STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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ENVOY OF ALEXANDRIA, LLC	**900 VIRGINIA AVENUE ALEXANDRIA, VA 22302**

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E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 1/23/19 through 1/25/19. The facility was in substantial compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities. No complaint(s) was/were investigated during the survey.	E 000		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 01/23/19 through 01/25/19. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. The census in this 111 certified bed facility was 95 at the time of the survey. The survey sample consisted of 28 current Resident reviews and three closed record reviews.	F 000		
F 557 SS=D	Respect, Dignity/Right to have Prsnl Property CFR(s): 483.10(e)(2) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(2) The right to retain and use personal possessions, including furnishings, and clothing, as space permits, unless to do so would infringe upon the rights or health and safety of other residents. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview facility document review and clinical record review, it was determined that facility staff failed to ensure care and services were provided	F 557	1. Social Worker facilitated clothing to be brought from home for Resident #20. Resident declined to wear the clothes at this time. Care plan and medical record	3/5/19

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed — TITLE — (X6) DATE: 02/14/2019

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

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in a manner to promote respect and dignity for one of 31 residents in the survey sample, Resident #20.

The facility staff failed to promote Resident # 20's dignity by assessing the residents preference for and obtaining her own personal clothing.

The findings include:

Resident # 20 was admitted to the facility on 10/31/18 with diagnoses that included but were not limited to: multiple sclerosis (1), dysphonia (2), breast cancer, atrial fibrillation (3), and dysphagia (4).

Resident # 20's most recent comprehensive MDS (minimum dada set) an admission assessment with an ARD (assessment reference date) of 11/07/18 coded the resident as scoring a 14 on the brief interview for mental status (BIMS) of a score of 0 - 15, 14 being cognitively intact for daily decision-making. Resident # 20 was coded as requiring extensive assistance of one staff member for activities of daily living and independent with eating. Section H "Bladder and Bowel" coded Resident # 20 as "Always incontinent" of urine and "Frequently incontinent" of bowel.

On 01/2419 at approximately 4:00 p.m. during an observation and conversation conducted with Resident # 20, revealed Resident # 20 sitting in her wheelchair in her room, next to her bed and in front of the wardrobe. Resident # 20 was wearing two hospital gowns, one place front to back and the second gown was placed on Resident # 20 back to front. Resident # 20 was appropriately covered. During the conversation with Resident #

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updated to reflect resident□s preferences.

OSM #2 re-educated by Director of Nursing regarding assisting residents with obtaining clothing and personal belongings upon admission to facility.

OSM #2 re-educated by Director of Nursing to document in the medical record and care plan any resident□s refusal to bring personal items or preference to wear a facility gown.

2. Residents in the facility were interviewed and observed between 1/28/19-1/31/19 to ensure they had access to clothing and personal items. Residents without personal items were assisted by the Social Worker in obtaining items
from the community. Residents who declined to wear clothing or bring personal items to facility were documented on and care plans updated.

3. Director of Nursing re-educated Social Worker regarding obtaining clothing and personal items for residents in the facility. Director of Nursing re-educated Social Worker
regarding documenting in the medical record and care plan,any refusals to wear clothing or bring personal items.

Nursing staff re-educated about notifying Social Worker or DON about any residents who do not have clothing or personal items upon admission. Nursing

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F 557	Continued From page 2 20, she stated that she did not have any of her own clothes. Resident # 20 was then asked by this and another female surveyor for permission to look inside her wardrobe. Observation of the wardrobe for Resident # 20 revealed it contained one large cabinet for hanging clothes. Below the cabinet section of the wardrobe, were two drawers. Observation of the inside of the two drawers failed to evidence any type of clothing. Observation of the inside of the cabinet of the wardrobe revealed one pair of women's slacks and a shirt on a hanger. On the bottom of the cabinet under a package of adult incontinent briefs, were another pair of women's slacks and a shirt. Further observation revealed a holiday gift bag containing a new woman's flannel nightgown that still had the store tag on it. Further observation of the flannel nightgown revealed it was too large for Resident # 20 to wear. An observation of the two pairs of woman's slacks and shirts failed to evidence Resident # 20's name inside the clothing. When Resident # 20 was shown the slacks and shirts Resident # 20 stated, "Those are not mine." When asked about her personal clothing Resident # 20 stated that she had clothes at her home. When asked what clothing she had been wearing since her admission on 10/31/18, Resident # 20 stated she had been wearing the hospital gowns. When asked if the facility staff attempted to obtain her own clothing Resident # 20 stated no. When asked if she had family that could obtain her clothes from her home, Resident # 20 stated that she had a daughter but her daughter lived in "(Name of another State). Resident #20 stated that she had an older "gentleman friend" who had access to her home who could get her some clothes. When asked if the facility had contacted her daughter or the "gentleman friend" about her	F 557	staff re-educated about notifying Social Worker or DON about any residents who wish to remain in a hospital gown. 4. Executive Director, or designee, to conduct Quality Monitoring Review of sample of 10 residents to determine personal clothing status, weekly for four weeks, bi-weekly for two weeks, then monthly. Follow up based on findings. Findings to be reported to QAPI Committee monthly and updated as indicated. Quality Monitoring schedule to be modified based on findings.	

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clothing, Resident # 20 stated that she didn't know. When asked how she felt about wearing hospital gowns all the time especially when she went out of her room Resident # 20 stated, "I try not to think about it."

Review of the facility's "Inventory of Personal Effects" dated 10/31/18 for Resident # 20 documented, "Clothing / Personal Affects: Dresses - 1 (one), Nightgowns - 1 (one), Glasses - 1(one) and Slippers - 1(one)."

The facility's "Occupational Therapy Initial Evaluation" dated "11/1/2018" documented, "Long-Term Goals: #1.0 Patient will safely perform Lower Body bathing routine seated in shower with supervision with assisted devices based on improved strength and functional activity tolerance. #2.0 Patient will safely perform LB (lower body) dressing routine seated in bed with supervision with based on improved functional activity tolerance, strength and dynamic sitting balance. #3.0 Patient will perform toileting routine seated in bathroom with supervision with assisted devices based on improved strength and functional activity tolerance."

The comprehensive care plan for Resident # 20 dated 11/08/2018 documented, "Focus: (Resident # 20) has an ADL (activities of daily living) self-care performance deficit r/t (related to) MS (multiple sclerosis), w/c (wheelchair) bound." Under "Interventions", it documented, "DRESSING: Assist (Resident # 20) to choose simple comfortable clothing that enhances the resident's ability to dress self. Assist as needed. Encourage independence. Date initiated: 11/08/2018." Further review of the Comprehensive care plan failed to evidence

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documentation of Resident # 20's choice to wear hospital gowns.

On 01/24/19 at approximately 4:34 p.m., an interview was conducted with OSM (other staff member) # 2, social worker. When asked to describe the procedure to ensure a resident has clothes, OSM # 2 stated, "They are provided by the family on admission. If they come from the hospital we reach out to the family for clothes." When asked if a resident should live in a hospital gown for months on end, OSM # 2 stated, "No." When asked if he was aware that Resident # 20 did not have any of her own personal clothing, OSM # 2 stated, "She does not have family in the area, the daughter lives and works out of state. We provide donated clothes." When asked if he contacted Resident# 20's daughter regarding Resident # 20's personal clothing, OSM # 2 stated, "I'll have to check." When asked if he had spoken to Resident # 20 about what type of clothes she would like to have, OSM # 2 stated, "No."

On 01/25/19 at 8:25 a.m., an interview was conducted with OSM # 1, business development coordinator. OSM # 1 stated that she is responsible for admissions. When asked if she talked to new residents being admitted about clothing, OSM # 1 stated, "Not specifically but I do tell them that they can bring their own clothing." When asked if she was part of the admission process for Resident # 20, OSM # 1 stated, "Yes I was. She was admitted from the hospital. (Resident # 20) never mentioned anything to me about her clothes." When asked who was responsible for ensuring residents had proper clothing available, OSM # 1 stated, "I believe it is social services."

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F 557	Continued From page 5 On 01/25/19 at 8:35 a.m., an interview was conducted with OSM # 2, social worker. When asked if he had any more information about obtaining clothes for Resident # 20, OSM # 2 stated, "I did speak to the daughter regarding (Resident # 20's) clothing." When asked if it was documented, OSM # 2 stated no. OSM # 2 further stated, "Rehab (Rehabilitation department) had offered her clothes when she got in here (when resident was admitted)." When asked if there was documentation of the rehabilitation department offering Resident # 20 clothing, OSM # 2 stated, "No." A section of the facility's "Resident Rights" policy was reviewed and discussed with OSM # 2. The section "Dignity and Self-Determination" documented, "You have the right to: Be treated with consideration, respect, and full recognition of your dignity and individuality. Receive reasonable accommodation of your individual needs and preferences, except when your health and/or safety or the health and/or safety of others would be endangered. Make choices about aspects of your life that are significant to you. Keep and use your personal possessions, as space permits, unless doing so would infringe on the rights, health and/or safety of other residents." When asked if these rights for Resident # 20 were up held to promote her dignity, OSM # 2 stated, "No but she never initiated anything about her clothes." When asked if it was Resident # 20's responsibility or his responsibility to initiate the conversation concerning Resident # 20's adequate and appropriate clothing, OSM # 2 stated, "I don't know." A section of the facility's policy and procedures for "Social Services" was reviewed and discussed with OSM # 2. The policy documented, "Policy: Medically-related	F 557		

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social services will be provided to attain or maintain the highest practical physical, mental, and psychosocial well-being of each resident." Under "Procedure" it documented, "2. Social Service personal will identify the medically related social and emotional needs of resident and their families and provide for those needs by: a. Making arrangements for obtaining clothing and personal items that may be necessary; g. Identifying and seeking ways to support a resident's individual needs and preferences; h. Building relationships between residents and staff, teaching staff how to understand and support residents' needs, dignity and self-image." When asked if those responsibilities were followed OSM # 2 stated, "No." When asked if he contacted Resident # 20's daughter yesterday (01/24/19) after our conversation OSM #2 stated, "No." OSM # 2 further stated that he did contact the friend of Resident # 20 to see if he could go to the resident's home to obtain some of her clothes. OSM # 2 stated, "There was no answer last night so I'm going call again today."

On 01/25/19 at 9:15 a.m., an interview was conducted with OSM # 5, occupational therapist. When asked about Resident # 20 receiving therapy OSM # 5 stated, "I work with (Resident # 20). We picked her up on caseload on 11/01/18." When asked what they worked on, OSM # 5 stated, ADLs (activities of daily living) which included dressing, showering and toileting." When asked about Resident # 20's clothing for the dressing therapy goal, OSM # 5 stated, "We offered her clothes from the donated clothes the facility has. She used them for practicing her dressing skills. When asked if Resident # 20 ever requested clothes from her home OSM # 5 stated, "I don't recall."

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On 01/25/19 at 10:51 a.m., an interview was conducted with ASM (administrative staff member) # 2, director of nursing. When asked about Resident # 20 not having personal clothing, ASM #2 stated that it should have been followed up. ASM # 2 further stated, "There was nothing documented until last evening regarding Resident # 20's preference of having her own clothing." ASM # 2 then provided this surveyor with a revised comprehensive care plan for Resident # 20 dated 01/24/2019.

The comprehensive care plan for Resident # 20 dated 11/08/2018 with a revision date of 01/24/2019 documented, "Focus: (Resident # 20) has an ADL (activities of daily living) self-care performance deficit r/t (related to) MS (multiple sclerosis), w/c (wheelchair) bound. Wears only Hosp. (hospital) gowns declines to wear any other clothes but her own from her house. Revision on: 01/24/2019." "Under "Interventions" it documented, "Offer to buy new clothes when unable to obtain from house. Resident declined. Date initiated: 01/24/2019."

On 01/25/19 at approximately 1:00 p.m. ASM (administrative staff member) # 1 the executive director, ASM # 2, director of nursing, were made aware of the findings.

No further information was provided prior to exit.

References:
(1) A nervous system disease that affects your brain and spinal cord. It damages the myelin sheath, the material that surrounds and protects your nerve cells. This damage slows down or blocks messages between your brain and your

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body, leading to the symptoms of MS. They can include visual disturbances, muscle weakness, trouble with coordination and balance, sensations such as numbness, prickling, or "pins and needles" and thinking and memory problems. This information was obtained from the website: https://medlineplus.gov/multiplesclerosis.html.

(2) Difficulty speaking due to spasms (dystonia) of the muscles that control the vocal cords. This information was obtained from the website: https://medlineplus.gov/ency/article/000753.htm.

(3) A problem with the speed or rhythm of the heartbeat. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/atrialfibrillation.html.

(4) A swallowing disorder. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/swallowingdisorders.html.

