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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CENTER HEALTH AND REHABILITATION	188 OLD FINCASTLE ROAD FINCASTLE, VA 24090

(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 02/12/19 through 02/14/19. The facility was in substantial compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities.	E 000		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 02/12/19 through 02/14/19. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirement. One complaint was investigated during the survey. The Life Safety Code survey/report will follow. The census in this 56 certified bed facility was 51 at the time of the survey. The final survey sample consisted of 16 current Resident reviews and 3 closed record reviews.	F 000		
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),	F 583		3/26/19

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

Electronically Signed | 03/18/2019

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F 583	Continued From page 1 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. (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 observation, staff interview and clinical record review, the facility staff failed to provide privacy during wound care for 1 of 19 residents in the survey sample (Resident #37). The findings included: Resident #37 was admitted to the facility on 9/18/18 with the following diagnoses of, but not limited to high blood pressure, neurogenic bladder, anxiety disorder, depression, manic depression and respiratory failure. On the MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 1/10/19 in which the resident was coded as having a BIMS (Brief Interview for Mental Status) score of 15 out of a possible score of 15. Resident #37 was also coded as being totally dependent on 2 or more staff members for dressing, personal hygiene and bathing.	F 583	Kissito Healthcare shares the state's focus on the health, safety and well being of facility residents. Although the facility does not agree with some of the findings and conclusions of the surveyors, we have implemented a plan of correction to demonstrate our continuing effort to provide quality care to our residents. F 583 LPN #1 immediately educated to pull privacy curtain completely around resident and close window blinds prior to providing personal care. Current residents in the center have the potential to be affected.	

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F 583	Continued From page 2 On 02/13/19 at 1:44 pm, the surveyor observed the wound LPN (licensed Practical Nurse) #1 performed wound care on the resident's right and left outer aspects of legs. The privacy curtain was not pulled the whole way around resident and was open. A staff member walked into the room and walked toward B bed in room while dressing change was being performed. In addition, the window blinds were left open and were not closed during this observation. The surveyor notified the DON (director of nursing) of the above documented findings on 2/13/19. The surveyor requested and received a policy titled "Wound Care/Treatments Guidelines". In this policy under the section of "Key Procedural Points", the surveyor noted the following: " ..."3. Privacy must be provided during treatments. The door must be closed and the curtains pulled ..." " The surveyor notified the administrative team of the above documented findings on 2/13/19 at approximately 4 pm in the conference room. No further information was provided to the surveyor prior to the exit conference on 2/14/19.	F 583	The clinical staff will be educated by the Director of Nursing Services/designee on providing privacy for residents during personal care to include pulling curtain all the way around the resident and closing window shades prior to providing care. The Director of Nursing Service/designee will monitor 5 residents for the provision of privacy while care is provided three times weekly The results will be reported to the monthly to the Quality Assurance Committee for review and discussion. Once the Quality Assurance Committee determines the problem no longer exists, audits will be conducted on a random basis. CAO/DON are responsible for implementation of the plan of correction.	
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in	F 684		3/26/19

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F 684	Continued From page 3 accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and clinical record review, the facility staff failed to provide privacy during wound care for 1 of 19 residents in the survey sample (Resident #37). The findings included: Resident #37 was admitted to the facility on 9/18/18 with the following diagnoses of, but not limited to high blood pressure, neurogenic bladder, anxiety disorder, depression, manic depression and respiratory failure. On the MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 1/10/19 in which the resident was coded as having a BIMS (Brief Interview for Mental Status) score of 15 out of a possible score of 15. Resident #37 was also coded as being totally dependent on 2 or more staff members for dressing, personal hygiene and bathing. On 02/13/19 at 1:44 pm, the surveyor observed the wound LPN (licensed Practical Nurse) #1 performed wound care on the resident's right and left outer aspects of legs. The privacy curtain was not pulled the whole way around resident and was open. A staff member walked into the room and walked toward B bed in room while dressing change was being performed. In addition, the window blinds were left open and were not closed during this observation. The surveyor notified the DON (director of nursing) of the above documented findings on 2/13/19. The surveyor requested and received a	F 684	F684 LPN #1 immediately educated to pull privacy curtain completely around resident and close window blinds prior to providing personal care. Current residents in the center have the potential to be affected. The clinical staff will be educated by the Director of Nursing Services/designee on providing privacy for residents during personal care to include pulling curtain all the way around the resident and closing window shades prior to providing care. The Director of Nursing Service/designee will monitor 5 residents for the provision of privacy while care is provided three times weekly The results will be reported to the monthly to the Quality Assurance Committee for review and discussion. Once the Quality Assurance Committee determines the problem no longer exists, audits will be conducted on a random basis. CAO/DON are responsible for implementation of the plan of correction.	

