STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 495327	MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	DATE SURVEY COMPLETE: 1/31/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ENVOY OF WESTOVER HILLS	4403 FOREST HILL AVENUE RICHMOND, VA

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 582	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section. §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility documentation review, facility staff failed to complete an Advanced Beneficiary Notice (ABN) for one of 3 sampled residents (Resident #100). The findings include: A review of Resident #100's ABN was conducted during the survey. The reviewed showed Form CMS-10055 was not signed by the resident or the authorized representative. The form did not show the estimated cost. An interview was conducted with the administrator on 01/30/19 at 05:10 PM. The administrator stated that this was a known concern.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495327	A. BUILDING _____ B. WING _____	C 01/31/2019

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E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 01/29/2019 through 01/31/2019. Corrections are required for compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities. No emergency preparedness complaints were investigated during the survey.	E 000	Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because the provision of the federal and state laws require it.	
E 022 SS=C	Policies/Procedures for Sheltering in Place CFR(s): 483.73(b)(4) [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. At a minimum, the policies and procedures must address the following:] (4) A means to shelter in place for patients, staff, and volunteers who remain in the [facility]. [(4) or (2),(3),(5),(6)] A means to shelter in place for patients, staff, and volunteers who remain in the [facility]. *[For Inpatient Hospices at §418.113(b):] Policies and procedures. (6) The following are additional requirements for hospice-operated inpatient care facilities only. The policies and procedures must address the following: (i) A means to shelter in place for patients, hospice employees who remain in the hospice. This REQUIREMENT is not met as evidenced by:	E 022	E022 Policies/Procedures No resident experienced any adverse outcomes, in regards to sheltering in place. All residents residing in the facility have the potential to be affected. ED/Designee will develop a shelter in place policy. ED/Designee will educate staff on the shelter in place policy. ED/designee will conduct quality monitoring rounds 3x a week for 1 month and randomly for 1 month to ensure the practices are being maintained. Results will be bought to QAPI x30 days for review and recommendations 3/17/2019	

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

Administrator 3/1/19

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

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E 022	Continued From page 1 Based on staff interview and facility documentation review, the facility staff failed to have policies and procedures for how it will provided a means to shelter in place for residents, staff, and volunteers. The findings include: On 01/31/2019 the facility's Emergency Preparedness Plan was reviewed with the administrator. The review showed that the facility's Emergency Preparedness Plan did not have policies and procedures for how it will provided a means to shelter in place for residents, staff, and volunteers. During the review the administrator stated that she was not able to locate the missing items. No further information was provided by the facility.	E 022		
E 024 SS=C	Policies/Procedures-Volunteers and Staffing CFR(s): 483.73(b)(6) [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. At a minimum, the policies and procedures must address the following:] (6) [or (4), (5), or (7) as noted above] The use of volunteers in an emergency or other emergency staffing strategies, including the process and role for integration of State and Federally designated	E 024	E024 Policies/Procedures-Volunteers and Staffing No resident experienced any adverse outcomes, in regards to procedures for volunteers and staffing. All residents and staff residing in the facility have the potential to be affected. ED/Designee will develop a policy and/or procedures for volunteers and staffing. ED/Designee will educate staff on the volunteer and staffing procedures. ED/designee will conduct quality monitoring rounds 3x a week for 1 month and randomly for 1 month to ensure the practices are being maintained. Results will be bought to QAPI x30 days for review and recommendations 3/17/2019	

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E 024	Continued From page 2 health care professionals to address surge needs during an emergency. *[For RNHCIs at §403.748(b):] Policies and procedures. (6) The use of volunteers in an emergency and other emergency staffing strategies to address surge needs during an emergency. *[For Hospice at §418.113(b):] Policies and procedures. (4) The use of hospice employees in an emergency and other emergency staffing strategies, including the process and role for integration of State and Federally designated health care professionals to address surge needs during an emergency. This REQUIREMENT is not met as evidenced by: Based on staff interview and facility documentation review, the facility staff failed to have policies and procedures for the use of volunteers and other staffing strategies. The findings include: On 01/31/2019 the facility's Emergency Preparedness Plan was reviewed with the administrator. The review showed that the facility's Emergency Preparedness Plan did not have policies and procedures for the use of volunteers and other staffing strategies. During the review the administrator stated that she was not able to locate the missing items. No further information was provided by the facility.	E 024		
E 026 SS=C	Roles Under a Waiver Declared by Secretary CFR(s): 483.73(b)(8)	E 026	E026 Roles Under a Waiver Declared by Secretary	

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E 026	Continued From page 3 [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. At a minimum, the policies and procedures must address the following:] (8) [(6), (6)(C)(iv), (7), or (9)] The role of the [facility] under a waiver declared by the Secretary, in accordance with section 1135 of the Act, in the provision of care and treatment at an alternate care site identified by emergency management officials. *[For RNHCIs at §403.748(b):] Policies and procedures. (8) The role of the RNHCI under a waiver declared by the Secretary, in accordance with section 1135 of Act, in the provision of care at an alternative care site identified by emergency management officials. This REQUIREMENT is not met as evidenced by: Based on staff interview and facility documentation review, the facility staff failed to have policies and procedures to describe the facility's role in providing care and treatment at alternate care sites under a 1135 waiver. The findings include: On 01/31/2019 the facility's Emergency Preparedness Plan was reviewed with the administrator. The review showed that the facility's Emergency Preparedness Plan did not	E 026	No resident experienced any adverse outcomes, in regards to waiver 1135. All residents residing in the facility have the potential to be affected. ED/Designee will develop a plan for providing care and treatment at alternate care site. ED/Designee will educate staff on the alternate care site protocol for care. ED/designee will conduct quality monitoring rounds 3x a week for 1 month and randomly for 1 month to ensure the practices are being maintained. Results will be bought to QAPI for 30 days for review and recommendations 3/17/2019	

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E 026	Continued From page 4 have policies and procedures to describe the facility's role in providing care and treatment at alternate care sites under a 1135 waiver. During the review the administrator stated that she was not able to locate the missing items. No further information was provided by the facility.	E 026		
E 032 SS=C	Primary/Alternate Means for Communication CFR(s): 483.73(c)(3) [(c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least annually.] The communication plan must include all of the following: (3) Primary and alternate means for communicating with the following: (i) [Facility] staff. (ii) Federal, State, tribal, regional, and local emergency management agencies. *[For ICF/IIDs at §483.475(c):] (3) Primary and alternate means for communicating with the ICF/IID's staff, Federal, State, tribal, regional, and local emergency management agencies. This REQUIREMENT is not met as evidenced by: Based on staff interview and facility documentation review, the facility staff failed ensure the emergency preparedness communication plan included primary and alternate means for communicating with facility staff, Federal, State, tribal, regional and local emergency management agencies	E 032	E032 Primary/Alternate Means for Communication No resident experienced any adverse outcomes, in regards to sheltering in place. All residents residing in the facility have the potential to be affected. ED/Designee will develop a shelter in place policy. ED/Designee will educate staff on the shelter in place policy. ED/designee will conduct quality monitoring rounds 3x a week for 1 month and randomly for 1 month to ensure the practices are being maintained. Results will be bought to QAPI for 30 days for review and recommendations 3/17/2019	

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E 032	Continued From page 5 The findings include: On 01/31/2019 the facility's Emergency Preparedness Plan was reviewed with the administrator. The review showed that the facility's emergency preparedness communication plan did not include primary and alternate means for communicating with facility staff, Federal, State, tribal, regional and local emergency management agencies. During the review the administrator stated that she was not able to locate the missing items. No further information was provided by the facility.	E 032		
E 033 SS=C	Methods for Sharing Information CFR(s): 483.73(c)(4)-(6) [(c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least annually.] The communication plan must include all of the following: (4) A method for sharing information and medical documentation for patients under the [facility's] care, as necessary, with other health providers to maintain the continuity of care. (5) A means, in the event of an evacuation, to release patient information as permitted under 45 CFR 164.510(b)(1)(ii). [This provision is not required for HHAs under §484.102(c), CORFs under §485.68(c), and RHCs/FQHCs under §491.12(c).] (6) [(4) or (5)]A means of providing information	E 033	E033 Methods for Sharing Information No resident experienced any adverse outcomes, in regards to emergency preparedness communication. All residents residing in the facility have the potential to be affected. ED/Designee will develop a concise communication plan for sharing information. ED/Designee will educate staff on the policy for sharing information. ED/designee will conduct quality monitoring rounds 3x a week for 1 month and randomly for 1 month to ensure the practices are being maintained. Results will be bought to QAPI for 30 days for review and recommendations 3/17/2019	

