form of abuse. Including verbal, sexual, mental, physical abuse, neglect, misappropriation	

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F 600	Continued From page 2 The note read, "(Resident # 1) was observed performing a sex act with 1/4/19 0430 (4:30 AM)- Send to _____ (Hospital A) ED (Emergency Department) for eval (evaluation)." Review of the care plan for Resident # 2 revealed documentation of entries on 1/4/18 (Note: the incident occurred on 1/4/2019) "Problem:'was observed with another resident's mouth on his penis' Goal: Resident will be kept separate away from that particular resident through the next review. Approaches: Resident was sent out to hosp. (hospital) for eval. Residents were separated." Resident # 1 was admitted to the facility on 9/15/2009 and readmitted on 5/18/2015. Diagnoses included but were not limited to: Vascular Dementia, Bipolar II Disorder, Convulsions, Bradycardia, senile degeneration of the brain, Gastroesophageal Reflux Disease, Hypertension, Diabetes Insipidus, Unspecified Psychosis and Kidney Failure. The most recent minimum data set (MDS) assessment was a quarterly assessment with an assessment reference date of 10/16/2018. Resident #1 was coded with a Brief Interview of Mental Status score of "1" out of a possible 15, indicating severe cognitive impairment. Resident # 1 required limited to total extensive assistance of one staff member with activities of daily living, to include bed mobility and transfer. The resident was coded as requiring supervision with ambulation on both on and off units. The resident was coded as always incontinent of bowel and	F 600	of property or exploitation. 3. Measures/systemic changes put in place to ensure this deficient practice does not reoccur: Education provided to all Staff by the Director of Nursing/Social Worker/designee on the abuse reporting policy and procedure including; identifying multiple and various forms of abuse, resident safety during suspected abuse, immediate reporting, documentation and overall review of abuse prevention. Daily Guardian angel round implemented to include questions to residents regarding abuse and mistreatment by staff, other residents or anyone else. Any answers that suggestion abuse will be immediately reported to the facility Administrator/designee for investigation. Abuse questions will be integrated into the facility morning team conference, the monthly resident council meeting and utilized monthly with residents/families during care plan meetings, to create an environment of freedom to report potential abuse. 4. Monitoring of corrective action to ensure the deficient practice does not reoccur: The Social Services Director will present the results of the questionnaires to the QAPI Committee for their review and recommendation if deemed necessary.	

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F 600	Continued From page 3 bladder. Review of the clinical record was conducted on 1/15/2019 and 1/16/2019. Review of the nurses notes revealed documentation: 1/4/2019 at 3:45 AM, "Was alerted by nurse assistant to come into the room. Resident (Resident # 1) was in his roommate bed naked. Both residents clothes and diapers were off. (sic) 1/4/19 0355 (3:55 AM) Unit Manager was notified. 1/4/19 0425 (4:25 AM) ER (Emergency Room) called to give report 1/4/19 0429 (4:29 AM) ____(transport service) called to give report 1/4/19 0510 (5:10 AM) R/P (Responsible Party) called to give report 1/4/19 0705 (7:05 AM) Director of Nursing returned call. Aware of the situation. 1/4/19 0725 (7:25 AM) Resident is lying in bed resting quietly. No s/s (signs or symptoms) of pain/discomfort noted will cont (continue) to observe 1/4/19 (no time listed) Dr (Doctor) called No answer." Note: All above documentation on 1/4/2019 from 1/4/19 at 3:45 AM - 1/4/2019 at 7:25 were done by LPN B. "1/4/2019 11 AM RP (Responsible Party) came into facility . Explained situation and that resident was placed on 1:1 observation until transfer to hospital. 1/4/19 12:00 PM Director of Nursing documented that she spoke to (Other C) explained incident and the need for resident to be evaluated. (Other C) stated to send resident to_____(Hospital C) ER (Emergency Room) since ___Hospital A said	F 600	The DON will present any findings from the nursing staff rounding to the QAPI committee, the MDS coordinator will present any findings from the care plan meetings and the Risk Manager will present any findings from the guardian angel rounds to the QAPI committee for their review and recommendations if deemed necessary. The findings will be reported until the committee is satisfied sustainable compliance has been achieved. 5. Complete date: 2-28-19	

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send to ____ (Hospital B) and Hospital B needed a family escort to evaluate. Resident remains on 1:1. ___(transport) contacted for transportation. Family visiting in room, but stated they were unable to transport to hospital but would meet him there."

Review of the Facility Investigation of the Facility Reported Incident revealed documentation of witness statements from all staff on duty at the time of the incident. There were a total of 18 Incident Statements from the staff on duty. The staff assigned on the Memory Care Secured Units reported that they did not witness the incident. One Certified Nursing Assistant assigned to the unit adjacent to the Memory Care Unit reported she witnessed the incident when she happened to be passing through the hallway on that unit after returning from a smoke break at 3:45 AM. Review of the documents revealed the staff notified the administration, Director of Nursing, the Responsible Parties, Doctors, and all appropriate authorities in a timely manner.