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F 684	Continued From page 4 policy titled "Wound Care/Treatments Guidelines". In this policy under the section of "Key Procedural Points", the surveyor noted the following: " ..."3. Privacy must be provided during treatments. The door must be closed and the curtains pulled ..." " The surveyor notified the administrative team of the above documented findings on 2/13/19 at approximately 4 pm in the conference room. No further information was provided to the surveyor prior to the exit conference on 2/14/19.	F 684		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, clinical record review and facility document review, the facility staff failed to provide proper treatment during a wound care observation for 2 of 19 residents in the survey sample (Resident #26	F 686	F686 LPN #1was educated on proper wound care including wound cleaning practices.	3/26/19

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F 686	Continued From page 5 and Resident #37). The findings included: 1. The wound care nurse did not use proper technique when cleaning Resident #26's wound during wound care observation. Resident #26 was readmitted to the facility on 12/20/18 with the following diagnoses of, but not limited to anemia, high blood pressure, obstructive uropathy, anxiety disorder, depression, manic depression, asthma and respiratory failure. On the quarterly MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 1/1/19 coded the resident as being totally dependent on 2 staff members for dressing, personal hygiene and bathing. During the wound care observation on 2/13/19 at approximately 1:56 pm, the surveyor observed the wound care nurse cleaning the wound going from top to bottom of the wound then using the same 4x4 sponge went back to the top of the wound. The surveyor notified the wound care nurse of the above documented findings on 2/13/19 at approximately 2:30 pm. The wound care nurse stated, "I didn't realize I did that. But you are right; I should had used another clean gauze to clean the wound once I got to the bottom." The surveyor notified the administrative team of the above documented findings on 2/13/19 at approximately 4 pm. The surveyor requested and received the policy titled "Wound Care/Treatments Guidelines". Under "Steps in Procedure ...14. Clean the wound according to	F 686	Current residents in the center who receive wound care have the potential of be affected. Licensed nurses will be educated by the Director of Nursing/designee on proper wound cleaning techniques to include cleaning in a circular motion from the inside out as well as using a single swipe when cleaning from top to bottom. Director of Nursing/Designee will to three random dressing changes weekly to ensure proper dressing change techniques. The results will be reported to the monthly to the Quality Assurance Committee for review and discussion. Once the Quality Assurance Committee determines the problem no longer exists, audits will be conducted on a random basis. CAO/DON are responsible for the implementation of the plan of correction.	

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F 686	Continued From page 6	F 686		

the order. Clean from the center outward ..."

No further information was provided to the surveyor prior to the exit conference on 2/14/19.

2. The facility staff failed to use proper technique when cleaning Resident #37's wound during the wound care observation.

Resident #37 was admitted to the facility on 9/18/18 with the following diagnoses of, but not limited to high blood pressure, neurogenic bladder, anxiety disorder, depression, manic depression and respiratory failure. On the MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 1/10/19 in which the resident was coded as having a BIMS (Brief Interview for Mental Status) score of 15 out of a possible score of 15. Resident #37 was also coded as being totally dependent on 2 or more staff members for dressing, personal hygiene and bathing.