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E 033	Continued From page 6 about the general condition and location of patients under the [facility's] care as permitted under 45 CFR 164.510(b)(4). *[For RNHCIs at §403.748(c):] (4) A method for sharing information and care documentation for patients under the RNHCI's care, as necessary, with care providers to maintain the continuity of care, based on the written election statement made by the patient or his or her legal representative. *[For RHCs/FQHCs at §491.12(c):] (4) A means of providing information about the general condition and location of patients under the facility's care as permitted under 45 CFR 164.510(b)(4). This REQUIREMENT is not met as evidenced by: Based on staff interview and facility documentation review, the facility staff failed to ensure Emergency Preparedness communication plan included: (A) a method for sharing information and medical documentation for residents under the facility's care, as necessary, with other health providers to maintain the continuity of care and; B) facility developed policies and procedures that address the means the facility will use to release resident information to include the general condition and location of residents. The findings include: On 01/31/2019 the facility's Emergency Preparedness Plan was reviewed with the administrator. The review showed that the	E 033		

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E 033	Continued From page 7 facility's Emergency Preparedness communication plan did not include a method for sharing information and medical documentation for residents under the facility's care, as necessary, with other health providers to maintain the continuity of care and that the facility's policies and procedures failed to address the means the facility will use to release resident information to include the general condition and location of residents. During the review the administrator stated that she was not able to locate the missing items. No further information was provided by the facility.	E 033		
E 039 SS=C	EP Testing Requirements CFR(s): 483.73(d)(2) (2) Testing. The [facility, except for LTC facilities, RNHCIs and OPOs] must conduct exercises to test the emergency plan at least annually. The [facility, except for RNHCIs and OPOs] must do all of the following: *[For LTC Facilities at §483.73(d):] (2) Testing. The LTC facility must conduct exercises to test the emergency plan at least annually, including unannounced staff drills using the emergency procedures. The LTC facility must do all of the following:] (i) Participate in a full-scale exercise that is community-based or when a community-based exercise is not accessible, an individual, facility-based. If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in a	E 039	E039 EP Testing Requirements No resident experienced any adverse outcomes, in regards to emergency testing. All residents residing in the facility have the potential to be affected. ED/Designee will schedule a time to participate in an emergency plan for disaster preparedness. ED/Designee will educate staff on the plan for disaster preparedness. ED/designee will conduct quality monitoring rounds 3x a week for 1 month and randomly for 1 month to ensure the practices are being maintained. Results will be bought to QAPI for 30 days for review and recommendations 3/17/2019	

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E 039	Continued From page 8 community-based or individual, facility-based full-scale exercise for 1 year following the onset of the actual event. (ii) Conduct an additional exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, facility-based. (B) A tabletop exercise that includes a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed. *[For RNHCIs at §403.748 and OPOs at §486.360] (d)(2) Testing. The [RNHCI and OPO] must conduct exercises to test the emergency plan. The [RNHCI and OPO] must do the following: (i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group discussion led by a facilitator, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (ii) Analyze the [RNHCI's and OPO's] response to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCI's and OPO's] emergency plan, as needed. This REQUIREMENT is not met as evidenced by: Based on staff interview and facility documentation review, the facility staff failed to	E 039		

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E 039	Continued From page 9 analyze exercises and update its emergency program based on the exercise analysis. The findings include: On 01/31/2019 the facility's Emergency Preparedness Plan was reviewed with the administrator. The review showed that the staff failed to analyze exercises and update its emergency program based on the exercise analysis. During the review the administrator stated that she was not able to locate the missing items. No further information was provided by the facility.	E 039		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard and complaint survey was conducted 1/29/2019 through 1/31/2019. Significant corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. One complaint was investigated during the survey. The census in this 174 certified bed facility was 164 at the time of the survey. The survey sample consisted of 54 resident reviews.	F 000	Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because the provision of the federal and state laws require it.	
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section.	F 550	F 550 Resident Rights/Exercise of Rights 1.Resident #102 experienced no adverse reactions, and voiced no complaints related to staff standing during feeding. Resident #80 experienced no adverse reactions or noted in any distress from staff failing to knock on door prior to entering room.	

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F 550	Continued From page 10 §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, clinical record review, and facility documentation, the facility staff failed to maintain respect and dignity for two residents (Resident #102, Resident #80)	F 550	2.As any resident residing in the facility have the potential to be affected, the DON/designee conducted a Quality monitoring review of staff interactions with residents that reside in the facility to ensure resident rights are maintained as evident by sitting during meal time and assistance with feeding. DON/designee conducted a Quality review of staff members entering resident rooms to ensure that staff is knocking on doors prior to entering any resident's room. 3. DON/designee will re-educate staff on respecting rights by way of the practice of sitting while assisting with feeding at meal times and knocking on resident room doors prior to entering the room. 4.DON/designee will conduct quality monitoring rounds 3 x week for 1 month. Quality improvement monitoring findings to be reported to the QAPI Committee for a period of 2 months for compliance and/or revisions. DOC: 3/17/2019	

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F 550	Continued From page 11 in a sample size of 54 residents. 1. For Resident #102, the facility staff failed to maintain respect and dignity by standing over the Resident to feed her. 2. For Resident #80, the facility failed to respect resident's private space by failing to knock before entering his room. The findings include: 1. For Resident #102, the facility staff failed to maintain respect and dignity by standing over the Resident to feed her. Resident #102, a 64-year old female was admitted to the facility on 07/20/2016. Diagnoses include but not limited to atrial fibrillation, aphasia following cerebral infarction, dysphagia, hypertension, hemiparesis and hemiplegia, and contracture. Resident # 102's most recent Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 12/18/2018 was coded as a quarterly assessment. Resident # 102 was coded with a Brief Interview of Mental Status (BIMS) score of "13" out of possible 15 indicating no cognitive impairment. Functional status for eating, dressing, and personal hygiene was coded as total dependence on staff. On 01/29/2019 at 12:55 PM, the Resident was observed in bed dressed in a hospital gown with the head of the bed elevated approximately 60 degrees. CNA A (certified nursing assistant) was observed standing on the right side of the	F 550		

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F 550	Continued From page 12 Resident's bed feeding the Resident food from a plate on the food tray placed on the tray table. On 01/30/2019 at 1:05 PM, the Resident was observed dressed, reclined in geri-chair. CNA B was observed standing by the left side of the geri-chair feeding the Resident food from a plate on the food tray. On 01/30/2019 at 2:50 PM, CNA B was interviewed. When asked about the Resident's lunch meal, CNA B stated the Resident ate "about 25%" of her lunch. When asked if he ever sits in a chair beside the Resident while feeding her, he stated "no" and that "I prefer to stand." On 01/30/2019 at approximately 4:20 PM, the Administrator and DON were notified of the concerns. When asked about the expectation of staff when feeding residents, the Administrator stated, "They should be sitting down" when feeding residents. On 01/31/2019 at 6:05 PM, when asked about a policy for feeding residents, the administrator stated, "We don't have one." After sharing the concerns with the Administrator and DON, they offered no further information. 2. For Resident #80 the facility failed to respect resident's private space by failing to knock before entering his room. Resident #80, a 62 year old man admitted to the facility on 3/22/2013 with diagnosis of but not limited to (Traumatic Brain Injury) TBI, Hypertension, Aphasiac, Seizures, neurosyphilis, Diabetes, and Schizophrenia. His latest	F 550		

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F 550	Continued From page 13 (Minimum Data Set) MDS (a screening tool) coded Resident #80 as O indicating the Resident is unable to complete interview, as Resident is unable to communicate verbally. On 01/30/2019 at 10:15 while observing Licensed Practical Nurse (LPN) performing medication administration, LPN C was observed entering Resident #80's room, which he shares with another Resident, without first knocking on the door. Both Residents were present in the room at the time. The DON was in the hall and observed the same. At that time, the DON said "Knock, Knock!" however LPN C was already at the Resident's bedside. On 1/30/2019 during end of day meeting Administrator was made aware of the incident and the DON agreed that LPN C did indeed walk in Resident #80's room without knocking. The DON stated that LPN C was not core staff but was working there through a staffing agency. No further information was provided.	F 550		
F 567 SS=D	Protection/Management of Personal Funds CFR(s): 483.10(f)(10(i)(ii) §483.10(f)(10) The resident has a right to manage his or her financial affairs. This includes the right to know, in advance, what charges a facility may impose against a resident's personal funds. (i) The facility must not require residents to deposit their personal funds with the facility. If a resident chooses to deposit personal funds with the facility, upon written authorization of a	F 567	F 567 Protection/Management of Personal Funds 1. Resident #89 had no adverse effects related to a delay in receiving her personal funds.	