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F 622 SS=D	Transfer and Discharge Requirements CFR(s): 483.15(c)(1)(i)(ii)(2)(i)-(iii)	F 622		3/5/19

§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;

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

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F 622	Continued From page 10 (i) Documentation in the resident's medical record must include: (A) The basis for the transfer per paragraph (c)(1)(i) of this section. (B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s). (ii) The documentation required by paragraph (c)(2)(i) of this section must be made by- (A) The resident's physician when transfer or discharge is necessary under paragraph (c) (1) (A) or (B) of this section; and (B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, and clinical record review, it was determined that facility staff failed to meet the appropriate transfer requirements for 6 of 31 residents in the survey sample; Resident #39,	F 622	1. Residents #39, 32, 54, 29, 61, and 77 returned to the facility from the acute care hospital. LPN #7 and #8 were re-educated by the	

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F 622	Continued From page 11 #32, #54, #29, #61, and #77. 1. Resident #39 was transferred to the hospital on 10/31/13, the facility staff failed to evidence physician required documentation regarding the facility initiated hospital transfer and failed to evidence the residents comprehensive care plan goals was sent to the receiving facility. 2. Resident #32 was transferred to the hospital on 10/1/18, the facility staff failed to evidence physician required documentation regarding the facility initiated hospital transfer and failed to evidence the residents comprehensive care plan goals was sent to the receiving facility. 3. Resident # 54 was transferred to the hospital on 10/23/2018, facility staff failed to evidence that comprehensive care plan goals were sent with and provided to the receiving hospital for the resident's facility initiated transfer to the hospital. 4. The facility staff failed to evidence that comprehensive care plan goals were sent with the Resident #29 to the receiving hospital for the facility initiated transfer dated 10/30/2018. 5. Resident #61 was transferred to the hospital on 11/16/18, the facility staff failed to evidence the residents comprehensive care plan goals was sent to the receiving facility and failed to evidence physician required documentation regarding the facility initiated hospital transfer. 6. Resident #77 was transferred to the hospital on 11/01/18, the facility staff failed to evidence the	F 622	Director of Nursing regarding ensuring comprehensive care plan with goals is sent to the receiving facility upon transfer or discharge. 2. Director of Nursing, or designee, reviewed discharges from 1/18/19-1/25/19 to verify that care plans were sent to the receiving facility upon transfer. Follow-up based on findings. Director of Nursing, or designee, reviewed discharges from 1/18/19-1/25/19 to verify physician□s documentation addressed the specific need the facility could not meet, facility'□s efforts to meet those needs, and specific services the receiving facility will provide to meet the needs of the resident. Follow-up based on findings. 3. Director of Nursing, or designee, re-educated the attending physicians regarding required documentation upon transfer or discharge from the facility. Director of Nursing, or designee, re-educated Medical Records Coordinator about the physician required documentation following a transfer or discharge of a resident. Director of Nursing, or designee, re-educated Licensed Nursing Staff about sending the comprehensive care plans with goals to the receiving facility upon transfer/discharge. 4. Director of Nursing, or designee, to conduct Quality Monitoring Review of	

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residents comprehensive care plan goals was sent to the receiving facility and failed to evidence physician required documentation regarding the facility initiated hospital transfer.

The findings include:

1. Resident #39 was transferred to the hospital on 10/31/13, the facility staff failed to evidence physician required documentation regarding the facility initiated hospital transfer and failed to evidence the residents comprehensive care plan goals was sent to the receiving facility.

Resident #39 was admitted to the facility on 3/27/18 with the diagnoses of but not limited to stroke, high blood pressure, diabetes, heart disease, heart failure, urinary retention, retinopathy, blindness, heart attack, benign prostatic hyperplasia, and chronic kidney disease. The most recent MDS (Minimum Data Set) was a significant change assessment with an ARD (Assessment Reference Date) of 11/27/18. The resident was coded as being cognitively intact in ability to make daily life decisions.

A nurse's note dated 10/31/18 documented, "Res (resident) alert, oriented yet slow to response {sic}. Reported not eating. PO (oral) fluids intakes encouraged. (Illegible) family member are at the bedside visiting with res. Social worker spoke with family regarding res situation of not eating and declining in progress. Order to transfer res to (illegible) ER (emergency room) hospital per family member given - MD (medical doctor) aware...."

The resident was readmitted on 11/9/18. A

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physician required documentation upon transfer/discharge to verify that all elements are present, weekly for four weeks, bi-weekly for two weeks, then monthly.

Director of Nursing, or designee, to conduct Quality Monitoring Review of nursing documentation to ensure comprehensive care plan was sent with resident to receiving facility upon transfer/discharge and it is reflected in the medical record, weekly for four weeks, bi-weekly for two weeks, then monthly. Follow-up based on findings. Findings to be reported to QAPI Committee monthly and updated as indicated. Quality Monitoring schedule to be
modified based on findings.

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physician's progress note, dated 11/11/18 documented, "Readmission note...Bacteremia / septicemia...." The note did not specifically document:
o The specific resident needs the facility could not meet;
o The facility efforts to meet those needs; and
o The specific services the receiving facility will provide to meet the needs of the resident which cannot be met at the current facility.

In addition, upon further review of the clinical record, there was no evidence that the comprehensive care plan goals were provided to the receiving hospital when the resident was transferred on 10/31/18.

On 1/24/19 at 3:43 p.m., ASM #2 (Administrative Staff Member - the Director of Nursing - DON), when presenting a POC (plan of correction) the facility implemented regarding admission/transfer/discharge regulation requirements, which had an effective date of completion of 12/3/18. It was noted that requirements for physician documentation and requirements related to what information is to be provided to the receiving hospital (both requirements for F622) was not addressed in the POC. ASM #2 stated the POC covered regulations at F623, F624, and F625. When asked if the POC covered the requirements for F622, she stated no.

On 1/25/19 at 8:43 a.m., in an interview with LPN #7, she stated that when a resident is sent to the hospital, the facility sends the transfer paper, list of meds, history and physical, telephone order, most recent labs, most recent progress notes, and the transfer paper includes mobility, adl's

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(activities of daily living), diet, etc. When asked if the comprehensive care plan goals are sent, she stated, "We don't send the care plan. The ADL's and treatments, etc., are all part of the care plan and are on the transfer form." When asked where is it documented what all was sent, she stated in the nurse's notes on the clinical record. When asked about what the doctor should be documenting, she stated they know what is going on, and give the order, so they should be documenting that.

A review of the facility policy, "Discharge of Resident to Home or Other Center" documented, "When the center transfers or discharges a resident under any of the circumstances listed above the facility will 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. Documentation in the medical record to include:
*The basis for the transfer;
*In the case of inability to meet resident needs...;
*The specific resident need(s) that cannot be met,
*The facility's attempts to meet the residents needs,
*And the service available at the receiving facility to meet those need(s).
*The documentation must be made by:
*The resident's physician when the transfer or discharge is necessary due to:
*The resident's welfare and the resident's needs cannot be met in the center....
*Information provided to the receiving provider must include but is not limited to:
*Contact information of the practitioner responsible for the care of the resident

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F 622	Continued From page 15 *Resident representative information including contact information *Advance Directives *Special care instructions or precautions for ongoing care as indicated *Comprehensive care plan goals *All other necessary information, including copies of the resident's discharge summary and other documentation, as applicable to ensure safe and effective transition of care...." On 1/24/19 at 5:30 p.m., at the end of day meeting, the executive director and the Director of Nursing (ASM #1 and #2 respectively - Administrative Staff Member) and ASM #2 were made aware of the findings. No further information was provided by the end of the survey. 2. Resident #32 was transferred to the hospital on 10/1/18, the facility staff failed to evidence physician required documentation regarding the facility initiated hospital transfer and failed to evidence the residents comprehensive care plan goals was sent to the receiving facility. Resident #32 was admitted to the facility on 9/20/18 with the diagnoses of but not limited to alcohol cirrhosis of the liver with ascites, osteoarthritis, high blood pressure, chronic obstructive pulmonary disease, and penile laceration and wound. The most recent MDS (Minimum Data Set) was a quarterly assessment with an ARD (Assessment Reference Date) of 11/20/18. The resident was coded as being cognitively intact in ability to make daily life decisions.	F 622		

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A review of the clinical record revealed a nurse's note dated 10/1/18, which documented, "Resident complained of bleeding to penile area. Penile area assessed. Bright red bleeding. Wound dehisced....wound cleaned with wound cleanser and dry gauze applied to area...." Another nurse's note dated 10/1/18 documented, "(Illegible) MD (medical doctor) of resident status. Resident appt (appointment) for urologist was turned down due to photo ID (identification) by (urologist) office. New orders received from MD to send resident to ER (emergency room) for further eval (evaluation) r/t (related to) penile wound dehised {sic}..."

The resident was readmitted on 10/3/18. A physician's progress note dated 10/3/18 documented, "Readmission Hx/px (history and physical)...Penile ulcer; possible penile trauma...Resident was admitted to (hospital) for penile (illegible) wound - post plastic surgery..."
The note did not specifically document:
o The specific resident needs the facility could not meet;
o The facility efforts to meet those needs; and
o The specific services the receiving facility will provide to meet the needs of the resident which cannot be met at the current facility.

In addition, upon further review of the clinical record, there was no evidence of what, if any, documentation of any kind (demographic information, medication and treatment lists, comprehensive care plan goals, etc.) were sent to the hospital when the resident was transferred on 10/1/18.

On 1/24/19 at 3:43 p.m., ASM #2 (Administrative

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Staff Member - the Director of Nursing - DON), when presenting a POC (plan of correction) the facility implemented regarding admission/transfer/discharge regulation requirements, which had an effective date of completion of 12/3/18. It was noted that requirements for physician documentation and requirements related to what information is to be provided to the receiving hospital (both requirements for F622) was not addressed in the POC. ASM #2 stated the POC covered regulations at F623, F624, and F625. When asked if the POC covered the requirements for F622, she stated no.

On 1/25/19 at 8:43 a.m., in an interview with LPN #7, she stated that when a resident is sent to the hospital, the facility sends the transfer paper, list of meds, history and physical, telephone order, most recent labs, most recent progress notes, and the transfer paper includes mobility, adl's (activities of daily living), diet, etc. When asked if the comprehensive care plan goals are sent, she stated, "We don't send the care plan. The ADL's and treatments, etc., are all part of the care plan and are on the transfer form." When asked where is it documented what all was sent, she stated in the nurse's notes on the clinical record. When asked about what the doctor should be documenting, she stated they know what is going on, and give the order, so they should be documenting that.

On 1/24/19 at 5:30 p.m., at the end of day meeting, the executive director and the Director of Nursing (ASM #1 and #2 respectively - Administrative Staff Member) and ASM #2 were made aware of the findings. No further information was provided by the end of the

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survey.

3. Resident # 54 was transferred to the hospital on 10/23/2018, facility staff failed to evidence that comprehensive care plan goals were sent with and provided to the receiving hospital for the resident's facility initiated transfer to the hospital.

Resident #54 was admitted to the facility on 07/13/16. His diagnoses included Chronic Obstructive Pulmonary Disease (1), Benign Prostatic Hyperplasia (2), End Stage Renal Disease (3), Gastro-Esophageal Reflux Disease (4), and Diabetes Mellitus Type 2 (a condition causing elevated blood sugar). Resident #54's most recent Minimum Data Set (MDS) Assessment was a Quarterly Assessment with and Assessment Reference Date (ARD) of 12/12/18. The Brief Interview for Mental Status (BIMS) coded Resident #54 at 15, indicating no impairment.

A review of Resident #54's record was conducted on 01/23/19. A nurse's note dated 10/23/18 at 3:00p.m., documented that Resident #54 had been sent to the hospital for hypoxia (low level of oxygen in the blood) and an elevated temperature. The nurse's note did not specify if comprehensive care plan goals were sent along with the resident to the hospital.

On 01/24/19 at 1:17 p.m., an interview was conducted with LPN #8 regarding transfer of Residents to the hospital. LPN #8 was asked to describe the process for sending a Resident to the hospital. She stated that after assessing the Resident, the nurse calls the Physician and gets an order for the transfer. An Aide is kept with the patient, while the Nurse calls the Responsible

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Party or Family as appropriate. The Nurse then prepares a Transfer Form, which documents basic information about the Resident including their most recent vital signs, most recent medications, and contact information for the Facility. LPN #8 stated that along with the Transfer Sheet, a Facesheet, Advanced Directives documentation if applicable, and most recent lab data are sent. When asked if the Resident's Care Plan Goals are sent, LPN #8 stated no.

A review of the Facility Policy entitled "Transfer/Discharge Notifications & Right to Appeal" revealed the following under the heading Documentation:

"Information provided to the receiving provider must include but is not limited to: ... Comprehensive Care Plan Goals..."

An interview was conducted on 01/24/19 at 3:49p.m. with Administrative Staff Member (ASM) #2, the Director of Nursing. ASM #2 stated that the facility had identified issues with their transfer and discharge process in the fall of 2018, and had made changes to resolve those issues. When asked about the requirements of sending comprehensive care plan goals to the hospital with the Resident at the time of transfer, ASM #2 stated that had not been identified as an issue, and was not included in their plan of correction.

The executive director, ASM #1 and ASM #2, the Director of Nursing were informed of the findings at the end of day meeting on 01/25/19. No further documentation was provided.

4. The facility staff failed to evidence that

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comprehensive care plan goals were sent with the Resident #29 to the receiving hospital for the facility initiated transfer dated 10/30/2018.

Resident #29 was admitted to the facility on 05/19/17. Her diagnoses included Parkinson's disease (5), Major Depressive Disorder (6), Diabetes Mellitus Type 2 (a disease causing elevated sugar in the blood), Hypertension (high blood pressure), and Hypothyroidism (7). Resident #29's most recent Minimum Data Set (MDS) Assessment was a Quarterly Assessment with an Assessment Reference Date (ARD) of 11/12/18. Resident #29 was coded on the Brief Interview for Mental Status (BIMS) as a 0, indicating profound cognitive impairment.

A review of Resident #29's record was conducted on 01/23/19. A nurse's note dated 10/30/18 revealed that Resident #29 was hospitalized for evaluation following Resident #29's removal of her intravenous fluid line. The nurse's note did not specify if comprehensive care plan goals were sent along with the resident to the hospital.