On 02/13/19 at 1:44 pm, the surveyor observed the wound care being performed by the wound care nurse. The wound care nurse cleaned the wound bed by wiping back and forth using a 4x4 gauze. The wound care nurse did not use a circular motion going from the center to the outside edges of the wound.

The surveyor notified the wound care nurse when she was performing wound care she cleaned the wound bed by wiping back and forth with a 4x4 gauze instead of using a circular motion going from the center to the outside edges of the wound.

The surveyor notified the administrative team at approximately 4 pm of the above documented

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F 686	Continued From page 7 findings that occurred during the wound care observation. The surveyor requested and received the policy titled "Wound Care/Treatments Guidelines". Under "Steps in Procedure ...14. Clean the wound according to the order. Clean from the center outward ..." No further information was provided to the surveyor prior to the exit conference on 2/14/19.	F 686		
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced	F 761		3/26/19

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F 761	Continued From page 8 by: Based on observation, staff interview, clinical record review and facility document review, the facility staff failed to properly label and store drugs and biologicals for 2 of 19 and in 2 of 3 medications carts and in the medication storage rooms (Residents #7, and #14, Medication Cart #1, Medication Cart #2 and Medication Storage Room). The findings included: 1. The facility staff failed to have the correct label on Resident #7's Potassium. Resident #7 was admitted to the facility on 9/12/12 with the following diagnoses of, but not limited to anemia, heart failure, high blood pressure, peripheral vascular disease, diabetes and seizure disorder. On the quarterly MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 11/20/18, the resident was coded as having a BIMS (Brief Interview for Mental Status) score of 15 out of a possible score of 15. Resident #7 was also coded for extensive assistance of 1 staff member for dressing, personal hygiene and bathing. During the Medication Administration Observation on 2/13/19 at 8:13 am, the surveyor noted that Resident #7's label on Potassium was not correct according to the physician's orders. The physician's order was for Potassium 10 meq (milliEquivalent) 2 tablets po (by mouth) daily. LPN (Licensed Practical Nurse) #4 administrated Potassium 10 meq 1 tablet. The pharmacy label for Potassium 10 meq 1 tablet po daily. On 2/13/19 at 9:30 am, the surveyor asked LPN	F 761	F761 A “direction change” alert was place on the potassium label for Resident #7. Pharmacy was contacted to send updated medication label. A ‘direction change’ alert was placed on Resident’s #14 oxybutynin labels. Pharmacy was contacted to send updated medication label. Loose unsecured medication tablets for medication cart #1 ad #2 was immediately disposed of. Expired vials of flu vaccine as disposed of from the medication refrigerator in the medication room. Current residents in the center have the potential to be affected. Licensed nursing in the center will be educated by the Director of Nursing/designee on closely checking medication carts for medications that have become dislodged from packaging as well as checking for expired items. In addition, Licensed Nurses will be educated to place an alert on medication labels that do not match current orders and promptly notify the pharmacy to obtain the correct labeling. Director of Nursing Services/Designee will monitor medication carts and medication room three times weekly for loose pills/expired items. The Director of	

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F 761	Continued From page 9 #4 if the pharmacy label was correct according to the current physician's order. LPN #4 reviewed the MAR (Medication Administration Record) and the physician's order for Potassium. LPN #4 stated, "I saw the 10 meq card and pulled the 10 meq and gave it. The order was for 2 tablets." LPN #4 immediately notified the physician and he gave the order for Potassium 20 meq 2 tablets by mouth now. On 2/13/19 at approximately 10 am, the surveyor notified the DON (director of nursing) of the above documented findings. The surveyor requested and received the facility's policy titled "Labeling of Medications". The policy read in part as follows: " ..."10. Only the issuing pharmacy may place a drug label on a medication container. " 11. The pharmacy must be informed of any changes in directions for the use of a drug... At approximately 4 pm, the surveyor notified the administrative team of the above documented findings. No further information was provided to the surveyor prior to the exit conference. 2. The facility staff failed to have the proper pharmacy label on Resident #14's medication. Resident #14 was admitted to the facility on 9/13/18 with the following diagnoses of, but not limited to anemia, heart failure, diabetes, anxiety disorder, depression and respiratory failure. On the quarterly MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 12/10/18, the resident was coded as having a BIMS (Brief Interview for Mental Status) score of 15 out of a	F 761	Nursing Services/designee will also compare medication orders to pharmacy labels for 5 random residents weekly. The results will be reported to the monthly to the Quality Assurance Committee for review and discussion. Once the Quality Assurance Committee determines the problem no longer exists, audits will be conducted on a random basis. CAO/DON are responsible for the implementation of the plan of correction.	