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F 567	Continued From page 14 resident, the facility must act as a fiduciary of the resident's funds and hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility, as specified in this section. (ii) Deposit of Funds. (A) In general: Except as set out in paragraph (f)(l0)(ii)(B) of this section, the facility must deposit any residents' personal funds in excess of $100 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.) The facility must maintain a resident's personal funds that do not exceed $100 in a non-interest bearing account, interest-bearing account, or petty cash fund. (B) Residents whose care is funded by Medicaid: The facility must deposit the residents' personal funds in excess of $50 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.) The facility must maintain personal funds that do not exceed $50 in a noninterest bearing account, interest-bearing account, or petty cash fund. This REQUIREMENT is not met as evidenced by: Based on observation, Resident interview, staff interviews, clinical record review, and facility documentation, the facility staff failed to honor a Resident's request for access to personal funds for one Resident (Resident #89) in a sample size of 54 residents. The facility did not provide personal funds of $40 on the day the Resident requested it.	F 567	2. ED/designee conducted a Quality Review of current residents to ensure they are being provided with access to their funds timely. 3. ED/designee provided re- education to business office staff on timely disbursement of resident funds. 4. ED/designee to complete Quality Improvement Monitoring of residents to ensure their have access to their personal funds. Monitoring will be conducted 3 x weekly for 1 month, and then quarterly, as needed. Findings to be reported to QAPI Committee monthly for a period of 1 month for further compliance and/or revision. Date of compliance. 3/17/19	

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F 567	Continued From page 15 The findings include: Resident #89, a 79-year old female, was admitted to the facility on 12/01/2018. Diagnoses include coronary artery disease, atrial fibrillation, chronic obstructive pulmonary disease, diabetes, cerebral infarction, and heart failure. Resident # 89's most recent Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 12/08/2018 was coded as an admission assessment. Resident # 89 was coded with a Brief Interview of Mental Status (BIMS) score of "15" out of possible 15 indicating no cognitive impairment. Functional status for eating, dressing, and personal hygiene was coded as resident highly involved in activity and limited assistance required by staff. On 01/29/2019 at 2:05 PM, the Resident was observed lying in her bed. The Resident was awake and agreeable to an interview. When asked about personal funds, the Resident stated she was supposed to receive $40 per month but had not received her money since she arrived at the facility on 12/01/2018. When asked if she spoke with someone at the facility about it, she verified she had spoken with the facility staff. She went on to say she is told she'll "get it in two days" then "you'll get it in two weeks" but she has yet to receive her money. On 01/29/2019 at 3:00 PM, any service concerns associated with this Resident were requested. On 01/29/2019 at 3:40 PM, the Activities Director presented a grievance report dated 01/21/2019 when the Resident requested a room change.	F 567		

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F 567	Continued From page 16 There was not a grievance report regarding not receiving her personal funds. On 01/31/2019 at 8:40 AM, an interview with Employee G from the Business Office was conducted. When asked about the process for managing resident's personal funds, she stated she tries to meet with residents in the first few days after they arrive. She also stated she uses a "Medicaid tracker" to document interactions pertaining to residents. When asked specifically about Resident #89, Employee G referred to the Medicaid tracker and stated that on December 16th, she made sure the Medicaid renewal was done. She also stated the Resident asked for her $40 at that time and added, "I advised her there could be a delay." When asked why there was a delay, Employee G stated that Employee J needed to sign the Representative Payee paperwork but Employee J was on vacation. Employee G stated that Employee J signed the paperwork on January 14, 2019. When asked what the expectation is for a Resident to receive their personal funds, Employee G stated if the funds are available, the Resident should "get it the same day" but there were "no funds here from social security" to give the Resident. A copy of the business office policy for providing residents their personal funds was requested. On 01/31/2019 at 12:25 PM, Employee G provided a copy of the policy entitled, "Resident Trust Fund - Overview" which does not address providing personal funds for residents in the form of cash advances. Employee G stated, "Our company does not have a policy for	F 567		

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F 567	Continued From page 17 advancements." On 01/31/2019 at 6:10 PM, the Administrator was asked who fills in for Employee J when he is on vacation and the Administrator named Employee K. When the Administrator was informed that Resident #89 had not received her personal funds for December 2018 or January 2019 due to the delay waiting for a signature from Employee J, the Administrator stated that Employee K would have signed for it. The Administrator and DON were notified of concerns and offered no further information.	F 567		
F 623 SS=D	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the	F 623	F623 Notice Requirements Before Transfer/Discharge 1. Residents #7, #50, and #131 had no adverse effects related to the ombudsman notifications not being sent. 2. ED/designee conducted a Quality Review of residents transferred and/or discharges over a 30 day look back to ensure notifications were sent to the ombudsman. Follow up was done based on findings. 3. ED/designee provided re-education to facility staff on ombudsman notifications. 4.ED/designee to complete Quality Improvement Monitoring of transfer/discharge notification. Monitoring will be conducted 3 x weekly for 1 month for a period of 1 months for further compliance and/or revision. 3/17/19	

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F 623	Continued From page 18 resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and	F 623		

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F 623	Continued From page 19 telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on resident interviews, staff interviews, clinical record reviews, and facility documentation, the facility staff failed to notify Ombudsman of transfer to hospital for 3 residents (Resident #7, #50, #131) in a sample size of 54 residents.	F 623		

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F 623	Continued From page 20 1. For Resident #7, the facility staff failed to notify the Ombudsman when transferred to hospital on 12/16/2018. 2. For Resident #50, the facility staff failed to notify the Ombudsman when transferred to hospital on 12/16/2018. 3. For Resident #131, the facility staff failed to notify the Ombudsman when transferred to hospital on 12/16/2018. The findings include: 1. For Resident #7, the facility staff failed to notify the Ombudsman when transferred to hospital on 12/16/2018. Resident #7, a 60-year old male was admitted to the facility on 12/24/2018. Diagnoses include but not limited to hypertension, heart failure, diabetes, cerebral infarction, depression, and convulsions. Resident #7's most recent Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 10/16/2018 was coded as a quarterly assessment. Resident # 7 was coded with a Brief Interview of Mental Status (BIMS) score of "14" out of possible 15 indicating no cognitive impairment. Functional status for dressing and personal hygiene was coded as total dependence on staff. Functional status for eating was coded as independent requiring set-up help only. On 01/29/2019 at approximately 10:50 AM, the Resident was observed lying in bed awake with the head of the bed elevated approximately 45 degrees. When asked about hospitalizations, the	F 623		

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F 623	Continued From page 21 Resident confirmed he had been hospitalized recently. On 01/30/2019, the nurse's notes were reviewed. An excerpt of an entry dated 12/16/2018 at 11:23 PM documented, "transport to [hospital] ER (emergency room) for eval of seizure activity. Resident was told that he was going to hospital and understood, bed hold sent to hospital with resident Emergency contact [name] notified. Report called to [hospital] ER along with facility information, resident sent to ER via stretcher. 122/76, 18, 68, 98.0 o2 sat (oxygen saturation) 97 on room air." On 01/31/2019 at 9:50 AM, a copy of the ombudsman notification was requested. The Administrator stated, "I can tell you; it wasn't done." A copy of facility policy regarding resident transfers was requested. On 01/31/2019 at approximately 12:00 PM, a paper entitled, "Hospital checklist for all resident transfers" was received. The body of the document contains the following checklist: "Facesheet, hospital transfer form, bed hold policy, care plan, call report to hospital, notify social services, MD orders, notify RP or emergency contact, and notify DCS/unit manager." On 01/31/2019 at approximately 6:15 PM, the Administrator and DON were notified of findings and they offered no further documentation or information. 2. For Resident #50, the facility staff failed to notify the Ombudsman when transferred to	F 623		

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F 623	Continued From page 22 hospital on 12/16/2018. Resident #50, a 69-year old male was admitted to the facility on 11/08/2018. Diagnoses include but not limited to congestive heart failure, diabetes, end stage renal disease, dependence on renal dialysis, and muscle weakness. Resident #50's most recent Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 11/15/2018 was coded as a quarterly assessment. Resident # 50 was coded with a Brief Interview of Mental Status (BIMS) score of "14" out of possible 15 indicating no cognitive impairment. Functional status for transfers, dressing, and personal hygiene were coded as requiring extensive assistance from staff. Functional status for eating was coded as requiring encouragement or cueing from staff but no physical help from staff required. On 01/29/2019 at approximately 1:00 PM, the Resident was observed in his room seated on the side of his bed. When asked about hospitalizations, the Resident confirmed he had been hospitalized recently. On 01/30/2019, the nurse's notes were reviewed. An excerpt of an entry dated 11/07/2018 at 5:20 AM documented, "EMT's (emergency medical transport) arrived to assist resident up from floor along with 3 staff members via hoyer lift. Unable to obtain vitals. Resident remains A&O x 3 (alert and oriented to person, place, and time) at baseline. MD (medical doctor) paged. Waiting a callback. Resident is his own RP (responsible party). Resident sent to [hospital] for further evaluation."	F 623		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ENVOY OF WESTOVER HILLS	4403 FOREST HILL AVENUE RICHMOND, VA 23225