On 01/24/19 at 1:17 p.m., an interview was conducted with LPN #8 regarding transfer of Residents to the hospital. LPN #8 was asked to describe the process for sending a Resident to the hospital. She stated that after assessing the Resident, the nurse calls the Physician and gets an order for the transfer. An Aide is kept with the patient, while the Nurse calls the Responsible Party or Family as appropriate. The Nurse then prepares a Transfer Form, which documents basic information about the Resident including their most recent vital signs, most recent medications, and contact information for the Facility. LPN #8 stated that along with the

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Transfer Sheet, a Facesheet, Advanced Directives documentation if applicable, and most recent lab data are sent. When asked if the Resident's Care Plan Goals are sent, LPN #8 stated no.

An interview was conducted on 01/24/19 at 3:49p.m., with Administrative Staff Member (ASM) #2, the Director of Nursing. ASM #2 stated that the facility had identified issues with their transfer and discharge process in the fall of 2018, and had made changes to resolve those issues. When asked about the requirements of sending comprehensive care plan goals to the hospital with the Resident at the time of transfer, ASM #2 stated that that had not been identified as an issue, and was not included in their plan of correction.

The executive director, ASM #1 and ASM #2, the Director of Nursing were informed of the findings at the end of day meeting on 01/25/19. No further documentation was provided.

1. Chronic obstructive pulmonary disease (COPD) is a chronic inflammatory lung disease that causes obstructed airflow from the lungs. Symptoms include breathing difficulty, cough, mucus (sputum) production and wheezing. It's caused by long-term exposure to irritating gases or particulate matter, most often from cigarette smoke. People with COPD are at increased risk of developing heart disease, lung cancer and a variety of other conditions. - https://www.mayoclinic.org/diseases-conditions/copd/symptoms-causes/syc-20353679

2. Benign prostatic hyperplasia (BPH) - also called prostate gland enlargement - is a common

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condition, as men get older. An enlarged prostate gland can cause uncomfortable urinary symptoms, such as blocking the flow of urine out of the bladder. It can also cause bladder, urinary tract or kidney problems. - https://www.mayoclinic.org/diseases-conditions/benign-prostatic-hyperplasia/symptoms-causes/syc-20370087

3. End-stage renal disease, also called end-stage kidney disease, occurs when chronic kidney disease - the gradual loss of kidney function - reaches an advanced state. In end-stage renal disease, your kidneys are no longer able to work, as they should to meet your body's needs. - https://www.mayoclinic.org/diseases-conditions/end-stage-renal-disease/symptoms-causes/syc-20354532

4. Gastroesophageal reflux disease (GERD) occurs when stomach acid frequently flows back into the tube connecting your mouth and stomach (esophagus). This backwash (acid reflux) can irritate the lining of your esophagus. - https://www.mayoclinic.org/diseases-conditions/gerd/symptoms-causes/syc-20361940

5. Parkinson's disease is a progressive nervous system disorder that affects movement. Symptoms start gradually, sometimes starting with a barely noticeable tremor in just one hand. Tremors are common, but the disorder also commonly causes stiffness or slowing of movement. In the early stages of Parkinson's disease, your face may show little or no expression. Your arms may not swing when you walk. Your speech may become soft or slurred. Parkinson's disease symptoms worsen as your condition progresses over time. -

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https://www.mayoclinic.org/diseases-conditions/parkinsons-disease/symptoms-causes/syc-20376055

6. Depression is a mood disorder that causes a persistent feeling of sadness and loss of interest. Also called major depressive disorder or clinical depression, it affects how you feel, think and behave and can lead to a variety of emotional and physical problems. You may have trouble doing normal day-to-day activities, and sometimes you may feel as if life isn't worth living. - https://www.mayoclinic.org/diseases-conditions/depression/symptoms-causes/syc-20356007

7. Hypothyroidism (underactive thyroid) is a condition in which your thyroid gland doesn't produce enough of certain crucial hormones. Hypothyroidism may not cause noticeable symptoms in the early stages. Over time, untreated hypothyroidism can cause a number of health problems, such as obesity, joint pain, infertility and heart disease. - https://www.mayoclinic.org/diseases-conditions/hypothyroidism/symptoms-causes/syc-20350284

5. Resident #61 was transferred to the hospital on 11/16/18, the facility staff failed to evidence the residents comprehensive care plan goals was sent to the receiving facility and failed to evidence physician required documentation regarding the facility initiated hospital transfer.

Resident # 61 was admitted to the facility on 07/16/2009 with a readmission of 11/24/18 with diagnoses that included but were not limited to peripheral vascular disease (1), type 2(two) diabetes (2), respiratory failure (3) gastroesophageal reflux disease (4), and

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hypertension (5).

Resident # 61's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 12/29/18, coded Resident # 61 as scoring a 14 on the brief interview for mental status (BIMS) of a score of 0 - 15, 14- being cognitively intact for making daily decisions. Resident # 61 was coded as requiring extensive assistance of one staff member for activities of daily living.

The nurse's "Progress Notes," dated 11/16/2018 for Resident # 61 documented, "1430 (2:30 p.m.) Lab (Laboratory) results rec'd (received), WBC (white blood count) (increased) @ (at) 19. H/H (hemoglobin and hematocrit) low. MD (medical doctor) with orders to send to ER (emergency room) non-emergency. Resident notified of reason for transfer."

Review of the clinical record for Resident # 61 failed to evidence documentation that that Resident # 61's care plan goals were provided to the receiving facility upon the facility initiated transfer. Review of the physician's most recent progress notes dated 12/15/18 failed to evidence documentation of the specific needs the facility could not meet, facility's efforts to meet the those needs and the specific needs the receiving facility could provide to meet the needs of Resident # 61.

On 1/24/19 at 3:43 p.m., an interview was conducted with ASM #2 (administrative staff member) # 2, director of nursing. When presenting a POC (plan of correction) the facility implemented regarding admission/transfer/discharge regulation requirements, which had an effective date of

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completion of 12/3/18, it was noted that requirements for physician documentation and requirements related to what information is to be provided to the receiving hospital (both requirements for F622) was not addressed in the POC. ASM #2 stated the POC covered regulations at F623, F624, and F625. When asked if the POC covered the requirements for F622, she stated no.

On 1/25/19 at 8:43 a.m. in an interview with LPN #7, she stated that when a resident is sent to the hospital, the facility sends the transfer paper, list of meds, history and physical, telephone order, most recent labs, most recent progress notes, and the transfer paper includes mobility, adl's (activities of daily living), diet, etc. When asked if the comprehensive care plan goals are sent, she stated, "We don't send the care plan. The ADL's and treatments, etc., are all part of the care plan and are on the transfer form." When asked where what all was sent is documented, LPN #7 stated in the nurse's notes on the clinical record. When asked about what the doctor should be documenting, she stated they know what is going on, and give the order, so they should be documenting that.

On 01/24/18 at approximately 5:30 p.m. ASM (administrative staff member) # 1, the executive director and ASM # 2, director of nursing were made aware of the findings.

No further information was provided prior to exit.

References:
(1) The vascular system is the body's network of blood vessels. It includes the arteries, veins and capillaries that carry blood to and from the heart.

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Arteries can become thick and stiff, a problem called atherosclerosis. Blood clots can clog vessels and block blood flow to the heart or brain. Weakened blood vessels can burst, causing bleeding inside the body.) This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/vasculardiseases.html.

(2) A chronic disease in which the body cannot regulate the amount of sugar in the blood. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/ency/article/001214.htm.

(3) When not enough oxygen passes from your lungs into your blood. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/respiratoryfailure.html.

(4) Stomach contents to leak back, or reflux, into the esophagus and irritate it. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/gerd.html.

(5) High blood pressure. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/highbloodpressure.html.

6. Resident #77 was transferred to the hospital on 11/01/18, the facility staff failed to evidence the residents comprehensive care plan goals was sent to the receiving facility and failed to evidence physician required documentation regarding the facility initiated hospital transfer.

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Resident # 77 was admitted to the facility on 11/01/17 with a readmission of 06/21/18 with diagnoses that included but were not limited to Parkinson's disease (1), dysphagia (2), dysarthria (3) schizoaffective disorder (4), and hypertension (5).

Resident # 77's most recent MDS (minimum data set), a 60-Day assessment with an ARD (assessment reference date) of 12/31/18, coded Resident # 77 as scoring a 15 on the brief interview for mental status (BIMS) of a score of 0 - 15, 15- being cognitively intact for making daily decisions. Resident # 77 was coded as requiring extensive assistance of one staff member for activities of daily living.

The nurse's "Progress Notes," dated 11/01/2018 for Resident # 77 documented, "4:30 p.m., MD (medical doctor) returned call with order to transfer resident 911 to (Name of Hospital) for further eval (evaluation)."

Review of the clinical record for Resident # 77 failed to evidence documentation that that Resident # 77's care plan goals were provided to the receiving facility upon the facility initiated transfer. Review of the physician's most recent progress notes dated 11/07/18 failed to evidence documentation of the specific needs the facility could not meet, facility's efforts to meet the those needs and the specific needs the receiving facility could provide to meet the needs of Resident # 77.

On 1/24/19 at 3:43 p.m. an interview was conducted with ASM #2 (administrative staff member) # 2, director of nursing. When presenting a POC (plan of correction) the facility implemented regarding

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admission/transfer/discharge regulation requirements, which had an effective date of completion of 12/3/18, it was noted that requirements for physician documentation and requirements related to what information is to be provided to the receiving hospital (both requirements for F622) was not addressed in the POC. ASM #2 stated the POC covered regulations at F623, F624, and F625. When asked if the POC covered the requirements for F622, she stated no.

On 1/25/19 at 8:43 a.m. in an interview with LPN #7, she stated that when a resident is sent to the hospital, the facility sends the transfer paper, list of meds, history and physical, telephone order, most recent labs, most recent progress notes, and the transfer paper includes mobility, adl's (activities of daily living), diet, etc. When asked if the comprehensive care plan goals are sent, she stated, "We don't send the care plan. The ADL's and treatments, etc., are all part of the care plan and are on the transfer form." When asked where what all was sent is documented, LPN #7 stated in the nurse's notes on the clinical record. When asked about what the doctor should be documenting, she stated they know what is going on, and give the order, so they should be documenting that.

On 01/24/18 at approximately 5:30 p.m. ASM (administrative staff member) # 1, the executive director and ASM # 2, director of nursing were made aware of the findings.

No further information was provided prior to exit.

References:
(1) A type of movement disorder. This

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information was obtained from the website: https://www.nlm.nih.gov/medlineplus/parkinsonsdisease.html.

(2) A swallowing disorder. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/swallowingdisorders.html.

(3) A condition in which you have difficulty saying words because of problems with the muscles that help you talk). This information was obtained from the website: https://medlineplus.gov/ency/article/007470.htm.

(4) A mental condition that causes both a loss of contact with reality [psychosis] and mood problems [depression or mania]. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/ency/article/000930.htm.

(5) High blood pressure. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/highbloodpressure.html.

F 656 SS=E	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)	F 656		3/5/19

§483.21(b) Comprehensive Care Plans
§483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive

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F 656	Continued From page 30 assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, facility document review, and clinical record review, it was determined that the facility staff failed to follow the comprehensive care plan for four of 31 residents in the survey sample; Residents #73, #71, #20, and #94.	F 656	1. Resident #73 was evaluated by physical therapy to establish Restorative Nursing Program and train nursing staff on the implementation of the program. Therapy determined resident is not safe to	

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1. The facility staff failed to follow Resident #73's comprehensive care plan related to providing "physical activity for strengthening and improved mobility" by failing to provide restorative nursing services.

2. The facility staff failed to follow Resident #71's comprehensive care plan for the administration of oxygen per physician's order.

3. The facility staff failed to follow Resident # 20's comprehensive care plan for the implementation for the ADL (activity of daily living) skill of dressing.

4. The facility staff failed to follow the comprehensive care plan for Resident # 94's pain management.

The findings include:

1. Resident #73 was admitted to the facility on 8/20/13 with the diagnoses of but not limited to intra-abdominal mass, hemiplegia, surgical aftercare, atrial fibrillation, stroke, contracture, high blood pressure, and spinal stenosis. The most recent MDS (Minimum Data Set) was a quarterly assessment with an ARD (Assessment Reference Date) of 12/28/18. The resident was coded as being cognitively intact in ability to make daily life decisions. The resident was coded as requiring total care for bathing and ambulation; extensive care for transfers, dressing, toileting and hygiene; supervision for eating; and as incontinent of bowel and bladder.

On 1/24/19 at 9:19 a.m., Resident #73 reported to

F 656

ambulate with
nursing staff. Resident #73 was offered a transfer and range of motion restorative program, but declined to participate. Care plan updated.

Resident #71'□s oxygen concentrator was set to the physician ordered level and in accordance with care plan. LPN #6 and LPN #7 were educated about ensuring oxygen concentrators are set to the physician prescribed level.

Resident #20 was provided clothing from home but
declined to wear it and remained in a hospital gown. Resident preference was documented in the medical record and care plan was updated.

Resident #94'□s care plan was updated to reflect current pain management methods. LPN #10 and LPN #1 were re-educated to respond to resident□s reports/signs of pain in accordance with the care plan.

2. Current residents in facility on Restorative Nursing Program had their care plan reviewed to ensure that the care plan was being followed. Follow-up based on findings.

Current residents in facility on oxygen therapy had their care plan reviewed to ensure that the care plan was being followed. Follow-up based on findings.

Current residents in facility had their care

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the survey team that she was recently receiving physical therapy and was supposed to get restorative nursing afterwards but that it has not occurred.

A review of the clinical record revealed an order dated 12/28/18, which documented, "Pt (patient) is discharged from skilled PT (physical therapy) services after today's visit."

A review of the Physical Therapy Discharge Summary dated 12/28/18 documented, "Discharge Recommendations: Restorative nursing upon discharge for continued ambulation."