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F 761	Continued From page 10	F 761		

possible score of 15. Resident #14 was also coded as requiring extensive assistance of 1 staff member for dressing and bathing.

During the Medication Administration Observation) on 2/13/19 at 8:30 am, the surveyor noted on the resident's Oxybutynin medication container. The pharmacy label had the following instructions: "Oxybutynin Chloride Tablet 5 mg (milligram) Give 1 tablet by mouth two times a day ..." The surveyor reviewed the physician's order was for this medication to be given 4 times a day.

At 9:30 am, the surveyor notified the DON (director of nursing) of the above documented findings. The DON stated, "We should had called pharmacy to get a new label."

The facility's policy titled "Labeling of Medications", under section "General Guidelines" read in part:
" ..."10. Only the pharmacy may place a drug label on a medication container.
" The pharmacy must be informed of any changes in directions for the use of the drug ..."

At 4 pm, the surveyor notified the administrative team of the above documented findings.

No further information was provided to the surveyor prior to the exit conference.

3. The facility staff failed to store and discard medications that were expired in Medication Cart #1.

The surveyor found the following issues identified top and left hand drawer of Medication Cart #1 on

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F 761	Continued From page 11	F 761		

2/12/19 at 11:04 am:
" (2) white capsules
" (1) small mustard color pill
" (1) (1/2) small pink pill
" Flonase label with the date of being opened was 12/31/18

The surveyor notified the DON of the above documented findings at 11:17 am. The surveyor requested a copy of the facility's policy regarding storage and discarding expired medications. The DON stated, "The Flonase is only good for 30 days after it has been opened.

The surveyor received a policy titled "Storage and Expiration Dating of Medications, Biologicals, Syringes and Needles" which read in part:
" ..."4.1 Have an expiry dates on the label.
" 4.2 Have not been retained longer than recommended by manufacture's guidelines ..."

The surveyor notified the administrative team of the above documented findings on 2/13/19 at approximately 4 pm.

No further information was provided to the surveyor prior to the exit conference on 2/14/19.

4. The facility staff failed to store medications that were in the top left hand of Medication Cart #2.

The surveyor found the following issues identified in Medication Cart #2 left and top hand drawer on 2/12/19 at 10:47 am:
" (1) pink pill
" (2) ½ white pills
" (1) yellow pill
" (1) medium white tablet

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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 761	Continued From page 12	F 761		

The surveyor requested and received the facility's policy titled "The surveyor received a policy titled "Storage and Expiration Dating of Medications, Biologicals, Syringes and Needles" which read in part:
" ..."4.1 Have an expiry dates on the label.
" 4.2 Have not been retained longer than recommended by manufacture's guidelines ..."
"
The surveyor notified the administrative team of the above documented findings on 2/13/19 at approximately 4 pm.

No further information was provided to the surveyor prior to the exit conference on 2/14/19.

5. The facility staff failed to discard expired medications that was in the medication refrigerator located in the Medication Storage room.

On 2/12/18 at 10:40 am, the surveyor found the following issue in the medication refrigerator located in the Medication storage room:

" (1) Opened vial of Influenza Vaccine multi use vial. There was a label on the Flonase, which the staff had documented being opened on 12/28/18.

The surveyor notified the DON of the above documented findings at 10:45 am. The DON stated, "This should be discarded after 30 days".