Review of the "Incident statement" from the Certified Nursing Assistant (CNA A) who reported that she witnessed the sexual act revealed the following statements:
_____(Resident # 2) was laying in the bed with brief off and ___(Resident # 1) was giving him oral sex. I told ___ (Resident # 1) to stop and I ran down the hall to get Nurse _____ (Licensed Practical Nurse B). CNA A checked the box indicating that she was not assigned to this resident. CNA A documented "yes" that she witnessed the incident.

There was another handwritten two page statement by CNA A which included specific

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statements about her witnessing Resident # 1 performing the sexual act on Resident # 2. In the handwritten note, CNA A stated she yelled for Resident # 1 to "STOP! STOP!" ___and I went to grab his arm but he threw his arms up in the air. So I walked to the door and yelled (Come Come) waving my hands so the nurse could come down the hallway. Nurse___(LPN B) came and saw __ (Resident # 1) sitting on the side of the bed with ___Resident # 2. Page one of the handwritten statement was dated "1-4-18" and page two was dated "1-4-19"

On 1/15/2019 at 4:58 PM, a telephone interview was conducted with CNA (Certified Nursing Assistant) A who stated she was the one who witnessed the incident. CNA A stated she normally does not work on that unit but worked on the unit adjacent to it. CNA A stated on 1/4/2019 at 3:45 AM while she was returning from a smoke break outside, she saw sheets on the floor of Resident # 1's room. CNA A stated she waked into the room, noticed that the privacy curtain was pulled toward the foot of the bed.

CNA A stated when she went around the curtain, she noticed the flat sheet and bedspread of Resident # 2 were on the floor and the fitted sheet and pad were tucked under Resident # 2's side. She saw Resident # 1 was naked and sitting on Resident # 2's bed. Resident # 2's brief was open and Resident # 1 was performing a sexual act orally on Resident # 2. CNA A stated she walked to the door, threw her arms up in the air to call other staff members to the room. CNA A stated Resident # 1 normally would strip and take his clothes off but was not inappropriate with staff or other residents.

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On 1/16/2019 at 7:22 AM, an interview was conducted with CNA A in person. CNA A had already talked with the surveyor via telephone on 1/15/2019. CNA A demonstrated what occurred. CNA A reiterated that she was returning from her smoke break when she witnessed the incident. CNA A stated she typically checks the rooms as she walks past them throughout the night and that the other CNAs do the same. CNA A stated "we look as we walk the halls." CNA A stated she yelled for Resident # 1 to stop and tried to pull his arm but he resisted her. CNA A stated she honestly couldn't remember what happened next because it was a fog. Stated she didn't remember if she ran into the hallway and to the desk to get help or if she stood in the doorway and called for help. CNA A stated she knew kept saying "come, come" CNA A stated she was shocked by what she saw and that she never would have imagined Resident # 1 "would do something like that."

On 1/16/2019 at 7:20 AM, an interview with CNA B who stated she completed rounds on the Memory Care Unit on 1/4/2019 at 3:15 AM. CNA B stated she was alerted by CNA A that Resident # 1 was out of his bed, naked and in the bed with Resident # 2. CNA B stated she witnessed Resident # 1 sitting of the side of Resident # 2's bed. CNA B stated Resident # 1 was completely naked. Resident # 2 had on a T-Shirt, brief was undone and pulled down. CNA B stated the sheets were bunched up under Resident # 2. CNA B stated she did not witness the Resident # 1 touching Resident # 2. CNA B stated she was very surprised because Resident # 1 had never exhibited any sexually inappropriate behavior. CNA B stated she made rounds regularly and Resident # 1 and Resident # 2 were both in their beds when she made rounds at approximately

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3:15 AM.

On 1/16/2019 at 7:27 AM, an interview was conducted with CNA C who stated she was working the night of 1/4/2019 at 3:45 AM when she saw CNA A telling everybody to come quickly to Resident # 1 and Resident # 2's room. CNA C stated she observed Resident # 1 sitting on the side of Resident # 2's bed. Resident # 1 was naked and Resident # 2 had on a T-Shirt but his brief was off. CNA C stated she did not witness any sexual act. CNA C stated when she did rounds at 3:15 AM, Resident # 1 and Resident # 2 were both in bed. CNA C stated she was shocked by this incident because Resident # 1 "had never done anything like that before."

On 1/16/2019 at 7:32 AM, an interview was conducted with RN A who was the Nurse in Charge on 1/4/2019 at 3:45 AM. RN A stated she was actually assigned to work on the Central Unit adjacent to the Memory Care Unit on that night but also was the Nurse in Charge. RN A stated that LPN B came to her stating that CNA A reported that she witnessed Resident # 1 performing oral sex on Resident # 2. RN A stated she asked her to repeat it because she could not believe it. RN A stated she went to the Room where Residents # 1 and # 2 resided. RN A stated the CNAs were in the room. Resident # 1 was sitting in the chair by the door. RN A stated she told LPN B to move Resident # 2 to another room and to notify the Administrator, Director of Nursing, Responsible Party and doctors. RN A stated she instructed LPN B to also do skin assessments, notify the appropriate people and send to the hospital for evaluation. RN A state she asked CNA A what happened and what made her go into the room. RN A stated was very

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surprised by the allegation because she had never observed any inappropriate behavior exhibited by Resident # 1. RN A stated the entire staff was surprised by the allegation of sexual abuse.