Further review of the clinical record revealed a "Restorative Nursing Evaluation" which was undated, but documented, "Proceed with Restorative program? Yes...No", Yes was checked. Beneath this were 3 (three) boxes, one each for "Ambulation," "Locomotion," and "Transfer." All three items were checked as reasons for the restorative program.

There was no evidence in the clinical record that restorative nursing ever occurred as of the survey review date of 1/24/19.

On 1/24/19 at 11:19 a.m., ASM #2 (Administrative Staff Member - the Director of Nursing) was asked about where documentation for the restorative program would be located. ASM #2 was also asked if Resident #73 was supposed to be receiving restorative nursing care.

On 1/24/19 at 11:43 a.m., ASM #2 returned with an update. ASM #2 stated that the resident (Resident #73) had been in therapy and that

plans reviewed to ensure they were provided clothing and personal belongings from home in accordance with their care plan. Follow-up based on findings.

Current residents in facility who experienced pain were reviewed to ensure their care plan was being followed. Follow-up based on findings.

3. Director of Nursing, or designee, re-educated facility staff regarding the implementation of residents'□ comprehensive care plans.

4. Director of Nursing, or designee, to conduct Quality Monitoring Review on sample of 10 residents to ensure their comprehensive care plan is being implemented, weekly for four weeks, bi-weekly for two weeks, then monthly. Follow up based on findings. Findings to be reported to QAPI committee monthly and updated as indicated. Quality Monitoring schedule to be modified based on findings.

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therapy did recommend the restorative nursing program. She stated that at the time, there was no unit manager and it fell on her to ensure that the restorative program was implemented for Resident #73. ASM#2 stated, "The ball was dropped" on getting Resident #73 restorative services. ASM #2 stated the restorative aid was notified on 1/16/19 about Resident #73 needing restorative services and the restorative aid completed the previously identified Restorative Nursing Evaluation mentioned above on that date (1/16/19). ASM #2 stated then the restorative program was stopped on 1/18/19, through the use of a designated aid for the position, and the services were going to be incorporated into the daily activities of all the aids, but that this had not happened yet. ASM #2 stated due these factors, ensuring therapy recommendations for restorative was followed through with did not occur, and Resident #73 was missed.

A review of the comprehensive care plan for Resident #73 revealed one for ".....at risk for falls r/t (related to) impaired transfer ability d/t (due to) history of CVA (stroke)...." This care plan dated 11/1/18, included an intervention dated 11/1/18, for: "Encourage (Resident #73) to participate in activities that promote exercise, physical activity for strengthening and improved mobility."

On 1/25/19 at 8:58 a.m., in an interview with LPN #7 (Licensed Practical Nurse), when asked if this includes the provision of restorative nursing services, LPN #7stated it would and that restorative nursing would be an important component of this intervention. When asked if Resident #73's care plan for this was followed, LPN #7 stated no.

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A review of the facility policy, "Plans of Care" documented, "An individualized person-centered plan of care will be established by the interdisciplinary team (IDT) with the resident and/or resident representative(s) to the extent practicable and updated in accordance with state and federal regulatory requirements.....Develop and implement an Individualized Person-Centered comprehensive plan of care by the Interdisciplinary Team....Review, update and/or revise the comprehensive plan of care based on changing goals, preferences and needs of the resident and in response to current interventions...."

On 1/24/19 at 5:30 p.m., at the end of day meeting, the executive director and the Director of Nursing (ASM #1 and #2 respectively - Administrative Staff Member) and ASM #2 were made aware of the findings. No further information was provided by the end of the survey.

2. The facility staff failed to follow Resident #71's comprehensive care plan for the administration of oxygen per physician's order.

Resident #71 was admitted to the facility on 1/12/18 with the diagnoses of but not limited to chronic kidney disease, falls, urinary retention, diabetes, high blood pressure, hypothyroidism, asthma, morbid obesity, lymphedema, congestive heart failure, dysphagia, and aortic valve disorder. The most recent MDS (Minimum Data Set) was an annual assessment with an ARD (Assessment Reference Date) of 12/26/18. The resident was coded as being cognitively intact in ability to make daily life decisions. The resident was coded as

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requiring total care for bathing, transfers, and toileting; extensive assistance for hygiene and dressing; supervision for eating; and as incontinent of bowel and bladder.

A review of the clinical record revealed a physician's order dated 4/25/18 for "Oxygen at 2L/Min (liters per minute) via nasal cannula continuously for shortness of breath."

On 1/24/19 at 9:12 a.m., and at 4:49 p.m., observations were made of Resident #71's oxygen. The flow rate was set at 1.75 L/min as evidenced by the ball on the oxygen concentrator flow meter being set between the 1.5 and 2.0-liter marks. At the second observation, Resident #71 was asked if she knew what her oxygen rate should be. She stated two liters.

On 1/24/19 at 4:50 p.m., LPN #6 (Licensed Practical Nurse) looked at the oxygen concentrator with this surveyor. LPN #6 verified the rate was incorrectly set at 1.75 L/min and that the rate should be 2 L/min.

A review of the comprehensive care plan revealed one dated 9/26/18 for: "(Resident #71) has altered respiratory status/difficulty breathing r/t (related to) Asthma and CHF (congestive heart failure)." This care plan included an intervention dated 9/26/18 for "Oxygen per MD (medical doctor) orders." In addition, there was a care plan dated 9/26/18 for "(Resident #71) has altered cardiovascular status r/t Hypertension, HLD (hyperlipidemia), CAD (coronary artery disease). This care plan included an intervention dated 9/26/18 for "Oxygen settings: O2 (oxygen) via nasal prongs per MD orders."

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On 1/25/19 at 8:58 a.m., in an interview with LPN #7, when asked if Resident #71's care plan was followed regarding the administration of oxygen, LPN #7 stated it was not. She stated that the oxygen rate should be checked every shift and overtime when staff is in the resident's room. LPN #7 stated she did not know what happened on 1/25/19 and how she missed that it was at the wrong flow rate.

On 1/24/19 at 5:30 p.m., at the end of day meeting, the executive director and the Director of Nursing (ASM #1 and #2 respectively - Administrative Staff Member) and ASM #2 were made aware of the findings. No further information was provided by the end of the survey.

3. The facility staff failed to follow Resident # 20's comprehensive care plan for the implementation for the ADL (activity of daily living) skill of dressing.

Resident # 20 was admitted to the facility on 10/31/18 with diagnoses that included but were not limited to: multiple sclerosis (1), dysphonia (2), breast cancer, atrial fibrillation (3), and dysphagia (4).

Resident # 20's most recent comprehensive MDS (minimum dada set) an admission assessment with an ARD (assessment reference date) of 11/07/18 coded the resident as scoring a 14 on the brief interview for mental status (BIMS) of a score of 0 - 15, 14 being cognitively intact for daily decision-making. Resident # 20 was coded as requiring extensive assistance of one staff member for activities of daily living and

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F 656	Continued From page 37 independent with eating. Section H "Bladder and Bowel" coded Resident # 20 as "Always incontinent" of urine and "Frequently incontinent" of bowel. On 01/2419 at approximately 4:00 p.m. during an observation and conversation conducted with Resident # 20, revealed Resident # 20 sitting in her wheelchair in her room, next to her bed and in front of the wardrobe. Resident # 20 was wearing two hospital gowns, one place front to back and the second gown was placed on Resident # 20 back to front. Resident # 20 was appropriately covered. During the conversation with Resident # 20, she stated that she did not have any of her own clothes. Resident # 20 was then asked by this and another female surveyor for permission to look inside her wardrobe. Observation of the wardrobe for Resident # 20 revealed it contained one large cabinet for hanging clothes. Below the cabinet section of the wardrobe, were two drawers. Observation of the inside of the two drawers failed to evidence any type of clothing. Observation of the inside of the cabinet of the wardrobe revealed one pair of women's slacks and a shirt on a hanger. On the bottom of the cabinet under a package of adult incontinent briefs, were another pair of women's slacks and a shirt. Further observation revealed a holiday gift bag containing a new woman's flannel nightgown that still had the store tag on it. Further observation of the flannel nightgown revealed it was too large for Resident # 20 to wear. An observation of the two pairs of woman's slacks and shirts failed to evidence Resident # 20's name inside the clothing. When Resident # 20 was shown the slacks and shirts Resident # 20 stated, "Those are not mine." When asked about her personal clothing Resident # 20 stated that	F 656		

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she had clothes at her home. When asked what clothing she had been wearing since her admission on 10/31/18, Resident # 20 stated she had been wearing the hospital gowns. When asked if the facility staff attempted to obtain her own clothing Resident # 20 stated no. When asked if she had family that could obtain her clothes from her home, Resident # 20 stated that she had a daughter but her daughter lived in "(Name of another State). Resident #20 stated that she had an older "gentleman friend" who had access to her home who could get her some clothes. When asked if the facility had contacted her daughter or the "gentleman friend" about her clothing, Resident # 20 stated that she didn't know. When asked how she felt about wearing hospital gowns all the time especially when she went out of her room Resident # 20 stated, "I try not to think about it."

Review of the facility's "Inventory of Personal Effects" dated 10/31/18 for Resident # 20 documented, "Clothing / Personal Affects: Dresses - 1 (one), Nightgowns - 1 (one), Glasses - 1(one) and Slippers - 1(one)."

The facility's "Occupational Therapy Initial Evaluation" dated "11/1/2018" documented, "Long-Term Goals: #1.0 Patient will safely perform Lower Body bathing routine seated in shower with supervision with assisted devices based on improved strength and functional activity tolerance. #2.0 Patient will safely perform LB (lower body) dressing routine seated in bed with supervision with based on improved functional activity tolerance, strength and dynamic sitting balance. #3.0 Patient will perform toileting routine seated in bathroom with supervision with assisted devices based on improved strength and

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functional activity tolerance."

The comprehensive care plan for Resident # 20 dated 11/08/2018 documented, "Focus: (Resident # 20) has an ADL (activities of daily living) self-care performance deficit r/t (related to) MS (multiple sclerosis), w/c (wheelchair) bound." Under "Interventions", it documented, "DRESSING: Assist (Resident # 20) to choose simple comfortable clothing that enhances the resident's ability to dress self. Assist as needed. Encourage independence. Date initiated: 11/08/2018."

On 01/25/19 at 10:51 a.m., an interview was conducted with ASM (administrative staff member) # 2, director of nursing regarding Resident # 20's care plan. When asked to describe the purpose of the care plan, ASM # 2 stated, "To identify resident specific issues, develop goals for residents, and address interventions for handling medical and behavioral concerns and a guide for staff on how to care for residents." After reviewing of Resident # 20's care plan for dressing (documented above), ASM # 2 was asked about the implementation of the dressing goal and the fact that the resident did not have any clothes. ASM # 2 stated that the care plan was not implemented.

On 01/25/19 at approximately 1:00 p.m. ASM (administrative staff member) # 1 the executive director, ASM # 2, director of nursing, were made aware of the findings.

No further information was provided prior to exit.

References:
(1) A nervous system disease that affects your

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brain and spinal cord. It damages the myelin sheath, the material that surrounds and protects your nerve cells. This damage slows down or blocks messages between your brain and your body, leading to the symptoms of MS. They can include visual disturbances, muscle weakness, trouble with coordination and balance, sensations such as numbness, prickling, or "pins and needles" and thinking and memory problems. This information was obtained from the website: https://medlineplus.gov/multiplesclerosis.html.

(2) Difficulty speaking due to spasms (dystonia) of the muscles that control the vocal cords. This information was obtained from the website: https://medlineplus.gov/ency/article/000753.htm.

(3) A problem with the speed or rhythm of the heartbeat. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/atrialfibrillation.html.

(4) A swallowing disorder. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/swallowingdisorders.html.