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 623	Continued From page 23 On 01/31/2019 at 9:50 AM, a copy of the ombudsman notification was requested. The Administrator stated, "I can tell you; it wasn't done." A copy of facility policy regarding resident transfers was requested. On 01/31/2019 at approximately 12:00 PM, a paper entitled, "Hospital checklist for all resident transfers" was received. The body of the document contains the following checklist: "Facesheet, hospital transfer form, bed hold policy, care plan, call report to hospital, notify social services, MD orders, notify RP or emergency contact, and notify DCS/unit manager." On 01/31/2019 at approximately 6:15 PM, the Administrator and DON were notified of findings and they offered no further documentation or information. 3. For Resident #131, the facility staff failed to notify the Ombudsman when transferred to hospital on 12/16/2018. Resident #131, a 71-year old male was admitted to the facility on 03/16/2016. Diagnoses include but not limited to hypertension, diabetes, end stage renal disease, and difficulty walking. Resident #131's most recent Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 12/26/2018 was coded as a quarterly assessment. Resident #131 was coded with a Brief Interview of Mental Status (BIMS) score of "15" out of possible 15 indicating no cognitive impairment. Functional status for dressing and personal hygiene was coded as total dependence	F 623		

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F 623	Continued From page 24 on staff. Functional status for eating was coded as independent requiring set-up help only. On 01/29/2019 at approximately 4:45 PM, the Resident was observed lying in bed awake with the head of the bed elevated approximately 45 degrees. When asked about hospitalizations, the Resident confirmed he had been hospitalized recently. On 01/30/2019, the nurse's notes were reviewed. An excerpt of an entry dated 01/25/2019 at 9:33 AM documented, "Resident currently being transported to [hospital] per request of [resident] via [ambulance service]. Alert and oriented x 2(person and place). Skin sweep completed. Care, plan, SBAR (situation, background, assessment, recommendation), transfer form, bed hold and progress notes given to EMT (emergency medical services)." On 01/31/2019 at 9:50 AM, a copy of the ombudsman notification was requested. The Administrator stated, "I can tell you; it wasn't done." A copy of facility policy regarding resident transfers was requested. On 01/31/2019 at approximately 12:00 PM, a paper entitled, "Hospital checklist for all resident transfers" was received. The body of the document contains the following checklist: "Facesheet, hospital transfer form, bed hold policy, care plan, call report to hospital, notify social services, MD orders, notify RP or emergency contact, and notify DCS/unit manager." On 01/31/2019 at approximately 6:15 PM, the Administrator and DON were notified of findings	F 623		

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F 623	Continued From page 25 and they offered no further documentation or information.	F 623		
F 645 SS=D	PASARR Screening for MD & ID CFR(s): 483.20(k)(1)-(3) §483.20(k) Preadmission Screening for individuals with a mental disorder and individuals with intellectual disability. §483.20(k)(1) A nursing facility must not admit, on or after January 1, 1989, any new residents with: (i) Mental disorder as defined in paragraph (k)(3)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission, (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services; or (ii) Intellectual disability, as defined in paragraph (k)(3)(ii) of this section, unless the State intellectual disability or developmental disability authority has determined prior to admission- (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services for intellectual disability. §483.20(k)(2) Exceptions. For purposes of this section-	F 645	F 645 PASARR Screening for MD & ID 1. Resident #80 did not have any adverse effects in relation to not having a level 2 PASARR. 2. Social Services Manager/designee conducted a Quality Review of residents that triggered for needing a level 2 PASARR Follow up was done based on findings. 3. ED/Designee provided education to the Interdisciplinary Team (IDT) on regulation F645 with emphasis on level 2 screening. 4. Social Services Manager/designee to conduct Quality Improvement Monitoring of PASARR. Monitoring will be conducted 3 x weekly for 1 month, and then quarterly, as needed. Findings to be reported to QAPI Committee monthly and updated as indicated for a period of 1 months for further compliance and/or revision. 3/17/19	

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F 645	Continued From page 26 (i)The preadmission screening program under paragraph(k)(1) of this section need not provide for determinations in the case of the readmission to a nursing facility of an individual who, after being admitted to the nursing facility, was transferred for care in a hospital. (ii) The State may choose not to apply the preadmission screening program under paragraph (k)(1) of this section to the admission to a nursing facility of an individual- (A) Who is admitted to the facility directly from a hospital after receiving acute inpatient care at the hospital, (B) Who requires nursing facility services for the condition for which the individual received care in the hospital, and (C) Whose attending physician has certified, before admission to the facility that the individual is likely to require less than 30 days of nursing facility services. §483.20(k)(3) Definition. For purposes of this section- (i) An individual is considered to have a mental disorder if the individual has a serious mental disorder defined in 483.102(b)(1). (ii) An individual is considered to have an intellectual disability if the individual has an intellectual disability as defined in §483.102(b)(3) or is a person with a related condition as described in 435.1010 of this chapter. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility documentation and clinical record review, the facility failed to obtain a Level 2 PASARR for one resident (Resident# 80) in the survey sample of 54 residents.	F 645		

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F 645	Continued From page 27 The Findings Include: Resident #80 was a 62 year old who was admitted to the facility on 8/28/18. Resident #80's diagnoses included Hypotension, Personal History of Traumatic Brain Injury, Generalized Muscle Weakness, Seizures, Neurosyphilis, Osteoarthritis, Prostate Cancer, Major Depressive Disorder, Anxiety Disorder, Cataracts in both eyes, Type 2 Diabetes Mellitus, Retention of Urine, Constipation, and Dementia with Behavioral Disturbance. The Minimum Data Set, which was a Quarterly Assessment with an Assessment Reference Date of 11/29/18, coded Resident #80 as having severely impaired cognition. On 1/29/19 at 11:30 A.M., an observation was conducted of Resident #80, who was in his bed. On 1/30/19, a review was conducted of Resident #80's clinical record, revealing a PASARR 1 that was completed on 6/15/15. It documented that Resident #80 had a serious mental illness that may lead to a chronic disability, and has resulted in functional limitations in major life activities, and has required treatment more intensive than outpatient care. On 1/31/19 at approximately 4:00 P.M., the facility Administrator (Employee A) was informed of the findings. The Administrator stated that the former social worker had not completed a level 2 PASARR, and further stated; "that was one of the reasons that she no longer works here." No further information was received.	F 645		

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F 656	Continued From page 28	F 656		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not 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	F 656	F656 Develop/ Implement Comprehensive Care Plan 1.Resident #144 and resident #51 had no adverse reactions related to patient centered care plan implementation. Resident #144 had a resident centered care plan implemented to address behaviors. Resident #51 had a person centered care plan developed to address behaviors. 2.MDSC/designee will perform a quality review of current residents to ensure resident centered care plans are developed and implemented addressing behaviors and dementia and communication deficit. MDSC/designee will review care plans for measurable objectives to ensure that those residents with dementia have patient centered care plans. 3. ED/designee will re-educate IDT team on patient centered care plans development and implementation. 4. MDSC/designee will conduct quality review of care plans of residents with dementia and behavioral needs 3 x week for 1 month. Quality improvement monitoring findings to be reported to the QAPI Committee for a period of 2 months for compliance and/or revisions. 3/17/2019	

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F 656	Continued From page 29 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 staff interview, clinical record review and facility documentation the facility failed to develop and implement a comprehensive care plan for 2 Residents (Resident #144 and #51) in a survey sample of 54 Residents. 1. For Resident # 144, the facility failed to develop and implement a person-centered care plan that addresses behaviors. 2. For Resident #51, the facility staff failed to develop a comprehensive dementia care plan The findings include: 1. For Resident # 144, the facility failed to develop and implement a person-centered care plan that addresses behaviors. Resident #144 a 68 year old woman admitted to the facility on 12/29/2017 with diagnoses of but not limited to Dementia with Behavioral Disturbances, Diabetes, and Hypertension, history of falls, Chronic Viral Hepatitis, and Mood Disorder. Resident last (Minimum Data Set) MDS (screening tool) was an annual coded Resident as having a (Brief Interview of Mental Status) BIMS score of 3 indicating severe cognitive impairment. On 1/29/19 this surveyor requested all Psychiatric	F 656		

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F 656	Continued From page 30 / Psychological consults for this resident and received a consult dated 12/06/2018 stating that Resident #144 has " Past Psychiatric History of Mood Disorder " " Diagnoses History - DM II [Type 2 Diabetes], Hyperlipidemia [high cholesterol], HTN [hypertension], generalized muscle weakness, Hep C+ [Positive for Hepatitis C], Dementia, CVA [Cerebral Vascular Accident or Stroke] and Encephalopathy [a broad term for diseases that affect cognitive functioning of brain] On 1/29/2019 a review of the MDS for the years from 2018-2019 was completed. The review showed in only 1 (one) look back period did the MDS indicate any behavioral disturbance. On the 10/30/2018 MDS the E-200 was coded as 1-3 days Resident exhibited Physical Symptoms - (kicking, scratching, hitting) 1-3 Days Verbal Symptoms - (threatening, yelling , cursing). The E-100 section entitled PSYCHOSIS for all MDS's (including the one for 10/30/2019) coded the Resident as Z - None of the above - Indicating the Resident has had no Delusions or Hallucinations. In all but 1 (one) MDS screening the E-200-Behaviors section the Resident was coded as 0=Behavior NOT exhibited. During a clinical record review on 1/29/2019, the Care Plan was reviewed and found to have a FOCUS AREA for Behaviors stating "[Resident #141's Name] has a potential behavior problem r/t [related to] Dementia psychosis reaching for items not there wandering, confusion, verbal and aggressions toward other residents refused cut nails refused flu vaccine history of cursing,	F 656		