On 1/16/2019 at 12:42 PM, an interview was conducted with the administrator who stated Resident # 1 had been discharged from the facility and would not be returning. The Administrator stated Resident # 1's responsible party called the facility on Friday, 1/11/2019 to inquire if Resident # 1 could return to the facility. The Administrator stated he was not in the office when the Responsible Party called and that he had not had time to return the call yet. The Administrator stated the facility probably would not accept him back at the facility because they have to protect the residents. The Administrator stated this was a first for the facility "We've never had anything like this happen before."

When the surveyor asked for a copy of the discharge policy, the Administrator also stated the facility "does not have a discharge policy but it is on a case by case basis." The Administrator stated he "could write something up right now" if he needed to. The Administrator also stated Resident # 1 "was a _____contract" and that the "facility had an agreement with the Hospital C to send residents to Hospital C if problems arise that could not be handled at the facility." The Administrator stated that since Resident # 1 was under Hospital C's contract and not Medicare or Medicaid, the facility did not have to follow the same guidelines and the facility did not have to take him back.

1/16/2019 at 2:19 PM, attempted to call LPN

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(Licensed Practical Nurse) B who was assigned to the Memory Care Secured Unit on the night of the incident on 1/4/2019. Left message to return call.

1/16/2019 at 2:23 PM, LPN B returned the telephone call and stated she had been employed at the facility for only a little over a month when the incident happened. LPN B stated she was sitting at the nurses station doing chart checks when CNA A came to the desk and stated she just witnessed Resident # 1 performing oral sex on Resident # 2. LPN B stated when she entered the room, she witnessed both residents were naked in Resident # 2's bed. LPN B stated Resident # 1 was sitting on the side of Resident # 2's bed. Resident # 2 was visibly shaking. LPN B stated she asked the CNAs to transfer Resident # 2 to another room. LPN B stated she assessed Resident # 2 and that he stated he was okay. CNAs put clothes on Resident # 2 and moved him to another room that was vacant and closer to the nurses station. LPN B stated she asked Resident # 2 if he was okay and he shook his head "yes". She stated she asked Resident # 2 if he remembered what happened and he stated "someone came in my room, took my diaper off and I don't remember anything else." LPN B stated the CNAs then dressed Resident # 1 and left him in his own room with 1:1 supervision. LPN B stated from the time of the incident until she went home at approximately 9:15 AM, she did not observe Resident # 1 leaving out of his room. When she left, Resident # 1 was lying across his bed and Resident # 2 was at Hospital #A.

LPN B stated she was very surprised at the allegation because she had not encountered any sexually inappropriate behavior by Resident # 1

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since she worked there.

On 1/16/2019 at 3:01 PM, an interview was conducted with (LPN C) the Unit Manager of the Memory Care Secured Unit and the adjacent Central Unit. LPN C stated the Nurse in Charge, RN (Registered Nurse) A called her on 1/4/2019 before 4 AM to report that LPN B had informed her that CNA A reportedly witnessed Resident # 1 performing a sexual act on Resident # 2. LPN C stated she asked her if she was joking to which RN A said no. LPN C confirmed that the residents had been separated and she instructed RN A to make sure all of the appropriate authorities were notified immediately. LPN C stated she told RN A where the forms were located and that the incident needed to be reported to the State Agency within 2 hours. LPN C stated she told RN A to get doctors' orders for both residents to be transferred to the Emergency Room for evaluation. LPN C stated Resident # 1's family gave consent for him to be sent to Hospital # C's Emergency Room. LPN C stated she never felt Resident # 1 was a threat to other residents. LPN C stated she would feel residents were safe if he returned if the doctors had evaluated him to determine why the behavior happened. LPN C stated this behavior was out of character for Resident # 1. LPN C stated the safety of all residents was the priority of the facility.