4. The facility staff failed to follow the comprehensive care plan for Resident # 94's pain management.

Resident # 94 was admitted to the facility on 08/22/16, with readmission on 05/23/2017, with diagnoses that included but were not limited to: low back pain, joint pain, Alzheimer's disease (1), hyperlipidemia (2), spinal stenosis (3) and

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F 656	Continued From page 41 dysphagia (4). Resident # 94's most recent comprehensive MDS (minimum dada set) a significant change assessment with an ARD (assessment reference date) of 01/10/19 coded the resident as scoring a 4 (four) on the brief interview for mental status (BIMS) of a score of 0 - 15, 4 (four) being severely impaired of cognition for daily decision-making. Resident # 94 was coded as requiring extensive assistance of one to two staff member for activities of daily living. On 01/24/19 at 10:35 a.m., an observation of Resident # 94's wound care was conducted. Resident # 94 presented with a stage IV (four) pressure ulcer on her sacrum measured by facility staff as seven centimeters by eight centimeters and one and a half centimeters deep. Two nurses performed the care, LPN (licensed practical nurse) # 10 who conducted the wound care and LPN # 1, unit manager, who assisted. Resident # 94 was administered 100mg (one-thousand milligrams) of Tylenol approximately 30 minutes prior to wound care. Observations during the wound care revealed that during the removal of the old wound dressing by LPN # 10 Resident # 94 vocalized a moaning sound of pain. When LPN # 10 was cleansing the wound with normal saline and applying the physician ordered treatment on the inside wall of the wound Resident # 94 again let out another vocalized moaning. Observation revealed when LPN # 10 packed the wound with gauze Resident # 94 vocalizing "Ow!" During further observation of wound care of Resident # 94's, right outer ankle Resident # 94 vocalized moaning when LPN # 10 cleansed the wound. Observation of the wound care failed to evidence LPN # 1 and #	F 656		

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F 656	Continued From page 42 10 pausing, stopping or providing another intervention to alleviate Resident # 94's pain during her care. The "Physician's Telephone Order" dated 01/11/19 for Resident # 94 documented, "Tylenol 500 mg - give 2 (two) tabs (tablets) p.o. (by mouth) q (every) morning prior to wound dressing change." The comprehensive care plan for Resident # 94 dated 11/14/18 documented, "Focus: Resident # 94) is at risk for pain r/t (related to) aging process. Date initiated 11/14/2018." Under "interventions" it documented, "Anticipate (Resident # 94's) need for pain relief and respond immediately to any complaint of pain. Date initiated 11/14/2018." On 01/25/19 at 10:51 a.m., an interview was conducted with ASM (administrative staff member) # 2, director of nursing regarding Resident # 94's care plan. When asked to describe the purpose of the care plan ASM # 2 stated, "To identify resident specific issues, develop goals for residents, address interventions for handling medical and behavioral concerns and a guide for staff on how to care for residents." After reviewing of Resident # 94's care plan for dressing ASM # 2 was asked about the implementation of the pain management goal and was informed of the observation of Resident # 94's responses during wound care. ASM # 2 stated that the care plan was not implemented. On 01/24/18 at approximately 5:30 p.m. ASM (administrative staff member) # 1, the executive director and ASM # 2, director of nursing were made aware of the findings.	F 656		

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F 656	Continued From page 43 No further information was provided prior to exit. References: (1) A brain disorder that seriously affects a person's ability to carry out daily activities). This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/alzheimersdisease.html. (2) Cholesterol is a fat (also called a lipid) that your body needs to work properly. Too much bad cholesterol can increase your chance of getting heart disease, stroke, and other problems. The medical term for high blood cholesterol is lipid disorder, hyperlipidemia, or hypercholesterolemia. This information was obtained from the website: https://medlineplus.gov/ency/article/000403.htm. (3) A narrowing of the spinal column that causes pressure on the spinal cord, or narrowing of the openings (called neural foramina) where spinal nerves leave the spinal column. This information was obtained from the website: https://medlineplus.gov/ency/article/000441.htm. (4) A swallowing disorder. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/swallowingdisorders.html.	F 656		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality.	F 658		3/5/19

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F 658	Continued From page 44 This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, and clinical record review, it was determined the facility staff failed to follow professional standards of practice for two of 31 residents in the survey, Residents #97 and #99. 1. The facility staff failed to ensure a RN (Registered nurse) documented the death of a resident, Resident #97. 2. The facility staff failed to obtain a physician order for a discharge for Resident #99. The findings include: 1. The facility staff failed to ensure a RN (Registered nurse) documented the death of a resident, Resident #97. Resident #97 was admitted to the facility 2/11/13 with diagnoses that included but were not limited to: asthma, heart disease, high blood pressure, stroke, history of a heart attack and schizophrenia [Any of a group of mental disorders characterized by gross distortions of reality, withdrawal of thought, language, perception and emotional response. (1)]. The most recent MDS (minimum data set) assessment, a reentry, quarterly assessment, with an assessment reference date of 10/7/18, coded the resident as scoring a "05" on the BIMS (brief interview for mental status) score, indicating he was severely impaired to make daily cognitive decisions. The physician orders dated, 7/23/13 and signed	F 658	1. Resident #97 expired and his medical record is closed. LPN #9 was educated about the Nursing Standard of Practice regarding Registered Nurse documentation of pronouncement of death. Registered Nurse who pronounced Resident #97 as expired was educated about documenting in the resident's medical record the absence of vital signs. Resident #99 discharged from the facility; the medical record is closed. LPN who discharged resident #99 from the facility was educated about ensuring that there is a physician's order prior to discharging a resident from the facility. 2. Director of Nursing, or designee, reviewed deaths in facility from 1/18/19-1/25/19, to verify that the Registered Nurse documented the pronouncement of death. Follow-up based on findings. Director of Nursing reviewed facility discharges from 1/18/19-1/25/19 to verify the presence of a physician's order to discharge resident. Follow-up based on findings. 3. Director of Nursing, or designee, re-educated Licensed Nursing staff about appropriate documentation by the	

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by the physician on 9/5/18, documented, "No CPR (cardiopulmonary resuscitation)."

The nurse's note dated, 10/26/18 at 11:30 p.m. documented in part, "Res (resident) observed with no pulse and unresponsive. Evening supervisor got notified. Night Supervisor RN pronounced res passing." This note was written by LPN (licensed practical nurse) #9.

The "Record of Death and Mortician's Receipt" documented in part, "Nurse present at time of death: (LPN #9)."

Further review of the clinical record failed to evidence documentation by the RN for the death of the resident.

An interview was conducted with administrative staff member (ASM) #2, the director of nursing, on 1/24/19 at 2:17 p.m. When asked to explain the process staff follows for documenting the death of a resident in the facility, ASM #2 stated, "The RN would pronounce them, and contact the RP (responsible party) and the doctor." The nurse's note above was shown to ASM #2. When asked if it is acceptable for the LPN to document that the RN pronounced the resident. ASM #2 stated, "I would expect the RN to write the note that they died." When asked if it is a professional standard of practice to write your own assessment, ASM #2 stated yes. When asked if anyone else should be documenting your assessment of the resident, ASM #2 stated, "No."

An interview was conducted with LPN #5 on 1/24/19 at 2:44 p.m.,regarding the process staff follows when a resident expires. LPN #5 stated she would first check to see if the resident was a

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Registered Nurse following the expiration of a resident.

Director of Nursing, or designee, re-educated Licensed Nursing staff about ensuring that there is a physician's order prior to
discharging a resident from the facility.

4. Director of Nursing, or designee, to conduct Quality Monitoring review of deaths in the facility to verify proper documentation,weekly for four weeks, bi-weekly for two weeks, then monthly.

Director of Nursing, or designee, to conduct Quality Monitoring Review of facility discharges to verify physician's order is
present, weekly for four weeks, bi-weekly for two weeks, then monthly. Follow up based on findings. Findings to be reported to QAPI Committee monthly and updated as indicated. Quality Monitoring schedule to be modified based on findings.

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full code or DNR (do not resuscitate). If the resident is a DNR she would call the doctor. I would check to see if there is an RN in the building. When asked what happens when if there isn't an RN in the building, LPN #5 stated, "We call the doctor." When asked who declares the resident's death, LPN #5 stated, "LPNs can't declare so we call the doctor and tell them the resident has no pulse or vital signs. The doctor declares it over the phone. The doctor tells us what to do." When asked if the RN is in the building, who writes the note of the declaration of death of the resident, LPN #5 stated, "The RN should write that."

An interview was conducted with RN #1, the unit manager, on 1/24/19 at 2:49 p.m., regarding the process staff follows when an LP finds a resident that has expired. RN #1 stated, "I would go in an do my assessment. Check for breathing and pulse. If nothing I will time it. Notify the doctor." When asked what is the staff to do if there is no RN in the building, RN #1 stated, "I don't live far, I can be here in a few minutes." When asked who writes the note of the resident's death, the LPN or the RN, RN #1 stated, "The RN must write a note. If there isn't a note by the RN, the assessment wasn't done. They need to write even just a line or two. I have to write a note if a declare someone's death."

A policy on the declaration of death in the facility was requested on 1/25/19 at approximately 10:30 a.m. No policy was presented prior to exit.

Administrative staff member (ASM) #1, the executive director and ASM #2, the director of nursing were made aware of the above findings on 1/24/19 at 5:32 p.m.

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(1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 522.

2. The facility staff failed to obtain a physician order for a discharge for Resident #99.

Resident #99 was admitted to the facility 10/31/18 with diagnoses that included but were not limited to: right leg weakness, high blood pressure, arthritis and ALS [Amyotrophic lateral sclerosis [ALS] is a nervous system disease that attacks nerve cells called neurons in your brain and spinal cord. These neurons transmit messages from your brain and spinal cord to your voluntary muscles - the ones you can control, like in your arms and legs. At first, this causes mild muscle problems. (1)].

The most recent MDS (minimum data set) assessment, an admission and discharge assessment, with an assessment reference date of 11/2/18, coded the resident as scoring a "15" on the BIMS (brief interview for mental status) score, indicating the resident was capable of making daily cognitive decisions. The resident was coded as requiring supervision or as being independent for all of his activities of daily living.

The nurse's note dated 11/2/18 at 10:00 a.m. documented, "Resident discharged at 9:42 a.m. No distress observed."

Review of the clinical record failed to evidence a physician order for the resident's discharge on 11/2/18.

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F 658	Continued From page 48 An interview was conducted with RN (registered nurse) #1, the unit manager, on 1/24/19 at 3:42 p.m. When asked if the nurse's needed a physician order for a resident to be discharged, RN #1 stated, "Yes." An interview was conducted with LPN (licensed practical nurse) #3 on 1/24/19 at 3:50 p.m. When asked if a physician order is needed for resident to be discharged, LPN #3 stated, "Yes." The facility policy, "Discharge of Resident to Home or Other Center" documented in part, "Procedure: 1. Upon determination by the interdisciplinary team that resident is appropriate for discharge, the nurse will obtain a physician's order for discharge to include: a) Place of discharge. b) community resources or referrals required. c) Status of medications on discharge [may discharge home with med{mediations}]." Administrative staff member (ASM) #1, the executive director, and ASM #2, the director of nursing were made aware of the above findings on 1/24/19 at 5:32 p.m. No further information was provided prior to exit. (1) This information was obtained from the following website: https://medlineplus.gov/amyotrophiclateralsclerosis.html	F 658		
F 661 SS=D	Discharge Summary CFR(s): 483.21(c)(2)(i)-(iv) §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident	F 661		3/5/19

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F 661

Continued From page 49

must have a discharge summary that includes, but is not limited to, the following:
(i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results.
(ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative.
(iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter).
(iv) A post-discharge plan of care that is developed with the participation of the resident and, with the resident's consent, the resident representative(s), which will assist the resident to adjust to his or her new living environment. The post-discharge plan of care must indicate where the individual plans to reside, any arrangements that have been made for the resident's follow up care and any post-discharge medical and non-medical services.
This REQUIREMENT is not met as evidenced by:
Based on staff interview, facility document review, and clinical record review, it was determined the facility staff failed to complete a discharge summary for one of three closed records, Resident #99.

The facility staff failed to complete the discharge summary for Resident #99.

The findings include:

F 661

1. Resident #99 discharged from the facility on 11/2/18; the medical record is closed.

2. Facility discharges from 1/21/19 to 1/28/19 were reviewed by the Director of Nursing to ensure that discharge summary was complete and present in the medical record. Follow-up based on findings.

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F 661 Continued From page 50

Resident #99 was admitted to the facility 10/31/18 with diagnoses, that included but were not limited to: right leg weakness, high blood pressure, arthritis and ALS [Amyotrophic lateral sclerosis [ALS] is a nervous system disease that attacks nerve cells called neurons in your brain and spinal cord. These neurons transmit messages from your brain and spinal cord to your voluntary muscles - the ones you can control, like in your arms and legs. At first, this causes mild muscle problems. (1)].

The most recent MDS (minimum data set) assessment, an admission and discharge assessment, with an assessment reference date of 11/2/18, coded the resident as scoring a "15" on the BIMS (brief interview for mental status) score, indicating the resident was capable of making daily cognitive decisions. The resident was coded as requiring supervision or being independent for all of his activities of daily living.

The nurse's note dated 11/2/18 at 10:00 a.m. documented, "Resident discharged at 9:42 a.m. No distress observed."

Review of the clinical record revealed a form, "Discharge Summary." This form was blank.

An interview was conducted with OSM (other staff member) #2, the social worker, on 1/24/19 at 3:08 p.m. The discharge summary form for Resident #99 was shown to OSM #2. OSM#2 was he was asked if he is involved with the discharge summary. OSM #2 stated he had never seen it though it has a section for social services.

An interview was conducted with RN (registered nurse) #1, the unit manager, on 1/24/19 at 3:42

F 661

3. Director of Nursing, or designee, re-educated Licensed Nursing Staff, Director of Rehab, Activities Director, and Social Worker
regarding completion of the discharge summary prior to an anticipated discharge.

4. Director of Nursing, or designee, to review the medical record of discharged residents in daily Clinical Meeting to ensure that discharge summary is complete and in the medical record.

Director of Nursing, or designee, to conduct Quality Monitoring Review of the medical record of discharged residents to ensure the discharge summary is completed weekly, for four weeks, biweekly for two weeks, then monthly. Follow up based on findings. Findings to be reported to QAPI Committee monthly and updated as indicated. Quality Monitoring schedule to be
modified based on findings.

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F 661	Continued From page 51	F 661		

p.m. When asked who completes the discharge summary, a summary of their stay, after a resident is discharged, RN #1 stated, "I'll have to find out who does that?

An interview was conducted with LPN #3 on 1/24/19 at 3:50 p.m. When asked who fills out the discharge summary form, LPN #3 stated, "I believe it's the RNs or unit managers." The blank form, "Discharge Summary" for Resident #99, was shown to LPN #3. LPN #3 stated, "The unit managers or the RNs fill those in."

An interview was conducted with administrative staff member (ASM) #2, the director of nursing, on 1/24/19 at 4:03 p.m. When asked who completes the discharge summary or the recapitulation of the stay, ASM #2 stated, "It's a combination of people, nursing, therapy, dietary, activities and social services." The blank form from Resident #99's clinical record was shown to ASM #2. When asked if the facility uses this form, ASM #2 stated, "Yes, we are supposed to use them."