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F 656	Continued From page 31 argumentative, combative resistant to care prefers to be left alone at times. The Care Plan Goal Stated "The resident will have fewer episodes of (SPECIFY BEHAVIOR) by review date." The Interventions on this Care Plan state "Administer medications as ordered Monitor/document for side effects and effectiveness. Dated 1/18/2019 Anticipate and meet the resident's needs. Dated 1/18/2019 Educate the (Resident's Name) / resident representative on successful coping and interaction strategies." The Care plan also stated under Focus [Resident Name] is on antipsychotic therapy (SPECIFY MEDICATION) r/t Psychosis. The Care plan also stated that [Resident Name] has a potential for pain related to Metabolic Encephalopathy, Herpes Zoster, Diabetes, Hypertension. Under Goal it states the resident will display a decrease in behaviors of inadequate pain control (Specify- irritability agitation restlessness grimacing, perspiring, hyperventilation, groaning crying) through the review date. Under INTERVENTIONS it stated Administer analgesia (SPECIFY MEDICATION) as per orders .Give 1/2 hour before treatment or care it also states Evaluate the effectiveness of pain, interventions (SPECIFY FREQUENCY) Review for compliance, alleviating of symptoms, dosing schedules and resident satisfaction. During the end of day conference on 1/30/19 the Administrator and the DON were made aware of these issues and no further information was	F 656		

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F 656	Continued From page 32 provided. 2. For Resident #51, the facility staff failed to develop a comprehensive dementia care plan Resident #51 was admitted on 08/15/2017 with diagnoses that included but are not limited to dementia. Resident #51's care plan was reviewed during the survey. The review showed a care plan focus area related to dementia with an initiated date of 12/26/2018. However, the care plan was not person centered and did not have measurable objectives.	F 656		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident	F 657	F 657 Care Plan timing and Revision 1. Resident # 14 had no adverse reactions from remaining in facility without care plan being updated with discharge planning. Resident #14 care plan has been updated to reflect discharge planning decisions. Resident #34 had no adverse reactions from remaining in facility without care plan being updated with code status. Resident #34 care plan has been updated to reflect current code status.	

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F 657	Continued From page 33 and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, resident interview, facility documentation review and clinical record review, the facility staff failed to 1) revise a care plan to include discharge planning regarding independent living for Resident #14, and 2) failed to revise the care plan with the correct coding status for Resident # 34. The survey sample consisted of 54 residents. The Findings included: 1) For Resident #14, the facility staff failed to revise a care plan to include discharge planning regarding independent living for Resident #14. Resident #14 was a 57 year old who was admitted to the facility on 11/7/17. Resident #14's diagnoses included Encounter for Attention to Tracheostomy, Iron Anemia, and Unspecified Vitamin Deficiency. The Minimum Data Set, which was an Annual Assessment, with an Assessment Reference Date of 10/24/18 was reviewed. Resident #14 was coded as having a Brief Interview of Mental Status Score of 14, indicating that he was	F 657	2. SSD/MDSC/designee will perform a quality review of all resident's care plans to ensure that code status preferences and discharge plans are accurate and up to date. 3. ED/designee will re-educate SSD and MDSC on revising care plans with discharge planning code status. 4. SSD/MDSC/designee will perform quality audits to ensure revisions are made to resident's care plans regarding discharge planning and code status 3 x week for 1 month. Quality improvement monitoring findings to be reported to the QAPI Committee for a period of 2 months for compliance and/or revisions. 3/17/2019	

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F 657	Continued From page 34 independent in decision making ability. On 1/29/19 at 12:19 P.M., Resident #14 stated with difficulty (due to a trachea) that he "was independent and did not need to live here." He stated that he wants to move to his own apartment, or to an assisted living apartment. He further stated that he had requested discharge assistance from the previous social worker, and that "she didn't know what she was doing." He stated that he had been "ready to leave for months." On 1/29/19 at approximately 1:00 P.M., an interview was conducted with the current social worker. She stated that she hasn't worked with the residents yet because she is still in orientation, and "cleaning up the office". She stated that the last social worker "left abruptly". In addition, the care plan was reviewed. It did not contain any community discharge planning documentation. On 1/31/19 at approximately 4:00 P.M., the facility Administrator (Employee A) was informed of the findings. No further information was received. 2. For Resident #34, the facility staff failed to revise the care plan with the correct coding status. Resident #34 was a Do Not Resuscitate (DNR) however, on the care plan Resident #34 was a full code. Resident #34 was admitted to the facility on 08/16/2018. A review of Resident #34's clinical record was conducted during the survey. Resident #34's care plan, revised on 09/04/2018,	F 657		

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F 657	Continued From page 35 read that Resident #34 was a full code. However, an "Advance Directives Discussion Document" dated 01/15/2019 showed that Resident #34 was a DNR. The "Advance Directives Discussion Document" was signed by Resident #34's Power of Attorney. In addition, a physician order dated 01/15/2019 read that Resident #34 was a DNR. On 01/31/2019, an interview was conducted with the Unit Manger Licensed Practical Nurse (LPN) N. LPN N stated that usually everything is updated the same day. The facility provided no further information.	F 657		
F 658 SS=G	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. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review and facility documentation the facility failed to provide care in accordance with accepted standards of practice for 1 Resident (Resident #144) in a survey sample of 54 Residents. For Resident # 141, the facility failed to clarify an ambiguous order from a physician resulting in an overdose of Xanax and subsequent harm. The findings include: Resident #141 a 38 year old man admitted to the	F 658	Past noncompliance: no plan of correction required.	

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F 658	Continued From page 36 facility on 11/15/2017 with diagnoses of but not limited to Schizoaffective disorder, altered mental status, Dysphagia, cognitive communication deficit, anemia, COPD, Major depressive disorder, Respiratory failure, Poisoning by Benzodiazepines accidental unintentional squela. Resident # 141's most recent (Minimum Data Set) MDS (a screening tool) coded Resident as having a (Brief Interview of Mental Status) BIMS score of 10 which indicates moderate cognitive impairment. On 1/30/2019 a clinical record review was conducted and it was found that Resident #141 had an appointment at the hospital for an MRI on 10/3/2018. He had an MRI the previous week at the same hospital on 9/26/18. The Resident had an order for Xanax* 2 (Milligram) MG po (by mouth) prior to MRI at 1 PM on 09/26/2018 and Xanax 2 MG prior to MRI at 8 AM on 10/3/2018. May take a 2nd pill if needed. *Xanax is used to treat anxiety disorders and panic disorder (sudden, unexpected attacks of extreme fear and worry about these attacks). Xanax is in a class of medications called benzodiazepines. It works by decreasing abnormal excitement in the brain. According to the Narcotic Count sheet 1 (one) pill (2 MG) was signed out on 09/26/2018 prior to MRI appointment. On 10/3/2018 prior to the MRI appointment the Resident was given 2 (two) pills of Xanax 2 MG each for a total of 4 MG of Xanax. According to the hospital documentation the Resident was taken to the hospital by medical	F 658		

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F 658	Continued From page 37 transport and was sent back to the facility because he did not need another MRI. According to Nurses Notes dated "10/04/2018 at 11:10 Resident went out to appt this AM and returned from appt as coming in became unresponsive sternal rub slow to respond, BS [blood sugar] 96. O2 [Oxygen] was placed on resident at 2 (Liters per Minute) LPM (nasal cannula) at 98% Resident was assessed by Nursing staff code called. 911 activated arrived at the time of incident to pick up another resident for appt they resumed over resident 0 CPR initiated d/t resident having pulse and respirations. Resident transported to (hospital name) for eval. MD aware RP (RP Name) aware was coming in to facility a time. Bed hold renewed." According to hospital record on 10/03/2018 Resident #141 a "38 year old male with developmental delay, Schizoaffective disorder, admitted to the ICU [Intensive Care Unit] intubated [artificial airway placed to provide oxygen for patient unable to breathe spontaneously] The story is not very clear sounds as though he was sent her from his NH [Name of Facility] for a head CT. In order to tolerate the scan was given 4 MG of Ativan [wrong medication entered should have been Xanax] prior to transport. On arrival was told he did not need the CT as he had just had an MRI last week (for which 2 MG of Ativan was given) [again medication should have said Xanax] EMS came to pick him back up and bring him back to his NH and he was noted to be lethargic. There is some report that a sheet (?) had to be tied around him. At some point started to become cyanotic and brought back to the ER [emergency room] where he was intubated for airway protection. Not long	F 658		