On 1/16/2019 at 3:45 PM, an interview was conducted with the Assistant Director of Nursing (ADON) who stated she was familiar with Resident # 1 and Resident # 2. The ADON stated she was very surprised to hear about the allegation of Resident # 1 sexually abusing Resident # 2. The ADON stated she never had any indication of any inappropriate behavior by

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F 600	Continued From page 11 Resident # 1. On 1/16/2019 at 4 PM, interview was conducted with the Social Worker (Employee D) who stated she had run Resident # 1's name in the Sex Offender Registry on yesterday (January 15, 2019) and found there was no history. Employee D stated she ran all of the residents' names through the sex offender registry on 1/15/2019 after the surveyor asked for a copy of the results for Resident # 1. Employee D stated none of the residents were listed on the registry. Employee D stated all new residents' names are checked in the registry prior to admission and the facility has a process of automatic notification of any sex offenders in the area. Employee D stated the facility did not already have Resident # 1's results because he was admitted prior to the implementation of that process. Review of Resident #1's Care Plan revealed documentation of Problem Onset: 1/4/2019 Resident displayed inappropriate behavior of a sexual manner to other resident. He was observed with his mouth on another male resident's penis. Goal: Resident will have a decrease in the number of sexual behaviors during the next review. Approaches: Administer medications as ordered by MD (medical doctor) monitor the effectiveness and side effects of medication Remove resident from public areas if behavior demonstrated approach resident about sexual behaviors	F 600		

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Report to physician and representative changes in behavioral status
Reinforce positive behavior
Investigate/monitor need for psychologically/psychiatric support. Provide services if desired by resident /representative and as ordered by physician
One on One supervision until seen by psych services or physician
If reasonable, discuss behavior with resident: explain/reinforce why behavior is unacceptable
Intervene needed to protect the rights and safety of others, approach in a calm manner, divert attention, remove from situation and take another location as needed
Notify appropriate authorities-administrator, APS (Adult Protective Services) State, Police, Family, MD (Medical Doctor)

On 1/16/2019 at 5:40 PM, the police officer returned the call to the surveyor. The officer stated the facility did report the incident and the police responded. The officer stated the facility followed its procedures regarding incidents involving possible abuse. The officer stated he was assigned to follow up on the case. He stated he contacted Adult Protective Services and was informed that the facility had already notified them. The officer stated he spoke with the Forensic Nurse at Hospital B and was told the victim (Resident # 2) would not need services since there was no sign of sexual abuse. A PERK (Physical Evidence Recovery Kit) was not used in this case due to no evidence of abuse. The officer stated Resident # 2 "was very uncooperative due to his diagnosis"

Both Resident # 1 and Resident # 2 were no longer in the facility at the time of the investigation

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F 600	Continued From page 13 of the complaint and unable to be interviewed. Resident # 2 was transferred to another facility by his family. Resident # 1 was discharged from the facility. Resident # 1 had a BIMS of 1 and Resident # 2 had a BIMS of 11. During the end of day debriefing on 1/16/2019 at 3:00 PM, the Administrator, Assistant Director of Nursing, LPN C and LPN B were informed of the findings. The Administrator, ADON and LPN C stated incident was very unexpected. The facility did not anticipate this behavior from Resident # 1. All staff members stated none of them noticed any sexually inappropriate behaviors from Resident # 1 prior to this incident. No further information was provided.	F 600		
F 622 SS=D	Transfer and Discharge Requirements CFR(s): 483.15(c)(1)(i)(ii)(2)(i)-(iii) §483.15(c) Transfer and discharge- §483.15(c)(1) Facility requirements- (i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless- (A) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility; (B) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility; (C) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident; (D) The health of individuals in the facility would otherwise be endangered; (E) The resident has failed, after reasonable and	F 622		2/28/19

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F 622	Continued From page 14	F 622		

appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or
(F) The facility ceases to operate.
(ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose.

§483.15(c)(2) Documentation.
When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider.
(i) Documentation in the resident's medical record must include:
(A) The basis for the transfer per paragraph (c)(1)(i) of this section.
(B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot

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F 622	Continued From page 15 be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s). (ii) The documentation required by paragraph (c)(2)(i) of this section must be made by- (A) The resident's physician when transfer or discharge is necessary under paragraph (c) (1) (A) or (B) of this section; and (B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care. This REQUIREMENT is not met as evidenced by: Based on staff interviews, facility documentation review, clinical record reviews and in the course of a complaint investigation, the facility staff failed to document in the clinical record the reason for a facility initiated transfer and discharge of one resident (Resident # 1) in a survey sample of two residents. For Resident # 1, the facility staff failed to notify the responsible party in writing and document in the clinical record regarding discharge.	F 622	F 622 SS=D Transfer and Discharge Requirements CFR(s): 483.15 (c)(1)(i)(ii)(2)(i)-(iii) This plan of correction constitutes the facilities written allegation of compliance for the deficiencies cited. However, submission of this plan of correction is not an admission that deficiencies exist of that one was cited correctly. The plan of	