The facility policy, "Interdisciplinary Discharge Summary" documented, "Policy: When the facility anticipates discharge, a resident must have a discharge summary completed that includes a recapitulation of the resident's stay. Procedure: 1. Social Services personnel or designee will initiate the Interdisciplinary Discharge Summary. 2. The following departments will give a final summary regarding the resident's stay in the facility on the Interdisciplinary Discharge Summary form: a. Social Services. b. Nursing Services. c. Dietary Services. d. Activities. e Rehab (rehabilitation). 3. Medical Records personnel or designee will ensure the completed Discharge Summary is

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F 661	Continued From page 52 placed in the resident's medical record." Administrative staff member (ASM) #1, the executive director and ASM #2, the director of nursing were made aware of the above findings on 1/24/19 at 5:32 p.m. No further information was provided prior to exit. (1) This information was obtained from the following website: https://medlineplus.gov/amyotrophiclateralsclerosis.html	F 661		
F 676 SS=D	Activities Daily Living (ADLs)/Mntn Abilities CFR(s): 483.24(a)(1)(b)(1)-(5)(i)-(iii) §483.24(a) Based on the comprehensive assessment of a resident and consistent with the resident's needs and choices, the facility must provide the necessary care and services to ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that such diminution was unavoidable. This includes the facility ensuring that: §483.24(a)(1) A resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living, including those specified in paragraph (b) of this section ... §483.24(b) Activities of daily living. The facility must provide care and services in accordance with paragraph (a) for the following activities of daily living:	F 676		3/5/19

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F 676	Continued From page 53 §483.24(b)(1) Hygiene -bathing, dressing, grooming, and oral care, §483.24(b)(2) Mobility-transfer and ambulation, including walking, §483.24(b)(3) Elimination-toileting, §483.24(b)(4) Dining-eating, including meals and snacks, §483.24(b)(5) Communication, including (i) Speech, (ii) Language, (iii) Other functional communication systems. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview, facility document review and clinical record review, it was determined that the facility staff failed to implement a restorative nursing program for one of 31 residents in the survey sample, Resident #73. Resident #73 concluded therapy services on 12/28/18, and the restorative nursing program was recommended. As of the survey review on 1/24/19, restorative services had not been provided. The findings include: Resident #73 was admitted to the facility on 8/20/13 with the diagnoses of but not limited to intra-abdominal mass, hemiplegia, surgical aftercare, atrial fibrillation, stroke, contracture, high blood pressure, and spinal stenosis. The most recent MDS (Minimum Data Set) was a	F 676	1. Resident #73 was evaluated by physical therapy to establish a Restorative Nursing Program and train nursing staff on the implementation of the program. Therapy determined that resident is not safe to ambulate with nursing staff. Resident #73 was offered a transfer and range of motion restorative program, but declined to participate. 2. Residents in facility were reviewed with Director of Rehab to determine potential for Restorative Nursing Program. Identified residents had a restorative nursing plan written and implemented. 3. Director of Nursing, or designee, re-educated nursing staff about providing and documenting Restorative Nursing Program	

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F 676	Continued From page 54 quarterly assessment with an ARD (Assessment Reference Date) of 12/28/18. The resident was coded as being cognitively intact in ability to make daily life decisions. The resident was coded as requiring total care for bathing and ambulation; extensive care for transfers, dressing, toileting and hygiene; supervision for eating; and as incontinent of bowel and bladder. On 1/24/19 at 9:19 a.m., Resident #73 reported to the survey team that she was recently receiving physical therapy and was supposed to get restorative nursing afterwards but that it has not occurred. A review of the clinical record revealed an order dated 12/28/18, which documented, "Pt (patient) is discharged from skilled PT (physical therapy) services after today's visit." A review of the Physical Therapy Discharge Summary dated 12/28/18 documented, "Discharge Recommendations: Restorative nursing upon discharge for continued ambulation." Further review of the clinical record revealed a "Restorative Nursing Evaluation" which was undated, but documented, "Proceed with Restorative program? Yes...No", Yes was checked. Beneath this were 3 (three) boxes, one each for "Ambulation," "Locomotion," and "Transfer." All three items were checked as reasons for the restorative program. There was no evidence in the clinical record that restorative nursing ever occurred as of the survey review date of 1/24/19.	F 676	for identified residents. Director of Rehab, or designee, re-educated nursing staff on how to implement resident specific restorative plans. 4. Director of Nursing, or designee, to conduct Quality Monitoring Review of residents on restorative program to ensure they are receiving program as ordered, weekly, for four weeks, bi-weekly for two weeks, then monthly. Follow up based on findings. Findings to be reported to QAPI Committee monthly and updated as indicated. Quality Monitoring schedule to be modified based on findings.	

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F 676	Continued From page 55	F 676		

On 1/24/19 at 11:19 a.m., ASM #2 (Administrative Staff Member - the Director of Nursing) was asked about where documentation for the restorative program would be located. ASM #2 was also asked if Resident #73 was supposed to be receiving restorative nursing care.

On 1/24/19 at 11:43 a.m., ASM #2 returned with an update. ASM #2 stated that the resident (Resident #73) had been in therapy and that therapy did recommend the restorative nursing program. She stated that at the time, there was no unit manager and it fell on her to ensure that the restorative program was implemented for Resident #73. ASM#2 stated, "The ball was dropped" on getting Resident #73 restorative services. ASM #2 stated the restorative aid was notified on 1/16/19 about Resident #73 needing restorative services and the restorative aid completed the previously identified Restorative Nursing Evaluation mentioned above on that date (1/16/19). ASM #2 stated then the restorative program was stopped on 1/18/19, through the use of a designated aid for the position, and the services were going to be incorporated into the daily activities of all the aids, but that this had not happened yet. ASM #2 stated due these factors, ensuring therapy recommendations for restorative was followed through with did not occur and Resident #73 was missed.

A review of the comprehensive care plan for Resident #73 revealed one for ".....at risk for falls r/t (related to) impaired transfer ability d/t (due to) history of CVA (stroke)...." This care plan dated 11/1/18, included an intervention dated 11/1/18, for: "Encourage (Resident #73) to participate in activities that promote exercise, physical activity for strengthening and improved mobility."

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F 676	Continued From page 56	F 676		

On 1/25/19 at 8:58 a.m., in an interview with LPN #7, when asked the process of ensuring restorative services are provided, she stated that therapy staff refers the resident to the unit manager, but that there was not a unit manager at the time. She stated that she did not know what happened for Resident #73, but that it should not have taken a month for the resident to get restorative services. When asked if the above care plan intervention includes the provision of restorative nursing services, she stated it would and that restorative nursing would be an important component of this intervention.

A review of the facility policy, "Restorative Nursing Services" documented, "Restorative Nursing will be provided to residents as indicated upon evaluation to assist in achieving the highest practicable level of physical functioning as possible."

On 1/24/19 at 5:30 p.m., at the end of day meeting, the executive director and the Director of Nursing (ASM #1 and #2 respectively - Administrative Staff Member) and ASM #2 were made aware of the findings. No further information was provided by the end of the survey.

F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2)	F 689		3/5/19

§483.25(d) Accidents.
The facility must ensure that -
§483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and

§483.25(d)(2)Each resident receives adequate

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supervision and assistance devices to prevent accidents.
This REQUIREMENT is not met as evidenced by:
Based on observation and staff interview, facility staff failed to maintain an environment free of hazards for one of five nursing units, lower level unit.

The primary entry/egress doorway for the Lower Level unit had a cracked and jagged plastic covering with edges exposed to persons ambulating through it.

The Findings Included:

A tour of the facility was conducted on the morning of 01/23/19. It was noted that the primary doorway into the Lower Level unit had a plastic covering panel on the front. This plastic panel was cracked and broken on the edge closest to the door hinge. The panel was affixed in such a way that, when the door was open, the hinge edge with cracked and jagged edge was in a position such that it faced persons ambulating through the doorway. This doorway was the only resident-accessible means of entry or egress to the Lower Level unit. Throughout the tour on 01/23/19, as well as throughout the survey on 01/24/19, Residents were observed ambulating through the doorway independently, with walkers, and with wheelchairs.

On 01/24/19 at 4:05p.m., an interview was conducted with Other Staff Member (OSM) #4, the Maintenance Director. OSM #4 was shown the Lower Level unit doorway with the cracked panel, and asked if she was aware of its condition. OSM #4 stated she was aware of the

F 689

1. The panel covering on the hallway door to the Terrace Unit was replaced with acrovyn panel on 1/24/19 by the Maintenance Department.

2. Director of Maintenance conducted a review of doors in the Center with panel coverings to ensure that there are no damages or sharp edges that present a hazard to residents. Follow-up based on findings.

3. Executive Director, or designee, re-educated the Director of Maintenance and Maintenance Assistant about inspecting panel coverings on doors to ensure that no safety hazards are present and identified issues are addressed immediately.

Executive Director, or designee, re-educated IDT Members about inspecting panel coverings on doors daily during rounds to ensure that safety hazards are not present. IDT to report identified issues to Maintenance Department immediately and enter the concerns in the Maintenance Log.

Director of Nursing, or designee, re-educated Nursing staff about inspecting panel coverings on doors daily during rounds to ensure safety hazards are not present. Nursing staff to report identified issues to Maintenance

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F 689	Continued From page 58 damage, and was in the process of ordering a new panel. OSM #4 was asked how the Maintenance Department is made aware of items needing repair. She stated that each unit has a maintenance request log that can be recorded in for items needing service. A review of the Lower Level maintenance log did not reveal a record of the damaged plastic cover for the unit door. On 01/24/19 at 4:11p.m., OSM #4 stated that maintenance staff were replacing the covering. The executive director ASM (administrative staff member) #1 and ASM #2, the Director of Nursing were informed of the findings at the end of day meeting on 01/25/19. No further documentation was provided.	F 689	Department immediately and enter the concerns in the Maintenance Log. 4. Executive Director, or designee, to conduct Quality Monitoring Review of panel coverings on a sample of 10 doors daily for two weeks, then weekly for four weeks, then bi-weekly for two weeks, then monthly. Follow up based on findings. Findings to be reported to QAPI Committee monthly and updated as indicated. Quality Monitoring schedule to be modified based on findings.	
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, facility document review, and clinical record review, it was determined that the facility staff failed to ensure the resident's oxygen concentrator was set at the correct physician	F 695	1. Oxygen concentrator for resident #71 was corrected and set to the flow rate prescribed by the physician. Director of Nursing re-educated LPN #7	3/5/19

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ordered rate for one of 31 residents in the survey sample; Resident #71.

The facility staff administered oxygen to Resident #71 at the wrong flow rate.

The findings include:

Resident #71 was admitted to the facility on 1/12/18 with the diagnoses of but not limited to chronic kidney disease, falls, urinary retention, diabetes, high blood pressure, hypothyroidism, asthma, morbid obesity, lymphedema, congestive heart failure, dysphagia, and aortic valve disorder. The most recent MDS (Minimum Data Set) was an annual assessment with an ARD (Assessment Reference Date) of 12/26/18. The resident was coded as being cognitively intact in ability to make daily life decisions. The resident was coded as requiring total care for bathing, transfers, and toileting; extensive assistance for hygiene and dressing; supervision for eating; and as incontinent of bowel and bladder.

A review of the clinical record revealed a physician's order dated 4/25/18 for "Oxygen at 2L/Min (liters per minute) via nasal cannula continuously for shortness of breath."

A review of the comprehensive care plan revealed one dated 9/26/18 for: "(Resident #71) has altered respiratory status/difficulty breathing r/t (related to) Asthma and CHF (congestive heart failure)." This care plan included an intervention dated 9/26/18 for "Oxygen per MD (medical doctor) orders." In addition, there was a care plan dated 9/26/18 for "(Resident #71) has altered cardiovascular status r/t Hypertension,

F 695

about ensuring that oxygen concentrators are set to the physician prescribed flow rate at all times.

2. Residents in the facility with oxygen in place were reviewed on 1/25/19 to ensure that their oxygen concentrator was set at the
physician prescribed rate. Follow-up based on findings.

3. Director of Nursing, or designee, re-educated Licensed Nursing Staff about ensuring oxygen flow rate is set at the physician
prescribed rate.

4. Director of Nursing, or designee, to conduct Quality Monitoring Review of oxygen flow rates to ensure concentrators are set at the prescribed rate, weekly, for four weeks, bi-weekly for two weeks, then monthly. Follow up based on findings. Findings to be reported to QAPI Committee monthly and updated as indicated. Quality Monitoring schedule to be modified based on findings.

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ENVOY OF ALEXANDRIA, LLC	**900 VIRGINIA AVENUE ALEXANDRIA, VA 22302**

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F 695	Continued From page 60	F 695		

HLD (hyperlipidemia), CAD (coronary artery disease). This care plan included an intervention dated 9/26/18 for "Oxygen settings: O2 (oxygen) via nasal prongs per MD orders."

On 1/24/19 at 9:12 a.m., and at 4:49 p.m., observations were made of Resident #71's oxygen. The flow rate was set at 1.75 L/min as evidenced by the ball on the oxygen concentrator flow meter being set between the 1.5 and 2.0-liter marks. At the second observation, Resident #71 was asked if she knew what her oxygen rate should be. She stated two liters.

On 1/24/19 at 4:50 p.m., LPN #6 (Licensed Practical Nurse) looked at the oxygen concentrator with this surveyor. LPN #6 verified the rate was incorrectly set at 1.75 L/min and that the rate should be 2 L/min.

On 1/25/19 at 8:58 a.m., in an interview with LPN #7, she stated that the oxygen rate should be checked every shift and every time staff is in the resident's room. She stated she did not know what happened on 1/25/19 and how she missed that it was at the wrong rate.

A review of the facility policy, "Oxygen Therapy" did not specifically state to administer per order; however it documented, "Physician's order for oxygen therapy shall include" Administration modality...liter flow; continuous or PRN (as needed)..."