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F 658	Continued From page 38 after this he started to wake up and follow commands so was extubated [tube removed] in the ER, However within 15 minutes of extubation was once again obtunded and reintubated. Is now in ICU on vent and unable to provide and subjective history." The Resident was admitted to the hospital with an admitting diagnosis of accidental overdose of Xanax. The Resident was discharged from the hospital on 10/8/2018 and returned to the facility. According to Perry & Potter 9th edition chapter 32 box 32-5 entitled "Steps to take to Prevent Medication Errors" Box 32-4 Steps To Take to Prevent Medication Errors o Prepare medications for only one patient at a time. o Follow the six rights of medication administration. o Be sure to read labels at least 3 times (comparing medication administration record [MAR] with label) before administering the medication. o Use at least two patient identifiers and review the patient's allergies whenever administering a medication. o Do not allow any other activity to interrupt administration of medication to a patient (e.g., phone call, pager, discussion with other staff) (Hopkinson and Jennings, 2013). o Double check all calculations and other high risk medication administration processes (e.g., patient-controlled analgesia, heparin, Insulin) and verify with another nurse. o Do not interpret illegible handwriting; clarify with	F 658		

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F 658	Continued From page 39 health care provider. o Question unusually large or small doses. On 1/31/2018 an interview was conducted with the DON who stated she was not present at the time of the incident however she felt in her opinion whoever took or transcribed the order should have had it clarified the order had no parameters to show when to give the second pill it only stated "May give second pill if necessary." DON was asked if 4 MG was a usual dose of Xanax for anxiety for a Resident prior to a procedure. She stated that it seemed like a high dose. She further stated that in her opinion as an RN and a DON an accidental overdose resulting in being intubated and hospitalized in the ICU for 5 days constituted harm. On 1/31/2018 in an interview with the Administrator she stated "I meant no lasting harm when I wrote in the FRI sustained no harm, of course he was harmed by the administration of the medicine and had to be intubated but I mean there were not lasting effects from it. " NOTE: This investigation is the result of a (Facility Reported Incident) FRI submitted to the OLC on 10/08/2018. The FRI stated that "On 10/03/2018 Resident #141 was administered and extra dose of Xanax prior to a procedure. He was sent to the hospital and admitted. He suffered no harm as a result of the incident and has since returned to the facility and is doing well." The facility Administrator stated that they had	F 658		

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F 658	Continued From page 40 self-identified the deficient practice prior to survey and presented the survey team with a Plan of Correction and requested a consideration for Past Non-Compliance, which is as follows: 1. Resident #141 no longer resides at the facility 2. DON/Designee conducted a Quality Review of Physician orders to ensure medication administration transcription to the Medication Administration Record (MAR) is correct. 3. DON/Designee provided re-education to licensed nurses. 4. DON/Designee to Quality improvement monitoring on all physician orders 5. Date of compliance 10/30/18 Past non-compliance	F 658		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, facility documentation, and clinical record review, the facility staff failed to act upon pharmacy alerts for # 9, failed to ensure the provision of care in accordance with resident's choice for # 14 in a survey sample of 54 Residents.	F 684	F 684 Quality of Care 1. Resident #9 had no adverse outcome to not addressing pharmacy alert. Resident #9 provider addressed pharmacy alert, with no new orders. Resident #14 has had no adverse outcome to not being in a less restrictive environment. Resident #14 has met with social services director to address discharge planning. 2. The DON/designee conducted a Quality monitoring review of current resident's pharmacy alerts to ensure they have been addressed. The SSD/designee conducted a quality monitoring review of current resident's discharge planning is current.	

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F 684	Continued From page 41 1. For Resident # 9, the facility failed to act on pharmacy alerts for medication interactions. 2. For Resident # 14, the facility staff failed to ensure the provision of care in accordance with the Resident's choice to live in a less restrictive environment. The findings include: 1. For Resident #9 the facility failed to act on pharmacy alerts of medications that were incompatible. Resident #9 is a 50 year old woman admitted to the facility on 7/11/2018 with diagnoses including but not limited to (Human immunodeficiency Disease) HIV, Dysarthria, contractures right hand, Anemia, Reflux, Psychosis not due to a substance or known physiological condition, polyneuropathy, hypertension, Herpes Viral Infection, right side hemiplegia (right sided weakness) and atrial fibrillation. A review of clinical record on 1/30/2019 showed that on 1/18/2019 at 19:11A the nurses notes read Note Text: The order you have entered Zoloft Tablet 50 MG [Milligrams] (Sertraline HC) Give 1 tablet by mouth one time a day related to Major Depressive Disorder, Recurrent Unspecified (F33.9) Has triggered the following drug protocol alerts/warnings.	F 684	3. DON/designee will re-educate nursing staff on pharmacy alerts are addressed. ED/designee will re-educate staff on discharge planning. 4.DON/designee will conduct quality monitoring to ensure pharmacy alerts are addressed to identify any drug to drug interaction messages 3 x week for 1 month. SSD/designee will conduct quality monitoring to ensure discharge planning is current 3 x week for 1 month. Quality improvement monitoring findings to be reported to the QAPI Committee for a period of 2 months for compliance and/or revisions. DOC: 3/17/2019	

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F 684	Continued From page 42 Drug to Drug Interaction The system has identified a possible drug interaction with the following orders. Metoprolol Tartrate Tablet 25 MG Give 25 MG by mouth every 12 hours for HTN SEVERITY: Moderate Interaction: Plasma concentrations and pharmacologic effects of Metoprolol Tartrate Tablet 25 MG may be increased by Zoloft Tablet 50 MG. The clinical significance of this interaction is unknown. Tramadol HCL Tablet 50 MG Give 1 tablet by mouth at bedtime related to chronic pain (G 89.29) SEVERITY: SEVERE Interaction: Coadministration of Tramadol tablet 50 MG and Zoloft Tablet 50 MG may be associated with an increased risk of serotonin syndrome and possibly increase risk of seizures. According to Physicians orders Resident #9 Resident also has order for Sertraline (ZOLOFT) 100 mg at bedtime as well as the order for 50 MG during the day. Resident also has a PRN (as needed) order for Tramadol 50 MG 1 tablet every 6 hours as needed for pain. As well as the routine Tramadol at bedtime. In an interview with DON when asked what nurse should do when pharmacy alerts come up she stated that the MD should be notified to decide if they want to change orders or keep them the same. There was no evidence that the nurse notified the MD.	F 684		

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F 684	Continued From page 43 On 01/31/2019 during the end of day meeting the Administrator and DON were made aware and no further information was provided. 2. For Resident # 14, the facility staff failed to ensure the provision of care in accordance with the Resident's choice to live in a less restrictive environment. Resident #14 was a 57 year old who was admitted to the facility on 11/7/17. Resident #14's diagnoses included Encounter for Attention to Tracheostomy, Iron Anemia, and Unspecified Vitamin Deficiency. The Minimum Data Set, which was an Annual Assessment, with an Assessment Reference Date of 10/24/18 was reviewed. Resident #14 was coded as having a Brief Interview of Mental Status Score of 14, indicating that he was independent in decision making ability. On 1/29/19 at 12:19 P.M., Resident #14 stated with difficulty (due to trachea) that he "was independent and did not need to live here." He stated that he wants to move to his own apartment, or to an assisted living apartment. He further stated that he had requested discharge assistance from the previous social worker, and that "she didn't know what she was doing." He stated that he had been "ready to leave for months." On 1/29/19 at approximately 1:00 P.M., an Interview was conducted with the current social worker. She stated that she hasn't worked with the residents yet because she is still in orientation, and "cleaning up the office". She stated that the last social worker "left abruptly". In	F 684		

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F 684	Continued From page 44 addition, The care plan was reviewed. It did not contain any community discharge planning documentation. On 1/31/19 at approximately 4:00 P.M., the facility Administrator (Employee A) was informed of the findings. No further information was received.	F 684		
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 observations, Resident interview, staff interviews, clinical record review, and facility documentation, the facility staff failed to provide social services for one Resident (Resident #131) in a sample size of 54 residents. The findings include: Resident #131, a 71-year old male was admitted to the facility on 03/16/2016. Diagnoses included but are not limited to hypertension, diabetes, end stage renal disease, and difficulty walking. Resident #131's most recent Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 12/26/2018 was coded as a quarterly assessment. Resident #131 was coded with a Brief Interview of Mental Status (BIMS) score of "15" out of possible 15 indicating no cognitive impairment. Functional status for dressing and personal hygiene was coded as total dependence on staff. Functional status for eating was coded	F 745	F745 Provision of Medically Related Social Service 1. Resident #131 had no adverse effect from not having a social worker to help with his community relations with his ex-wife. 2. ED/designee conducted a Quality Review of current residents to ensure that there psychosocial needs are being met. Follow up was done based on findings. 3. ED/designee provided re-education to social services on regulation F745 with emphasis on psychosocial needs. 4. ED/designee to complete Quality Improvement monitoring to ensure psychosocial needs are being met. Monitoring will be conducted 3 x weekly for 1 month, and then quarterly, as needed. Findings to be reported to QAPI Committee monthly and updated as indicated. 5. Date of compliance: 3/17/19	