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F 622	Continued From page 16 Findings included: Resident # 1 was admitted to the facility on 9/15/2009 and readmitted on 5/18/2015. Diagnoses included but were not limited to: Vascular Dementia, Bipolar II Disorder, Convulsions, Bradycardia, senile degeneration of the brain, Gastroesophageal Reflux Disease, Hypertension, Diabetes Insipidus, Unspecified Psychosis and Kidney Failure. The most recent minimum data set (MDS) assessment was a quarterly assessment with an assessment reference date of 10/16/2018. Resident #1 was coded with a Brief Interview of Mental Status score of "1" out of a possible 15, indicating severe cognitive impairment. Resident # 1 required limited to total extensive assistance of one staff member with activities of daily living, to include bed mobility and transfer. The resident was coded as requiring supervision with ambulation on both on and off units. The resident was coded as always incontinent of bowel and bladder. Review of the clinical record was conducted on 1/15/2019 and 1/16/2019. Review of the Nurses Notes revealed documentation: 1/4/19 12:00 PM Director of Nursing documented that she spoke to (Other C) explained incident and the need for resident to be evaluated. (Other C) stated to send resident to_____(Hospital C) ER (Emergency Room) since ___Hospital A said send to ____ (Hospital B) and Hospital B needed a family escort to evaluate. Resident remains on	F 622	correction is submitted to meet requirements established by federal and state law. With regard to the alleged deficient practice, the facility has taken the following action: 1. Corrective actions(s) accomplished for those residents found to have been affected by the alleged deficient practice. 1-4-19 Resident #1 was discharged from facility 1-5-19 Social Worker spoke with RP in reference to bed hold that we were not going to take resident back due to behavior towards another resident. 1-8-19 discharge notice mailed to RP 2-13-19 discharge notice faxed to ombudsman 2. Identify other residents who have the potential to be affected by the same deficient practice and what corrective action was taken. Facility has identified all residents with a facility initiated transfer or discharge as having potential to be affected by this deficient practice. The Risk Manager/Director of Nursing have audited all facility initiated transfers or discharges for the past 30 days to assure the transfer or discharge is documented in the resident□s medical record and the appropriate information is communicated to the receiving health care institution or provider	

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F 622	Continued From page 17 1:1. ___(transport) contacted for transportation. Family visiting in room, but stated they were unable to transport to hospital but would meet him there. 1/4/19 1 PM- The Director of Nursing (DON) documented that the transportation company arrived to transport resident to ___(Hospital C). The doctor was made aware of the location change from original order. Resident transported via stretcher in no acute distress. Family present. Stated will go to hospital. 1/4/18 (sic) 6:35 PM "Notify DON that __(Hospital C) wants to know can they send resident back to facility. Dr ____want to be called if they can or not. Gave DON Dr. ____# number) and extension to call her." On 1/16/2019 at 11:40 AM, an interview was conducted with the Social Worker who stated the facility did not have a discharge policy. The Surveyor asked for a copy of the Admissions Packet. On 1/16/2019 at 11 55 AM, the Social Worker came to the conference room and stated there was a form called an Interdisciplinary Discharge Summary started on every resident when they leave the facility even if they were admitted to a hospital, discharged to home or other destination. The Social Worker presented a blank copy of the Interdisciplinary Discharge Summary Form for Resident # 1. The Surveyor asked the Social Worker for the Interdisciplinary form for Resident # 1. The Social Worker brought a copy of the Admissions Packet. Review of the Admissions Packet revealed	F 622	3. Measures/systemic changes put in place to ensure this deficient practice does not reoccur: Education was provided to the Nursing Home Administrator, Director of Nursing and Social Services Director per the Regional Nurse regarding facility initiated transfer and discharge Requirements to include that documentation is in the resident□s medical record and appropriate information is communicated to the receiving healthcare facility institution or provider. Education provided to the Licensed nursing staff by the Director of Nursing/Risk Manager regarding facility initiated transfer and discharge Requirements Facility must ensure that the transfer or discharge is documented in the resident□s medical record: Appropriate information is communicated to the receiving health care institution or provider Social Services Director/Risk Manager/Director of Nursing will audit facility- initiated transfers or Discharges for the next 90 days for documentation in the resident□s medical record including basis for transfer/discharge, responsible party notification , appropriate information communicated to the receiving healthcare institution or provider 4. Monitoring of corrective action to ensure the deficient practice does not reoccur:	

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F 622	Continued From page 18 statements on Page 13 Bill of Rights: (P) Admission, Transfer, Discharge Rights 2. Transfer and discharge requirements a. the facility must permit you to remain in the facility and not transfer or discharge you from the facility unless: (i) it is necessary for your welfare and your needs cannot be met in the facility; ..(iii)if the safety of individuals in the facility is endangered (iv) if the health of individuals in the facility would other wise be endangered; on Page 14 Resident Bill of Rights: 3. Documentation a. If the facility transfers or discharges you under any circumstances, the clinical record must be documented. The documentation must be made by: (i) your physician when transfer or discharge is necessary for your welfare and the needs cannot be met by the facility: or (ii) a physician when transfer or discharge is necessary because the health of individuals would otherwise be endangered. 4. Notice before transfer a. the facility must notify you and if known, a family member or legal representative of the transfer or discharge and the reason for the move in writing and in a language and manner you understand; b. record the reason in your clinical record; and c. include in the notice the following: (i) reason for transfer or discharge (ii) the effective date of transfer or discharge	F 622	The Social Services Director/Risk Manager/Director of Nursing will present the audit findings to the QAPI Committee monthly for their review and recommendation if deemed necessary. The findings will be reported to the committee until the committee is satisfied sustainable compliance has been achieved. 5. Complete date 2-28-19	

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(iii) the location to which you are transferred or discharged;
(iv) a statement that you have the right to appeal the action to the state
(v) the name, address, and telephone number of the state long term care ombudsman;
(vii) for nursing facility residents who are mentally(sic) the mailing address and telephone number of the agency responsible for the protection and advocacy of mentally ill individuals.