A review of the facility's manufacturer's booklet on the oxygen concentrator equipment documented, "Turn the flowrate knob to the setting prescribed by your physician or therapist....To properly read the flowmeter, locate the prescribed flowrate line

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F 695	Continued From page 61 on the flowmeter. Next, turn the flow knob until the ball rises to the line. Now, center the ball on the L/min line prescribed." On 1/24/19 at 5:30 p.m., at the end of day meeting, the executive director and the Director of Nursing (ASM #1 and #2 respectively - Administrative Staff Member) and ASM #2 were made aware of the findings. No further information was provided by the end of the survey.	F 695		
F 697 SS=D	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and clinical record review, it was determined that facility staff failed to provide pain management for one of 31 residents in the survey sample, Resident # 94. The facility staff failed to manage Resident # 96's pain during wound care. The findings include: Resident # 94 was admitted to the facility on 08/22/16 with a readmission on 05/23/2017 with diagnoses that included but were not limited to: low back pain, joint pain, Alzheimer's disease (1), hyperlipidemia (2), spinal stenosis (3) and dysphagia (4).	F 697	1. Pain Assessment for Resident #94 was completed on 1/24/19. Physician was contacted and orders received to administer Oxycodone 5mg daily prior to dressing change and then as needed (PRN) every 4 hours for pain. Director of Nursing re-educated LPN #10 and LPN #1 about how to address pain during a treatment, and objective and subjective signs and symptoms of pain. 2. Residents with pressure ulcers were assessed on 1/28/19 for the presence of pain before, during, and after completion of dressing changes. Follow-up based on	3/5/19

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Continued From page 62

Resident # 94's most recent comprehensive MDS (minimum dada set) a significant change assessment with an ARD (assessment reference date) of 01/10/19 coded the resident as scoring a 4 (four) on the brief interview for mental status (BIMS) of a score of 0 - 15, 4 (four) being severely impaired of cognition for daily decision-making. Resident # 94 was coded as requiring extensive assistance of one to two staff member for activities of daily living.

On 01/24/19 at 10:35 a.m., an observation of Resident # 94's wound care was conducted. Resident # 94 presented with a stage IV (four) pressure ulcer on her sacrum measuring seven centimeters by eight centimeters and one and a half centimeters deep. Two nurses, LPN (licensed practical nurse) # 10 who conducted the wound care and LPN # 1, unit manager, who assisted. Resident # 94 was administered 100mg (one-thousand milligrams) of Tylenol approximately 30 minutes prior to wound care. Observations during the wound care revealed that during the removal of the old wound dressing by LPN # 10 Resident # 96 vocalized a moaning sound of pain. When LPN # 10 was cleansing the wound with normal saline and applying the physician ordered treatment on the inside wall of the wound Resident # 94 again let out another vocalizing moaning. Observation revealed when LPN # 10 packed the wound with gauze Resident # 94 vocalizing "Ow!" Further observation of wound care of Resident # 94 right outer ankle Resident # 94 vocalizing moaning when LPN # 10 cleansed the wound. During the observation of the wound care failed to evidence LPN # 1 and # 10 to pause, stop or provide another intervention to alleviate Resident # 94's pain during her care.

F 697

findings.

3. Director of Nursing, or designee, re-educated Licensed Nursing Staff about pain management including:
pre-medicating
residents prior to treatments; monitoring resident during treatments for the presence of pain; stopping treatments and contacting physician if resident expresses pain during
treatments; objective and subjective signs and symptoms of pain; and pain management in residents with dementia.

4. Director of Nursing, or designee, to conduct Quality Monitoring Review of pain management for residents with pressure ulcers before, during, and after treatments to ensure adequate pain management, weekly for four weeks, bi-weekly for two weeks,then monthly. Follow up based on findings. Findings to be reported to QAPI Committee monthly and updated as indicated.
Quality Monitoring schedule to be modified based on findings.

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F 697	Continued From page 63 The "Physician's Telephone Order" dated 01/11/19 for Resident # 94 documented, "Tylenol 500 mg - give 2 (two) tabs (tablets) p.o. (by mouth) q (every) morning prior to wound dressing change." The comprehensive care plan for Resident # 94 dated 11/14/18 documented, "Focus: Resident # 94) is at risk for pain r/t (related to) aging process. Date initiated 11/14/2018." Under "Interventions" it documented, "Anticipate (Resident # 94's) need for pain relief and respond immediately to any complaint of pain. Date initiated 11/14/2018." On 01/24/19 at 1:08 p.m. an interview was conducted with LPN (licensed practical nurse) # 10 regarding Resident's pain management during wound care. LPN # 10 stated she conducted the Resident # 94's wound care on 01/24/19 at 10:35 a.m. When asked how she would know if a resident was in pain, LPN # 10 stated, "By their vocalizations, moaning, facial expression (sad face) for a resident who cannot speak. If a resident can speak they would tell you that they are in pain." When asked if Resident # 94 was in any type of pain during her wound care, LPN # 10 stated, "I pre medicated her with Tylenol 500mg two tablets thirty minutes prior to the wound care." When asked to describe what stage Resident # 94's wound was, LPN # 10 stated "The would clinic said it's a stage four." When asked to describe a stage four wound, LPN # 10 stated, "It's deep, cannot see the bone, slough in the center of the wound and some granulation around the slough." When asked if a stage four-pressure ulcer is painful, LPN # 10 stated, "Yes." When asked to describe the procedure for	F 697		

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F 697	Continued From page 64	F 697		

Resident # 94's wound care, LPN stated, "I cleaned the wound, with saline wash, using a gauze pad with moistened with saline, wiping the wound, pat it dry with a gauze pad, treatment is sprayed on the gauze pad and a q-tip is used to spread the treatment inside the wound." When asked if the wound care process is painful, LPN # 10 stated, "Yes that why we pre medicated her." When asked about Resident # 94's vocalizations of moaning and verbalizing "ow" during the wound care, LPN # 10 stated, "I don't recall her moaning or saying ow." When asked if she thought that the Tylenol was enough to manage Resident' # 96s pain during her wound treatment, LPN # 10 stated, "Yes."

On 01/24/19 at 1:08 p.m., an interview was conducted with LPN (licensed practical nurse) # 1, unit manager, regarding Resident's pain management during wound care. LPN # 1 stated he was present during Resident # 94's wound care on 01/24/19 at 10:35 a.m. When asked how he would know if a resident who could not speak was in pain, LPN # 1 stated, "By grimacing, verbalize ouch, moaning." When asked if Resident # 94 exhibited any of those behaviors during her wound care, LPN # 1 stated, "Yes." When asked what resident # 94 said, LPN # 1 stated, "She said 'ouch' when the other nurse was cleaning the wound." When asked if a stage four-pressure ulcer is painful, LPN # 1 nodded his head. When asked if she thought that the Tylenol was enough to manage Resident' # 94s pain during her wound treatment, LPN # 10 stated, "No. Coming out of the room today, I made a note to contact the physician to recommend a stronger pain medication. I left a message and I'm waiting for a call back." When asked how often Resident # 94 receives wound care, LPN # 1 stated, "She

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receives wound care every day and prn (as needed)." When asked what he would do if a resident demonstrated that they were in pain during a treatment, LPN # 1 stated, "We could stop the treatment and notify the physician." When asked if this was attempted during Resident # 94's wound care, LPN # 1 stated, "No."

On 01/24/19 at 1:56 p.m., an interview was conducted with ASM (administrative staff member) # 2, director of nursing. When asked to describe a stage four wound, ASM # 2 stated, "You can see the wound bed, most likely bone; it goes through the tissue and muscle. When asked if is painful, ASM # 2 stated, "It can, but most likely it will be." When asked if the nurse's should have done anything different after being informed of the observation information of Resident # 94's wound care, ASM # 2 stated, "If she was in that amount of discomfort and moaning they should have stopped and either tried later or called the physician and let him know she could not tolerate the treatment or tell me."

On 01/24/18 at approximately 5:30 p.m. ASM (administrative staff member) # 1, the executive director and ASM # 2, director of nursing were made aware of the findings.

No further information was provided prior to exit.

References:
(1) A brain disorder that seriously affects a person's ability to carry out daily activities). This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/alzheimersdisease.html.

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F 697	Continued From page 66 (2) Cholesterol is a fat (also called a lipid) that your body needs to work properly. Too much bad cholesterol can increase your chance of getting heart disease, stroke, and other problems. The medical term for high blood cholesterol is lipid disorder, hyperlipidemia, or hypercholesterolemia. This information was obtained from the website: https://medlineplus.gov/ency/article/000403.htm. (3) A narrowing of the spinal column that causes pressure on the spinal cord, or narrowing of the openings (called neural foramina) where spinal nerves leave the spinal column. This information was obtained from the website: https://medlineplus.gov/ency/article/000441.htm. (4) A swallowing disorder. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/swallowingdisorders.html.	F 697		
F 745 SS=D	Provision of Medically Related Social Service CFR(s): 483.40(d) §483.40(d) The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview facility document review and clinical record review, it was determined that facility staff failed to provide medically related social services for one of 31 residents in the survey sample, Resident #20. The facility staff failed to provide Resident # 20 with medically related social services to assess	F 745	1. Social Worker facilitated clothing to be brought from home for Resident #20. Resident declined to wear the clothes at this time. Care plan and medical record updated to reflect resident□s preferences. OSM #2 re-educated by Director of Nursing regarding assisting residents with	3/5/19

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F 745 Continued From page 67

Resident #20's preference for wearing her own clothing and failed to assist the resident with obtaining her clothing to wear while residing at the facility since her admission in October of 2018.

The findings include:

Resident # 20 was admitted to the facility on 10/31/18 with diagnoses that included but were not limited to: multiple sclerosis (1), dysphonia (2), breast cancer, atrial fibrillation (3), and dysphagia (4).

Resident # 20's most recent comprehensive MDS (minimum dada set) an admission assessment with an ARD (assessment reference date) of 11/07/18 coded the resident as scoring a 14 on the brief interview for mental status (BIMS) of a score of 0 - 15, 14 being cognitively intact for daily decision-making. Resident # 20 was coded as requiring extensive assistance of one staff member for activities of daily living and independent with eating. Section H "Bladder and Bowel" coded Resident # 20 as "Always incontinent" of urine and "Frequently incontinent" of bowel.

On 01/2419 at approximately 4:00 p.m. during an observation and conversation conducted with Resident # 20, revealed Resident # 20 sitting in her wheelchair in her room, next to her bed and in front of the wardrobe. Resident # 20 was wearing two hospital gowns, one place front to back and the second gown was placed on Resident # 20 back to front. Resident # 20 was appropriately covered. During the conversation with Resident # 20, she stated that she did not have any of her own clothes. Resident # 20 was then asked by

F 745

obtaining clothing and personal belongings upon admission to facility.

OSM #2 re-educated by Director of Nursing to document in the medical record and care plan any resident'�s refusal to bring personal items or preference to wear a facility gown.

2. Residents in the facility were interviewed and observed between 1/28/19-1/31/19 to ensure that they had access to clothing and personal items. Residents without personal items were assisted by the Social Worker in obtaining items from the community. Residents who declined to wear clothing or bring personal items to facility were documented on and care plans updated.

3. Director of Nursing re-educated Social Worker regarding obtaining clothing and personal items for residents in the facility. Director of Nursing re-educated Social Worker regarding documenting in the medical record and care plan, any refusals to wear clothing or bring personal items.

Nursing staff re-educated about notifying Social Worker or DON about any residents who do not have clothing or personal items upon admission. Nursing staff re-educated
about notifying Social Worker or DON about any residents who wish to remain in a hospital gown.

4. Executive Director, or designee, to

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F 745	Continued From page 68 this and another female surveyor for permission to look inside her wardrobe. Observation of the wardrobe for Resident # 20 revealed it contained one large cabinet for hanging clothes. Below the cabinet section of the wardrobe, were two drawers. Observation of the inside of the two drawers failed to evidence any type of clothing. Observation of the inside of the cabinet of the wardrobe revealed one pair of women's slacks and a shirt on a hanger. On the bottom of the cabinet under a package of adult incontinent briefs, were another pair of women's slacks and a shirt. Further observation revealed a holiday gift bag containing a new woman's flannel nightgown that still had the store tag on it. Further observation of the flannel nightgown revealed it was too large for Resident # 20 to wear. An observation of the two pairs of woman's slacks and shirts failed to evidence Resident # 20's name inside the clothing. When Resident # 20 was shown the slacks and shirts Resident # 20 stated, "Those are not mine." When asked about her personal clothing Resident # 20 stated that she had clothes at her home. When asked what clothing she had been wearing since her admission on 10/31/18, Resident # 20 stated she had been wearing the hospital gowns. When asked if the facility staff attempted to obtain her own clothing Resident # 20 stated no. When asked if she had family that could obtain her clothes from her home, Resident # 20 stated that she had a daughter but her daughter lived in "(Name of another State). Resident #20 stated that she had an older "gentleman friend" who had access to her home who could get her some clothes. When asked if the facility had contacted her daughter or the "gentleman friend" about her clothing, Resident # 20 stated that she didn't know. When asked how she felt about wearing	F 745	conduct Quality Monitoring Review of sample of 10 residents to determine personal clothing status, weekly for four weeks, bi-weekly for two weeks then monthly. Follow up based on findings. Findings to be report to QAPI Committee monthly and updated as indicated. Quality Monitoring schedule to be modified based on findings.	