The surveyor was given the policy titled "Storage and Expiration Dating of Medications, Biologicals, Syringes and Needles" which read in part:
" ..."4.1 Have an expiry dates on the label.
" 4.2 Have not been retained longer than

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	495218	A. BUILDING _____ B. WING _____	C 02/14/2019

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F 761	Continued From page 13 recommended by manufacture's guidelines ..." The surveyor notified the administrative team on 2/13/19 at approximately 4 pm in the conference room. No further information was given to the surveyor prior to the exit conference on 2/14/19.	F 761		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and facility document review, the facility staff failed to ensure the dish machine was in proper working order. The findings included: The facility failed to ensure the dish machine in	F 812	F812 The Maintenance supervisor immediately assessed the dish washer for mechanical issues and adjusted water temperatures to the machine in order to ensure the proper temperature range was attained.	3/26/19

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F 812	Continued From page 14 the dietary department reached the required temperature during the wash cycle. This dish machine was in use at the time of the survey. On 02/12/19 at 10:16 a.m., the surveyor and the dietary director checked the dish machine. The directions located on the side of the dish machine read that a minimum of 120 degrees was required for the wash and rinse cycles. The dietary director began a wash/rinse cycle in the presence of the surveyor the needle of the temperature gauge did not move. The dietary director ran the dish machine through four cycles. The wash temperature never reached the minimum requirement of 120 degrees on any of the wash cycles. The highest wash temperature observed was 116 degrees. This temperature was observed on the fourth wash/rinse cycle. The dietary director stated she would have maintenance check the machine. A review of the temperature logs for February 2019 revealed that the facility staff had documented wash temperatures of less than 120 degrees on 02/01, 02/03, 02/04, 02/05, and 02/06 (110). A temperature of 116 had been recorded on 02/09 and 02/12. All of these temperatures were recorded for the breakfast meal. The directions on the bottom of this form read, "wash/Rinse Temp should be 120 or above." On 02/12/19 at 1:21 p.m., the director of maintenance stated he had checked the dish machine and had increased the temperature on the water tank to 160 degrees and that the outside temperature made a difference on the temperature of the dish machine.	F 812	Current facility residents have potential to be affected. The Director of Dietary services will be educated by the Chief Administrative Officer /designee to monitor dishwasher temperature logs closely to ensure proper temperatures are present and to immediately notify maintenance if temperatures are noted to be out of range. Current dietary staff will be also educated that temperatures must be checked per schedule and if any temperature is outside of the required range, must immediately notify the supervisor. CAO/designee will monitor dish washer temperatures 5 times weekly to ensure minimum temperatures are attained. The results will be reported to the monthly to the Quality Assurance Committee for review and discussion. Once the Quality Assurance Committee determines the problem no longer exists, audits will be conducted on a random basis. CAO/DON are responsible for the implementation of the plan of correction.	

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F 812	Continued From page 15 On 02/12/19 at 1:59 p.m., the maintenance director clarified that he had only adjusted the water to the laundry and dish room. The surveyor rechecked the temperatures after the dish machine had been checked by maintenance the dish machine wash temperature read 136 and the rinse read 140. The administrative staff were notified of the issue regarding the dish machine on 2/13/19 at 2:55 p.m. On 02/14/19 at 9:12 a.m., the regional maintenance director stated he had the contracting company come to the facility and check the dish machine to ensure it was in proper working order and that the dietary staff had a mandatory in-service on 02/13/19 regarding checking and recording dish-machine temperatures. The facility provided the surveyor with the dish machine operation manual. Page 2 of this document included the wash temperature specifications-"WASH...(minimum) 120." No further information regarding this issue was provided to the survey team prior to the exit conference.	F 812		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in	F 842		3/26/19

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F 842	Continued From page 16	F 842		

accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so.

§483.70(i) Medical records.
§483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are-
(i) Complete;
(ii) Accurately documented;
(iii) Readily accessible; and
(iv) Systematically organized

§483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is-
(i) To the individual, or their resident representative where permitted by applicable law;
(ii) Required by Law;
(iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;
(iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.

§483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.