5. Timing of notice
a. the facility must give a 30 day notice before you are transferred or discharged except as stated above,or if you have not resided in the facility for 30 days and
b. the notice must contain the effective date, reason, the location to which you are transferred or discharged, a reminder that the action of the facility may be appealed to an appropriate agency and the name and address of the State Long term Care Ombudsman.

On 1/16/2019 at 12:42 PM, an interview was conducted with the administrator who stated Resident # 1 had been discharged from the facility and would not be returning. The Administrator stated Resident # 1's responsible party called the facility on Friday, 1/11/2019 to inquire if Resident # 1 could return to the facility. The Administrator stated he was not in the office when the Responsible Party called and that he had not had time to return the call yet. The Administrator stated the facility probably would not accept him back at the facility because they have to protect the residents. The Administrator stated this was a first for the facility "We've never had anything like this happen before."

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While the Surveyor was looking through the clinical record and Admissions packet along with the Administrator and Assistant Director of Nursing in the conference room, LPN A came in and stated she needed the clinical record to document information on a form. LPN A had an Interdisciplinary Discharge Summary Form with the top two sections (Recapitulation of Resident's Stay and Social Services) were filled out by the Social Worker and dated 1/5/2019. On the back of the form under additional comments was documentation dated 1/5/19 which stated " ___ (Resident # 1) sent to ____(Hospital C) for eval (evaluation R/t (Related to) inappropriate sexual behavior exhibited toward roommate. Per DON (Director of Nursing) he cannot return to facility."

LPN A stated she had just been given the form to complete. The Nursing Services Section, Dietary Status, Activities and Rehab Services Sections were not completed.

The clinical record was returned to the surveyor along with the completed Interdisciplinary Discharge Summary Form. Information in Nursing Services Section, Dietary Status, Activities and Rehab Services Sections were completed and dated 1/16/19 in each of those sections.

Further review of the clinical record revealed no documentation by the physician regarding the discharge. The most recent Physician's Progress note was dated 12/23/18. There were no other notes from the physician in the clinical record.

On 1/16/2019 at 3:34 PM, spoke with Hospital C's Contract Nursing Home representative (Other C) who stated she had been informed that a staff

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member found (Resident # 1) in his room performing a sexual act on his roommate. Other C stated she spoke with the Director of Nursing and asked about the facility's protocol. Other C stated she advised the Director of Nursing to follow the facility's protocol, and if the resident was assessed by a nurse or physician or the emergency department and deemed unsuitable for the facility, the Hospital # 3 would evaluate him.

Other C stated she did hear from Hospital C's Social Worker that Resident # 1 could not return to the facility. Other C stated Resident # 1 was currently residing at Hospital C's Community Living Center. Other C stated it was hard to find placement for residents with those behaviors. Other C stated Resident # 1 and his family have ties to the Emporia area and she hoped he would be able to return to the facility. Other C stated she understood "the facility is in a tough situation because they have to protect other residents too."

Further review of the clinical record revealed no documentation of written notice of discharge to the Responsible Party.

On 1/16/2019 at 4:45 PM during the end of day debriefing, the Administrator, Assistant Director of Nursing, Unit Manager on Memory Care Unit, Ombudsman, and Nursing Supervisor were informed of the findings.

On 1/16/2019 at 4:50 PM, the Social Worker presented a copy of a "Facility Transfer/Discharge Notice" with a handwritten note in the upper left corner which read "mailed 1/8/19 to ____(Resident # 1's Responsible Party's name and address." The notice stated "This is to notify

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F 622	Continued From page 22 you that you are being transferred/discharged on 1/4/19 to the below noted location. The reason for this transfer/discharge is behaviors" Your physician has written an order for us to send you to the hospital listed below (Hospital C)" There was also a form "Notice of Bed Hold Policy" dated 1/5/19 with a handwritten note by the Social Worker which stated Resident # 1 was "not allowed to return due to behaviors towards another resident-safety issues." On the bottom of the form under "Bed Hold Agreement, on the signature line, the form was signed by the Social worker and dated on 1/5/19 with a note "spoke with ____Resident # 1's Responsible Party on the telephone. Underneath that signature, on the line for Signature/Title-Facility Official , the form was signed by the Social Worker and dated on 1/5/19. When the surveyor asked where this form was located in the clinical record and why it had not been given to the surveyor sooner when staff was first asked about information about the discharge, the Social Worker stated the form was not in Resident # 1's clinical record but was in her office. The Social Worker apologized and stated she just remembered the form when the surveyor talked about it again in the debriefing. No further information was provided.	F 622		
F 623 SS=D	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and	F 623		2/28/19

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the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman.
(ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and
(iii) Include in the notice the items described in paragraph (c)(5) of this section.