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F 745	Continued From page 45 as independent requiring set-up help only. On 01/29/2019 at 4:45 PM, the Resident was observed lying in bed awake in a hospital gown with the head of the bed elevated approximately 45 degrees. When asked if the Resident has seen a social worker since arriving at the facility, the Resident stated "no." The Resident went on to list his psychosocial needs associated with his living/financial arrangements, marital status, and obtaining personal items from home, including his clothes and his wheelchair. On 01/30/2019, the nurse's notes with a date range 12/22/2018 to 01/29/2019 were reviewed. A social services note dated 12/22/2018 at 3:35 PM documented, "Social Services attempted to meet and complete admission paperwork but the resident stated that he was in too much pain. Social Services expressed that she understood and would come back at a later date." No subsequent social services notes were documented up to the first day of survey on 01/29/2019. On 01/30/2019 at 11:20 AM, an interview with certified nursing assistant, CNA B, was conducted. When asked about the Resident's personal items, CNA B stated, "He doesn't have much clothes." On 01/31/2019 at 9:45 AM. An interview with Employee F, the social worker, was conducted. When asked about Resident #131, Employee F stated, I have been here 7 days and I have no information about [resident name]." On 01/31/2019 at approximately 4:40 PM, the Administrator provided a timeline of social worker	F 745		

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F 745	Continued From page 46 staffing. One social worker term of employment was 08/30/2018 - 01/03/2019. A subsequent social worker's employment term was 01/02/2019 - 01/26/2019. The current social worker's first day of work was 01/23/2019. On 01/31/2019 at approximately 6:20 PM, the Administrator and DON were notified of findings of lack of social services for this Resident and they offered no further documentation or information.	F 745		
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of	F 755	F755 Pharmacy Services/ Procedures/ Pharmacist/Records 1. Expired heparin flushes observed in medication room was discarded 1/29/2019. There were no adverse reactions noted from the presence of the flushes. 2. As all medication storage rooms have the potential to be affected, the DON/designee conducted quality monitoring on all medication rooms to ensure no expired medications existed. 3. DON/designee will re-educate licensed nursing staff on quality monitoring of medication rooms to ensure the absence of and discarding of expired medications. 4. DON/designee will conduct quality monitoring rounds in medication rooms to ensure no expired medications exist 3 x weekly for 1 month. Quality improvement monitoring findings to be reported to the QAPI Committee for a period of 2 months for compliance and/or revisions. DOC: 3/17/2019	

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F 755	Continued From page 47 receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview the facility staff failed to ensure expired medications were not available for use on 1 of 2 sampled medication rooms. In the wing 3 medication room a heparin flush that had an expiration date on 10/31/2018 was available for use. The findings included: On 01/29/19 at 01:06 PM an observation was made of the wing 3 medication room with Licensed Practical Nurse (LPN) M. The observation showed a heparin flush with an expiration date on 10/31/2018. LPN M agreed that the heparin flush should have been discarded after the expiration date. The facility provided no further information.	F 755		
F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart.	F 756	F 756 Drug Regimen Review, Report irregular, Act on 1. Resident #51 had no adverse reactions from not having pharmacy medication regimen review signature in December 2018. A medication regimen was conducted, with no new recommendations made.	

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F 756	Continued From page 48 §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review, facility staff failed to ensure a Medication Regimen Review was completed for one resident (Resident # 51) in a sample of 54 residents. Resident #51, Medication Review Regimen for the month of December was not completed. The findings include:	F 756	2. DON/designee conducted quality monitoring review to ensure current residents have had a medication regimen review. 3. DON/designee will re-educate pharmacy consultant on ensuring residents receive medication regimen review monthly and the log is signed. 4. DON/designee will monitor the review of medication regimen review are conducted monthly for 2 months. Quality improvement monitoring findings to be reported to the QAPI Committee for a period of 2 months for compliance and/or revisions. DOC: 3/17/2019	

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F 756	Continued From page 49 Resident #51 was admitted on 08/15/2017 with diagnoses that included but are not limited to dementia. A review of Resident #51's clinical record was conducted during the survey. The review showed that Resident #51's Medication Regimen Review for the month of December 2018 was not completed by the pharmacist. On 01/31/19 at approximately 06:00 PM, the Director of Nursing stated that pharmacist should be documenting Medication Regimen Reviews on the yellow Medication Review Regimen form. The facility provided no further information.	F 756		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented	F 758	F 758 Free from unnecessary psychotropic meds/PRN use 1. Resident #144 and #51 had no adverse effects related to psychotropic medication not having diagnosis. Resident #51 has been discharged from the facility. Resident #144 has been stable, and medication is discontinued. 2. As all resident receiving antipsychotic medication have the potential to be affected, a quality medication review will be conducted for those residents currently receiving antipsychotic medications to ensure proper diagnosis for medications.	

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F 758	Continued From page 50 in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review and facility documentation the facility failed to ensure two residents were free from unnecessary antipsychotic medications (Resident #144 and Resident #51) in a survey sample of 54 Residents. 1. For Resident # 144 the facility failed to prevent unnecessary medication specifically	F 758	3. RDCS/designee will re-educate MDs, NPs, and nursing management staff on ensuring proper diagnosis for antipsychotic medication use. 4. DON/designee will conduct quality monitoring of residents ordered to have antipsychotic medications will be reviewed weekly to ensure proper diagnosis for those residents receiving antipsychotic medications for 1 month. Quality Improvement monitoring findings will be reported to QAPI Committee monthly for a period of 2 months for further compliance and/or revision. 3/17/2019	

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F 758	Continued From page 51 antipsychotics to a resident (Resident #141) who does not have a diagnosis to support the use of anti-psychotics. 2. For Resident #51, the facility staff failed to have an appropriate diagnosis for the use of Risperidone. The Findings Include: Resident #144 a 68 year old woman admitted to the facility on 12/29/2017 with diagnoses of but not limited to Dementia with Behavioral Disturbances, Diabetes, and Hypertension, history of fall, Chronic Viral Hepatitis, and Mood Disorder. Resident last (Minimum Data Set) MDS (screening tool) was an annual coded Resident as having a (Brief Interview of Mental Status) BIMS score of 3 indicating severe cognitive impairment. On 1/29/2019 during a clinical record review it was noted that Resident #144 was taking the antipsychotic medication Seroquel 25 (milligrams) MG twice a day and Seroquel 50 MG at bedtime. The Resident's diagnoses include Dementia with Behavioral Disturbance and Mood Disorder, neither of which support the use of Anti Psychotics. On 1/29/19, this surveyor requested all Psychiatric / Psychological consults for this resident and received a consult dated 12/06/2018 stating that Resident #144 has " Past Psychiatric - History of Mood Disorder NOS [Not Otherwise Specified] " Diagnoses History - DM II [Type 2 Diabetes], Hyperlipidemia [high cholesterol], HTN [hypertension], generalized muscle weakness,	F 758		

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F 758	Continued From page 52 Hep C+ [Positive for Hepatitis C], Dementia, CVA [Cerebral Vascular Accident or Stroke] and Encephalopathy [a broad term for diseases that affect cognitive functioning of brain]." On 1/29/2019 a review of the MDS for the year from 2018-2019 in only 1 (one) look back period does the MDS indicate any behavioral disturbance. On the 10/30/2018 MDS the E-200 was coded as 1-3 days Resident exhibited Physical Symptoms - (kicking, scratching, hitting) 1-3 Days Verbal Symptoms - (threatening, yelling , cursing). In MDS Section E-100 - PSYCHOSIS for all evaluations (including 10/30/2019) Resident #144 was coded as Z - None of the above Indicating the Resident has had no Delusions or Hallucinations. In all but 1 (one) MDS the E-200- Behaviors section the Resident was coded as 0=Behavior NOT exhibited. A copy of original order for Seroquel which was dated 10/25/2018 was reviewed. The Order Summary States "Quetiapine Fumarate [generic name for Seroquel] 25 MG Give 1 tablet by mouth two times per day. Related to Mood Disorder due to known physiological condition with depressive features." On 1/30/2019 the DON was asked about use of Antipsychotics in Dementia patients and she stated she was aware of the black box warning for use with Dementia patients. She also stated she was aware that Resident #141 had a diagnosis of Mood Disorder which was not a	F 758		

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F 758	Continued From page 53 diagnosis for using an anti-psychotic. On 1/31/19 during the end of day conference the Administrator was made aware and no further information was provided. 2. For Resident #51, the facility staff failed to have an appropriate diagnosis for the use of Risperidone for a resident that has dementia. The findings include Resident #51 was admitted on 08/15/2017 with diagnoses that included but are not limited to dementia. A Minimum Data Set with an Assessment Reference Date of 11/15/2018 coded Resident #51 as cognitively intact. Resident #51's physician orders were reviewed during the survey . The physician orders showed an order dated 01/28/2019 that read that Resident #51 was to get a 1 milligram tablet of Risperidone at bedtime for "mood." Risperidone has a boxed warning for people with dementia. According to medlineplus.gov: "Studies have shown that older adults with dementia (a brain disorder that affects the ability to remember, think clearly, communicate, and perform daily activities and that may cause changes in mood and personality) who take antipsychotics (medications for mental illness) such as risperidone have an increased risk of death during treatment. Older adults with dementia may also have a greater chance of having a stroke or ministroke during treatment. Tell your doctor and pharmacist if you are taking	F 758		