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F 745	Continued From page 69 hospital gowns all the time especially when she went out of her room Resident # 20 stated, "I try not to think about it." Review of the facility's "Inventory of Personal Effects" dated 10/31/18 for Resident # 20 documented, "Clothing / Personal Affects: Dresses - 1 (one), Nightgowns - 1 (one), Glasses - 1(one) and Slippers - 1(one)." The facility's "Occupational Therapy Initial Evaluation" dated "11/1/2018" documented, "Long-Term Goals: #1.0 Patient will safely perform Lower Body bathing routine seated in shower with supervision with assisted devices based on improved strength and functional activity tolerance. #2.0 Patient will safely perform LB (lower body) dressing routine seated in bed with supervision with based on improved functional activity tolerance, strength and dynamic sitting balance. #3.0 Patient will perform toileting routine seated in bathroom with supervision with assisted devices based on improved strength and functional activity tolerance." The comprehensive care plan for Resident # 20 dated 11/08/2018 documented, "Focus: (Resident # 20) has an ADL (activities of daily living) self-care performance deficit r/t (related to) MS (multiple sclerosis), w/c (wheelchair) bound." Under "Interventions", it documented, "DRESSING: Assist (Resident # 20) to choose simple comfortable clothing that enhances the resident's ability to dress self. Assist as needed. Encourage independence. Date initiated: 11/08/2018." Further review of the Comprehensive care plan failed to evidence documentation of Resident # 20's choice to wear hospital gowns.	F 745		

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On 01/24/19 at approximately 4:34 p.m., an interview was conducted with OSM (other staff member) # 2, social worker. When asked to describe the procedure to ensure a resident has clothes, OSM # 2 stated, "They are provided by the family on admission. If they come from the hospital we reach out to the family for clothes." When asked if a resident should live in a hospital gown for months on end, OSM # 2 stated, "No." When asked if he was aware that Resident # 20 did not have any of her own personal clothing, OSM # 2 stated, "She does not have family in the area, the daughter lives and works out of state. We provide donated clothes." When asked if he contacted Resident# 20's daughter regarding Resident # 20's personal clothing, OSM # 2 stated, "I'll have to check." When asked if he had spoken to Resident # 20 about what type of clothes she would like to have, OSM # 2 stated, "No."

On 01/25/19 at 8:25 a.m., an interview was conducted with OSM # 1, business development coordinator. OSM # 1 stated that she is responsible for admissions. When asked if she talked to new residents being admitted about clothing, OSM # 1 stated, "Not specifically but I do tell them that they can bring their own clothing." When asked if she was part of the admission process for Resident # 20, OSM # 1 stated, "Yes I was. She was admitted from the hospital. (Resident # 20) never mentioned anything to me about her clothes." When asked who was responsible for ensuring residents had proper clothing available, OSM # 1 stated, "I believe it is social services."

On 01/25/19 at 8:35 a.m., an interview was

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F 745	Continued From page 71 conducted with OSM # 2, social worker. When asked if he had any more information about obtaining clothes for Resident # 20, OSM # 2 stated, "I did speak to the daughter regarding (Resident # 20's) clothing." When asked if it was documented, OSM # 2 stated no. OSM # 2 further stated, "Rehab (Rehabilitation department) had offered her clothes when she got in here (when resident was admitted)." When asked if there was documentation of the rehabilitation department offering Resident # 20 clothing, OSM # 2 stated, "No." A section of the facility's "Resident Rights" policy was reviewed and discussed with OSM # 2. The section "Dignity and Self-Determination" documented, "You have the right to: Be treated with consideration, respect, and full recognition of your dignity and individuality. Receive reasonable accommodation of your individual needs and preferences, except when your health and/or safety or the health and/or safety of others would be endangered. Make choices about aspects of your life that are significant to you. Keep and use your personal possessions, as space permits, unless doing so would infringe on the rights, health and/or safety of other residents." When asked if these rights for Resident # 20 were up held to promote her dignity, OSM # 2 stated, "No but she never initiated anything about her clothes." When asked if it was Resident # 20's responsibility or his responsibility to initiate the conversation concerning Resident # 20's adequate and appropriate clothing, OSM # 2 stated, "I don't know." A section of the facility's policy and procedures for "Social Services" was reviewed and discussed with OSM # 2. The policy documented, "Policy: Medically-related social services will be provided to attain or maintain the highest practical physical, mental,	F 745		

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and psychosocial well-being of each resident." Under "Procedure" it documented, "2. Social Service personal will identify the medically related social and emotional needs of resident and their families and provide for those needs by: a. Making arrangements for obtaining clothing and personal items that may be necessary; g. Identifying and seeking ways to support a resident's individual needs and preferences; h. Building relationships between residents and staff, teaching staff how to understand and support residents' needs, dignity and self-image." When asked if those responsibilities were followed OSM # 2 stated, "No." When asked if he contacted Resident # 20's daughter yesterday (01/24/19) after our conversation OSM #2 stated, "No." OSM # 2 further stated that he did contact the friend of Resident # 20 to see if he could go to the resident's home to obtain some of her clothes. OSM # 2 stated, "There was no answer last night so I'm going call again today."

On 01/25/19 at 9:15 a.m., an interview was conducted with OSM # 5, occupational therapist. When asked about Resident # 20 receiving therapy OSM # 5 stated, "I work with (Resident # 20). We picked her up on caseload on 11/01/18." When asked what they worked on, OSM # 5 stated, ADLs (activities of daily living) which included dressing, showering and toileting." When asked about Resident # 20's clothing for the dressing therapy goal, OSM # 5 stated, "We offered her clothes from the donated clothes the facility has. She used them for practicing her dressing skills. When asked if Resident # 20 ever requested clothes from her home OSM # 5 stated, "I don't recall."

On 01/25/19 at 10:51 a.m., an interview was

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conducted with ASM (administrative staff member) # 2, director of nursing. When asked about Resident # 20 not having personal clothing, ASM #2 stated that it should have been followed up. ASM # 2 further stated, "There was nothing documented until last evening regarding Resident # 20's preference of having her own clothing."

On 01/25/19 at approximately 1:00 p.m. ASM (administrative staff member) # 1 the executive director, ASM # 2, director of nursing, were made aware of the findings.

No further information was provided prior to exit.

References:
(1) A nervous system disease that affects your brain and spinal cord. It damages the myelin sheath, the material that surrounds and protects your nerve cells. This damage slows down or blocks messages between your brain and your body, leading to the symptoms of MS. They can include visual disturbances, muscle weakness, trouble with coordination and balance, sensations such as numbness, prickling, or "pins and needles" and thinking and memory problems. This information was obtained from the website: https://medlineplus.gov/multiplesclerosis.html.

(2) Difficulty speaking due to spasms (dystonia) of the muscles that control the vocal cords. This information was obtained from the website: https://medlineplus.gov/ency/article/000753.htm.

(3) A problem with the speed or rhythm of the heartbeat. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/atrialfibrillation.html.

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F 745	Continued From page 74 (4) A swallowing disorder. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/swallowingdisorders.html.	F 745		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and facility document review, it was determined the facility staff failed store narcotics securely in one of five	F 761	1. The narcotic lock box in the Terrace medication room refrigerator was replaced immediately by the Director of	3/5/19

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F 761	Continued From page 75 medication rooms, the Terrace Unit. The facility staff failed to ensure the lock on the narcotics box was functional and failed to ensure that narcotics stored in the box, were locked and secured, in the Terrace Unit, medication room refrigerator. The findings include: Observation was made of the medication room on the Terrace Unit on 1/24/19 at 9:11 a.m. The refrigerator in the medication room was observed. The refrigerator was not locked. Upon opening the refrigerator, a clear acrylic box was securely attached to the refrigerator shelf. The lock on the box did not appear to be locked. LPN (licensed practical nurse) #4 attempted to unlock and open the narcotics box. The lock mechanism did not turn. LPN #4 was able to open the lock by pulling on the lock with the key inserted into it. An unopened box of Lorazepam Concentrate [used to treat anxiety (1)], with an expiration date of 1/2020, was located in the acrylic narcotic box. When asked how narcotics are to be stored, LPN #4 stated, "They have to be in a locked medication cart or locked in the refrigerator." When asked if the Lorazepam was securely locked in the refrigerator, LPN #4 stated, "No, Ma'am." An interview was conducted with other staff member (OSM) #4, the maintenance director; on 1/24/19 at 9:22 a.m., OSM #4 was shown the lock on the acrylic box in the refridgerator of the Terrace Unit medication room. When asked if the lock acrylic box in the refrigerator locked, OSM #4 stated, "No. I am going to change it out now."	F 761	Maintenance. 2. Director of Nursing and Director of Maintenance conducted review of all 5 medication rooms and medication carts to ensure that narcotic lock bocks are in working condition. Follow-up based on findings. 3. Director of Nursing, or designee, re-educated Licensed Nursing Staff about ensuring that all narcotics are stored under double lock system at all times. Director of Nursing, or designee, re-educated Licensed Nursing Staff about ensuring that narcotic box locks are in working condition during change of shift count. Licensed nursing staff re-educated to report any issues with narcotic locks to the Director of Nursing immediately. 4. Director of Nursing, or designee, to conduct Quality Monitoring Review of all narcotic boxes, weekly for four weeks, bi-weekly for two weeks, then monthly. Follow up based on findings. Findings to be reported to QAPI Committee monthly and updated as indicated. Quality Monitoring schedule to be modified based on findings.	

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An interview was conducted with OSM #4 on 1/24/19 at 11:28 a.m. When asked how notify maintenance when something is broken, OSM #4 stated, "The can tell me. Write it in the book, each nurse's station has a book. The books are checked every day."

The work order book on the Terrace Unit was reviewed for the past three months that was available in the book. There was no documentation in the book, evidencing the lock on the acrylic box in the medication refrigerator was functioning and in needed repair.

The facility policy, "Controlled Substances" documented in part, "1. All controlled substances prescribed for all residents must be double locked in a secure container in the residence."

Administrative staff member (ASM) #1, the executive director and ASM #2, the director of nursing were made aware of the above findings on 1/24/19 at 5:32 p.m.

No further information was obtained prior to exit.

(1) This information was obtained from the following website:
https://pubchem.ncbi.nlm.nih.gov/compound/lorazepam

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F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5)	F 842		3/5/19

§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

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F 842	Continued From page 77 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.	F 842		

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F 842	Continued From page 78 §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 clinical record review, staff interview, and facility document review, it was determined the facility staff failed to maintain a complete and accurate clinical record for one of 31 residents in the survey sample, Resident #99. The facility staff failed to maintain an accurate clinical record for the discharge of Resident #99. The findings include: Resident #99 was admitted to the facility 10/31/18 with diagnoses, that included but were not limited to: right leg weakness, high blood pressure, arthritis and ALS [Amyotrophic lateral sclerosis [ALS] is a nervous system disease that attacks nerve cells called neurons in your brain and	F 842	1. Resident #99 has discharged from the facility; the medical record is closed. LPN who discharged resident #99 was educated about completing a detailed discharge note. 2. Director of Nursing, or designee, reviewed discharges from 1/18/19-1/25/19 to ensure complete and accurate discharge note was present in the resident□s medical record. Follow up based on findings. 3. Director of Nursing, or designee, re-educated Licensed Nursing staff regarding the completion of a detailed and accurate discharge note, including	

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F 842	Continued From page 79 spinal cord. These neurons transmit messages from your brain and spinal cord to your voluntary muscles - the ones you can control, like in your arms and legs. At first, this causes mild muscle problems.] (1) The most recent MDS (minimum data set) assessment, an admission and discharge assessment, with an assessment reference date of 11/2/18, coded the resident as scoring a "15" on the BIMS (brief interview for mental status) score, indicating the resident was capable of making daily cognitive decisions. The resident was coded as requiring supervision or being independent for all of his activities of daily living. The nurse's note dated 11/2/18 at 10:00 a.m. documented, "Resident discharged at 9:42 a.m. No distress observed." An interview was conducted with RN (registered nurse) #1, the unit manager, on 1/24/19 at 3:42 p.m., regarding what should be documented in a nurse's note when a resident is discharged. RN #1 stated, "The note should say where they went, home or assisted living, picked up by whom, what prescriptions they were given, any education provided to the resident and/or family with them, and their condition upon discharge, stable." When shown the nurse's note above, RN #1 stated that was unacceptable. An interview was conducted with LPN (licensed practical nurse) #3 on 1/24/19 at 3:50 p.m., regarding what the nurse's note should include when a resident is discharged. LPN #3 stated, "It should state when the resident left, what condition they were in upon discharge, where did they go, who accompanied them, prescriptions given and	F 842	discharge location, medication status, transportation method, education provided, and home health services. 4. Director of Nursing, or designee, to complete Quality Monitoring Review of facility discharges to ensure the presence of a complete and accurate discharge note, weekly for four weeks, bi-weekly for two weeks, then monthly. Follow-up based on findings. Findings to be reported to QAPI Committee monthly and updated as indicated. Quality Monitoring schedule to be modified based on findings.	

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mode of transportation they went by." When asked if the copy of the Discharge instructions be used instead of nurse's note, LPN #3 stated, "No, you still have to write a note."

An interview was conducted with administrative staff member (ASM) #2, the director of nursing, on 1/24/19 at 4:03 p.m., regarding the process staff follows for documentation in the clinical record when a resident is discharged. ASM #2 stated, "The nurse should document where the resident went, with whom, which medications were going with the resident or what medications were called in, any education provided, and what home services they were going home with and that needs to be specific to home health, therapy or whatever services were set up for discharge." The nurse's note above was shown to ASM #2. ASM #2 stated, "That note is not sufficient."

The facility policy, "Discharge of Resident to Home or Other Center" documented in part, "6. Document final disposition in the resident's clinical record."

Administrative staff member (ASM) #1, the executive director and ASM #2, the director of nursing were made aware of the above findings on 1/24/19 at 5:32 p.m.

No further information was provided prior to exit.