§483.15(c)(4) Timing of the notice.
(i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged.
(ii) Notice must be made as soon as practicable before transfer or discharge when-
(A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section;
(B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;
(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;
(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or
(E) A resident has not resided in the facility for 30 days.

§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495375	A. BUILDING _____ B. WING _____	C 01/16/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMPORIA MANOR LLC	200 WEAVER AVENUE EMPORIA, VA 23847

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 623	Continued From page 24 (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available.	F 623		

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F 623	Continued From page 25 §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on staff interview, facility documentation review and clinical record review and in the course of an investigation of a complaint, the facility staff failed to provide written notice of a facility initiated discharge and failed to notify the ombudsman of that discharge for one resident (Resident # 1) in a survey sample of 2 residents. For Resident # 1,the facility staff failed to notify in writing the Resident Representative of a facility initiated discharge as soon as it was determined that he could not return. Resident # 1 was discharged to the hospital on 1/4/2019, however the Resident Representative was not mailed a written notice of discharge until 1/8/2019. In addition, the discharge notice did not provide the name, address and telephone number of the Ombudsman. For Resident #1 the facility failed to notify the ombudsman of a discharge on 1/4/2019. The findings Included: Resident # 1 was admitted to the facility on 9/15/2009 and readmitted on 5/18/2015. Diagnoses included but were not limited to:	F 623	F 623 SS=D Notice Requirements Before Transfer/Discharge CFR(s): 483.15 (c)(3)-(6)(8) This plan of correction constitutes the facilities written allegation of compliance for the deficiencies cited. However, submission of this plan of correction is not an admission that deficiencies exist of that one was cited correctly. The plan of correction is submitted to meet requirements established by federal and state law. With regard to the alleged deficient practice, the facility has taken the following action: 1. Corrective actions(s) accomplished for those residents found to have been affected by the alleged deficient practice. 1-4-19 Resident #1 was discharged from facility 1-5-19 Social Worker spoke with RP in reference to bed hold that we were not going to take resident back due to behavior towards another resident	

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F 623	Continued From page 26 Vascular Dementia, Bipolar II Disorder, Convulsions, Bradycardia, senile degeneration of the brain, Gastroesophageal Reflux Disease, Hypertension, Diabetes Insipidus, Unspecified Psychosis and Kidney Failure. The most recent minimum data set (MDS) assessment was a quarterly assessment with an assessment reference date of 10/16/2018. Resident #1 was coded with a Brief Interview of Mental Status score of "1" out of a possible 15, indicating severe cognitive impairment. Resident # 1 required limited to total extensive assistance of one staff member with activities of daily living, to include bed mobility and transfer. The resident was coded as requiring supervision with ambulation on both on and off units. The resident was coded as always incontinent of bowel and bladder. Review of the clinical record was conducted on 1/15/2019 and 1/16/2019. Review of nurses notes revealed documentation 1/4/19 12:00 PM Director of Nursing documented that she spoke to (Other C) explained incident and the need for resident to be evaluated. (Other C) stated to send resident to_____(Hospital C) ER (Emergency Room) since ___Hospital A said send to ____ (Hospital B) and Hospital B needed a family escort to evaluate. Resident remains on 1:1. ___(transport) contacted for transportation. Family visiting in room, but stated they were unable to transport to hospital but would meet him there. 1/4/19 1 PM- The Director of Nursing (DON) documented that the transportation company	F 623	1-8-19 Discharge notice mailed to RP 2-13-19 discharge noticed faxed to ombudsman 2. Identify other residents who have the potential to be affected by the same deficient practice and what corrective action was taken. Facility has identified all residents with a facility initiated transfer or discharge as having potential to be affected by this deficient practice. The Risk Manager /Director of Nursing have audited all facility initiated transfer or discharges for the past 30 days to assure the transfer or discharge is documented in the resident□s medical record and the appropriate information is communicated to the receiving healthcare institution or provider 3. Measures/systemic changes put in place to ensure this deficient practice does not reoccur: Education was provided to the Nursing Home Administrator , Director of Nursing and Social Services Director per the Regional Nurse regarding facility initiated transfer or discharge requirements and to include documentation in the resident□s medical record and appropriate information is communicated to the receiving healthcare facility institution or provider. Education provided to the Licensed nursing staff by Director of Nurses /Risk Manager regarding facility initiated transfer/discharge requirements: facility	