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F 758	Continued From page 54 furosemide (Lasix). Risperidone is not approved by the Food and Drug Administration (FDA) for the treatment of behavior problems in older adults with dementia. Talk to the doctor who prescribed this medication if you, a family member, or someone you care for has dementia and is taking risperidone."	F 758	F 760 Residents are free from significant medication error 1. Resident #80 had no adverse reactions from not having BP checked for ordered PRN medication. The MD and RP were made aware and medication was discontinued. Resident #80 has had no adverse reactions or change of condition. 2. As any resident is at risk for significant medication errors, a quality review will be conducted on all current medication orders to ensure proper assessments are performed to determine administration of medications. 3. DON/designee will re-educate licensed nursing staff to assess residents with medication administration parameters per physician orders. 4. DON/designee will conduct quality medication review 3 x week for 1 month to ensure residents are free from significant medication error. Quality improvement findings to be reported to QAPI Committee monthly for a period of 2 months for further compliance and/or revision. 3/17/19	
F 760 SS=G	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review and facility documentation the facility failed to ensure two Residents were free from significant medication error in a survey sample of 54 Residents. 1. For Resident # 141 the facility failed to ensure Resident received proper dose of medication causing significant medication error and harm resulting in Resident being hospitalized and intubated and placed on Ventilator. 2. For Resident #80, the facility staff repeatedly failed for 90 opportunities (30 consecutive days times every 8 hours), to ensure physician-ordered blood pressure monitoring for a PRN (as needed) low blood pressure medication (Midodrine). The findings include: 1. For Resident # 141 the facility failed to ensure	F 760		

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F 760	Continued From page 55 Resident received proper dose of medication causing significant medication error and harm resulting in Resident being hospitalized and intubated and placed on Ventilator. Resident #141 a 38 year old man admitted to the facility on 11/15/2017 with diagnoses of but not limited to Schizoaffective disorder, altered mental status, Dysphagia, cognitive communication deficit, anemia, COPD, Major depressive disorder, Respiratory failure, Poisoning by Benzodiazepines accidental unintentional squela. Resident # 141's most recent (Minimum Data Set) MDS (a screening tool) coded Resident as having a (Brief Interview of Mental Status) BIMS score of 10 which indicates moderate cognitive impairment. On 1/30/2019 a clinical record review was conducted and it was found that Resident #141 had an appointment at the hospital for an MRI on 10/3/2018. He had an MRI the previous week at the same hospital on 9/26/18. The Resident had an order for Xanax* 2 (Milligram) MG po (by mouth) prior to MRI at 1 PM on 09/26/2018 and Xanax 2 MG prior to MRI at 8 AM on 10/3/2018. May take a 2nd pill if needed. *Xanax is used to treat anxiety disorders and panic disorder (sudden, unexpected attacks of extreme fear and worry about these attacks). Xanax is in a class of medications called benzodiazepines. It works by decreasing abnormal excitement in the brain. According to the Narcotic Count sheet 1 (one) pill (2 MG) was signed out on 09/26/2018 prior to	F 760		

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F 760	Continued From page 56 MRI appointment. On 10/3/2018 prior to the MRI appointment the Resident was given 2 (two) pills of Xanax 2 MG each for a total of 4 MG of Xanax. According to the hospital documentation the Resident was taken to the hospital by medical transport and was sent back to the facility because he did not need another MRI. According to Nurses Notes dated "10/04/2018 at 11:10 Resident went out to appt this AM and returned from appt as coming in became unresponsive sternal rub slow to respond, BS [blood sugar] 96. O2 [Oxygen] was placed on resident at 2 (Liters per Minute) LPM (nasal cannula) at 98% Resident was assessed by Nursing staff code called. 911 activated arrived at the time of incident to pick up another resident for appt they resumed over resident 0 CPR initiated d/t resident having pulse and respirations. Resident transported to (hospital name) for eval. MD aware RP (RP Name) aware was coming in to facility a time. Bed hold renewed." According to hospital record on 10/03/2018 Resident #141 a "38 year old male with developmental delay, Schizoaffective disorder, admitted to the ICU [Intensive Care Unit] intubated [artificial airway placed to provide oxygen for patient unable to breathe spontaneously] The story is not very clear sounds as though he was sent her from his NH [Name of Facility] for a head CT. In order to tolerate the scan was given 4 MG of Ativan [wrong medication entered should have been Xanax] prior to transport. On arrival was told he did not need the CT as he had just had an MRI last week (for which 2 MG of Ativan was given) [again medication should have said Xanax] EMS came	F 760		

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F 760	Continued From page 57 to pick him back up and bring him back to his NH and he was noted to be lethargic. There is some report that a sheet (?) had to be tied around him. At some point started to become cyanotic and brought back to the ER [emergency room] where he was intubated for airway protection. Not long after this he started to wake up and follow commands so was extubated [tube removed] in the ER, However within 15 minutes of extubation was once again obtunded and reintubated. Is now in ICU on vent and unable to provide and subjective history." The Resident was admitted to the hospital with an admitting diagnosis of accidental overdose of Xanax. The Resident was discharged from the hospital on 10/8/2018 and returned to the facility. On 1/31/2018 an interview was conducted with the DON who stated she was not present at the time of the incident however she felt in her opinion whoever took or transcribed the order should have had it clarified the order had no parameters to show when to give the second pill it only stated "May give second pill if necessary." DON was asked if 4 MG was a usual dose of Xanax for anxiety for a Resident prior to a procedure. She stated that it seemed like a high dose. She further stated that in her opinion as an RN and a DON an accidental overdose resulting in being intubated and hospitalized in the ICU for 5 days constituted harm. On 1/31/2018 in an interview with the Administrator she stated "I meant no lasting harm when I wrote in the FRI sustained no harm, of	F 760		

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F 760	Continued From page 58 course he was harmed by the administration of the medicine and had to be intubated but I mean there were not lasting effects from it." NOTE: This investigation is the result of a (Facility Reported Incident) FRI submitted to the OLC on 10/08/2018. The FRI stated that "On 10/03/2018 Resident #141 was administered and extra dose of Xanax prior to a procedure. He was sent to the hospital and admitted. He suffered no harm as a result of the incident and has since returned to the facility and is doing well." The facility Administrator stated that they had self-identified the deficient practice prior to survey and presented the survey team with a Plan of Correction and requested a consideration for Past Non-Compliance, however the deficient practice of medication errors continued during the survey and thus the Past Non-Compliance was not accepted by the survey team. 2. For Resident #80, the facility staff repeatedly failed for 90 opportunities (30 consecutive days times every 8 hours), to ensure physician-ordered blood pressure monitoring for a PRN (as needed) low blood pressure medication (Midodrine). Resident #80 was a 62 year old who was admitted to the facility on 8/28/18. Resident #80's diagnoses included Hypotension, Personal History of Traumatic Brain Injury, Generalized Muscle Weakness, Seizures, Neurosyphilis, Osteoarthritis, Prostate Cancer, Major Depressive Disorder, Anxiety Disorder, Cataracts in both eyes, Type 2 Diabetes Mellitus, Retention	F 760		

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F 760	Continued From page 59 of Urine, Constipation, and Dementia with Behavioral Disturbance. The Minimum Data Set, which was a Quarterly Assessment with an Assessment Reference Date of 11/29/18, coded Resident #80 as having severely impaired cognition. On 1/29/19, a review was conducted of Resident #80's clinical record, revealing the following signed physician's order dated 1/1/19: "Midodrine HCl Tablet 10 MG. Give 1 tablet by mouth every 8 hours as needed for systolic blood pressure less than 95 mmhg/Hypotension." The clinical record contained the Medication Administration Record for January, 2019. The facility staff failed to document the blood pressure, and failed to administer the medication if needed during the entire month of January. The nurses' notes did not contain documentation of the blood pressure monitoring on any shift, nor the administration, if needed of the medication. On 1/29/19, a review was conducted of facility documentation, revealing a Medication Administration Policy dated 9/22/17. It read: "Chart on Medication Administration Record according immediately following when medication is given and before proceeding to the next resident." On 1/31/19 at 2:15 P.M. the Assistant Director of Nursing (Employee C) was interviewed. When asked about the importance of monitoring blood pressure, she stated, "The importance of monitoring the blood pressure is that if it is low then we administer the PRN order for Midodrine. If you're not monitoring the blood pressure you wouldn't know when to give it. I expect the nurses	F 760		

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F 760	Continued From page 60 to document administration as soon as they give it." On 1/31/19 at approximately 4:00 P.M., the facility Administrator (Employee A) was informed of the findings. No further information was received.	F 760		