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F 842	Continued From page 17 §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review the facility staff failed to ensure a complete and accurate clinical record for 1 of 19 Residents, Resident #22. The findings included: For Resident #22 the facility staff to ensure a complete PASRR (pre-admission screening and Resident review) form. Resident #22 was admitted to the facility on 09/12/18 and readmitted on 10/24/18. Diagnoses included but not limited to congestive heart failure, hypertension, obstructive uropathy, diabetes mellitus, hyperlipidemia, bipolar disorder, and respiratory failure.	F 842	F842 PASRR for Resident #22 was immediately corrected. An audit was conducted for current residents in the center to ensure their PASRR(s) to ensure completeness/correctness. The Director Social Services will be educated on ensuring PASRRs for residents are completed in its entirety. Director of Nursing Services/Designee will monitor PASRRs for newly admitted residents five times weekly to ensure they are completed in its entirety and ensure	

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F 842	Continued From page 18 The most recent MDS (minimum data set) with an ARD (assessment reference date) of 12/20/18 coded the Resident as 15 of 15 in section C, cognitive patterns. This is a quarterly MDS. Resident #22's clinical record was reviewed on 02/13/19. It contained a level I PASRR form dated 10/24/18, which read in part "2. DOES THE INDIVIDUAL HAVE A CURRENT SERIOUS MENTAL ILLNESS (MI)? (Check 'Yes' only if answers a, b, and c below are 'Yes' ...)". This question was marked as "yes", but neither a, b, or c were marked. This form was completed by the facility SW (social worker). Surveyor spoke with SW on 02/13/19 at approximately 1255. SW stated that she had just forgotten to mark these questions on the form. The concern of the incomplete PASRR was discussed with the administrative team during a meeting on 02/13/19 at approximately 1455. No further information provided prior to exit.	F 842	the PASRR is correct. The results will be reported to the monthly to the Quality Assurance Committee for review and discussion. Once the Quality Assurance Committee determines the problem no longer exists, audits will be conducted on a random basis. CAO/DON are responsible for the implementation of plan of correction.	
F 921 SS=E	Safe/Functional/Sanitary/Comfortable Environ CFR(s): 483.90(i) §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility staff failed to ensure a hazard free environment on 3 of 3 halls.	F 921	F921 Jagged and splintered edges for doors 105, 109, 111, 112, 200, 201, 202, 203,	3/26/19

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F 921	Continued From page 19 The findings included: Numerous entrance/exit doors to Resident rooms were observed with jagged and splintered edges. During initial tour of the facility on 01/12/19 beginning at approximately 10:15 a.m., the surveyors observed numerous entrance/exit doors to the Residents rooms with jagged/splintered edges. These doors were observed by all 3 surveyors and included the entrance/exit doors to rooms 105, 109, 111, 112, 200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 301, 303, 304, 305, and 307. On 02/13/19 at 9:10 a.m., the maintenance director was notified of the jagged/splintered edges on the Residents exit/entrance doors. The maintenance director stated they did a lot of room changes and sometimes they would hit the doorframes with beds. The administrative staff were notified of the splintered/jagged doors during a meeting with the survey team on 2/13/19 at 2:55 p.m. Prior to the exit conference, the facility was observed by the survey team to be repairing the doors. No further information regarding this issue was provided to the survey team prior to the exit conference.	F 921	204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 301, 303, 304, 305, 307 were immediately repaired. The Director of Maintenance completed an audit of facility doors to ensure they were in good repair. The Director of Maintenance will be educated by the Chief Administrative Officer/designee on maintaining a safe/functional environment and the need to immediately address such identified issues. Facility staff educated to assist in identifying such issues and immediately reporting such findings to the Director of Maintenance. CAO/designee will monitor via director observation facility doors twice weekly to ensure the doors are in good repair. The results will be reported to the monthly to the Quality Assurance Committee for review and discussion. Once the Quality Assurance Committee determines the problem no longer exists, audits will be conducted on a random basis. CAO/DON are responsible for implementation of the plan of correction.	