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F 623	Continued From page 27 arrived to transport resident to ___(Hospital C). The doctor was made aware of the location change from original order. Resident transported via stretcher in no acute distress. Family present. Stated will go to hospital. 1/4/18 (sic) 6:35 PM "Notify DON that __(Hospital C) wants to know can they send resident back to facility. Dr ____want to be called if they can or not. Gave DON Dr. ____# number) and extension to call her." On 1/16/2019 at 12:42 PM, an interview was conducted with the administrator who stated Resident # 1 had been discharged from the facility and would not be returning. The Administrator stated Resident # 1's responsible party called the facility on Friday, 1/11/2019 to inquire if Resident # 1 could return to the facility. The Administrator stated he was not in the office when the Responsible Party called and that he had not had time to return the call yet. The Administrator stated the facility probably would not accept him back at the facility because they have to protect the residents. The Administrator stated this was a first for the facility "We've never had anything like this happen before." While the Surveyor was looking through the clinical record and Admissions packet along with the Administrator and Assistant Director of Nursing in the conference room, LPN A came in and stated she needed the clinical record to document information on a form. LPN A had an Interdisciplinary Discharge Summary Form with the top two sections (Recapitulation of Resident's Stay and Social Services) were filled out by the Social Worker and dated 1/5/2019. On the back of the form under additional comments was	F 623	must ensure that the transferor discharge is documented in the resident□s medical record: appropriate information is communicated to the receiving health care institution or provider Social Services Director/Risk Manager/Director of Nursing will audit all facility-initiated discharges or transfers for the next 90 days for documentation in the resident□s medical record □ including basis for transfer /discharge , responsible party notification, appropriate information communicated to the receiving healthcare institution or provider 4. Monitoring of corrective action to ensure the deficient practice does not reoccur: The Social Services Director/Risk Manager/Director of Nursing will present the audit findings to the QAPI Committee monthly for their review and recommendation if deemed necessary. The findings will be reported to the committee until the committee is satisfied sustainable compliance has been achieved. 5. Complete date: 2-28-19	

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F 623	Continued From page 28	F 623		

documentation dated 1/5/19 which stated " ___ (Resident # 1) sent to ____(Hospital C) for eval (evaluation R/t (Related to) inappropriate sexual behavior exhibited toward roommate. Per DON (Director of Nursing) he cannot return to facility."

The clinical record was returned to the surveyor along with the completed Interdisciplinary Discharge Summary Form. Information in Nursing Services Section, Dietary Status, Activities and Rehab Services Sections were completed and dated 1/16/19 in each of those sections.

On 1/16/2019 at 3:34 PM, an interview was conducted with Hospital C's Contract Nursing Home representative (Other C) who stated she had been informed that a staff member found (Resident # 1) in his room performing a sexual act on his roommate. Other C stated she spoke with the Director of Nursing and asked about the facility's protocol. Other C stated she advised the Director of Nursing to follow the facility's protocol, and if the resident was assessed by a nurse or physician or the emergency department and deemed unsuitable for the facility, the Hospital # 3 would evaluate him.

Other C stated she did hear from Hospital C's Social Worker that Resident # 1 could not return to the facility. Other C stated Resident # 1 was currently residing at Hospital C's Community Living Center. Other C stated it was hard to find placement for residents with those behaviors. Other C stated Resident # 1 and his family have ties to the Emporia area and she hoped he would be able to return to the facility. Other C stated she understood "the facility is in a tough situation because they have to protect other residents too."

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F 623	Continued From page 29	F 623		

Further review of the clinical record revealed no documentation of written notice of discharge to the Responsible Party.

On 1/16/2019 at 4:45 PM during the end of day debriefing, the Administrator, Assistant Director of Nursing, Unit Manager on Memory Care Unit, Ombudsman, and Nursing Supervisor were informed of the findings.

On 1/16/2019 at 4:50 PM, the Social Worker presented a copy of a "Facility Transfer/Discharge Notice" with a handwritten note in the upper left corner which read "mailed 1/8/19 to ____(Resident # 1's Responsible Party's name and address." The notice stated "This is to notify you that you are being transferred/discharged on 1/4/19 to the below noted location. The reason for this transfer/discharge is behaviors" Your physician has written an order for us to send you to the hospital listed below (Hospital C)"

There was also a form "Notice of Bed Hold Policy" dated 1/5/19 with a handwritten note by the Social Worker which stated Resident # 1 was "not allowed to return due to behaviors towards another resident-safety issues." On the bottom of the form under "Bed Hold Agreement, on the signature line, the form was signed by the Social worker and dated on 1/5/19 with a note "spoke with ____Resident # 1's Responsible Party on the telephone. Underneath that signature, on the line for Signature/Title-Facility Official , the form was signed by the Social Worker and dated on 1/5/19.

When the surveyor asked where this form was located in the clinical record and why it had not been given to the surveyor sooner when staff was

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F 623	Continued From page 30 first asked about information about the discharge, the Social Worker stated the form was not in Resident # 1's clinical record but was in her office. The Social Worker apologized and stated she just remembered the form when the surveyor talked about it again in the debriefing. The facility administration was informed of the findings during a briefing on 1/16/2019 at 3:00 PM. No further information was presented by the facility.	F 623		