STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495308	A. BUILDING _____ B. WING _____	C 03/22/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERSIDE REHABILITATION CENTER AT HAMPTON	414 ALGONQUIN RD HAMPTON, VA 23661

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 3/20/19 through 3/22/19. 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		
E 007 SS=C	EP Program Patient Population CFR(s): 483.73(a)(3) [(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do the following:] (3) Address patient/client population, including, but not limited to, persons at-risk; the type of services the [facility] has the ability to provide in an emergency; and continuity of operations, including delegations of authority and succession plans.** *Note: ["Persons at risk" does not apply to: ASC, hospice, PACE, HHA, CORF, CMCH, RHC, FQHC, or ESRD facilities.] This REQUIREMENT is not met as evidenced by: Based on staff interviews and review of the facility's emergency preparedness program, the facility staff failed to identify the residents in the facility to properly plan for their needs in the event of an emergency. The findings include: On 3/22/19 at 9:10 a.m., an interview was conducted with the Administrator and the Director of Maintenance. The Administrator presented a	E 007	1. On 4/8/19, the centers unit managers completed a list of at risk residents and identified their individual needs so care can be met in the event of an emergency. 2. All residents who reside at the center have the potential to be affected. 3. IDT/leadership educated by facility administrator on process of maintaining current list of resident's at high risk and their individual needs on 4/9/19. After each update the list will be printed and	4/26/19

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

Electronically Signed | 04/12/2019

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E 007	Continued From page 1 policy that indicated the following regarding the at risk residents during an emergency event: "In order to ensure the facility is capable of providing adequate care to all its residents, the facility accepts only those residents whose needs can be adequately managed. During an emergency, groups of residents who may become at higher risk include-non-ambulatory resident, skilled nursing residents, patients requiring supporting technologies, expectant residents, bariatric resident, hearing/vision-impaired residents, non-English speaking residents, memory impaired residents and elopement risk residents." The Administrator or the Director of Maintenance was not able to present the individual needs of each of the aforementioned resident type if there was an immediate emergency without having to go through each resident profile which would possibly delay a necessary service for the residents.	E 007	available 24/7 to staff. On 4/8/19 all Unit Managers have developed a list of residents determined to be at risk in the event of an emergency. The list consists of non-ambulatory, those requiring supportive technology, bariatric, vision/hearing impaired, non-English speaking, memory impaired and those at risk for elopement. The list will be updated and reviewed daily M-F in facility department head meeting and in IDT risk meeting weekly. Updated copies will be placed in evacuation kit. 4. Facility administrator will audit for completion of the Emergency Resident List 3 times weekly times 12 weeks. The results of the audits will be reported by the facility administrator /designee at the Clinical Operations Review and the QA meetings for evaluation of compliance, ongoing monitoring for continuous improvement and to determine if any modifications to the action plans are necessary after the implementation.	
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 3/20/19 through 3/22/19. Three complaints were investigated during the survey. Corrections are required for compliance with the following 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. The census in this 130 certified bed facility was 98 at the time of the survey. The survey sample consisted of 38 residents: 33 current resident	F 000		

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F 000	Continued From page 2 reviews and 5 closed record reviews.	F 000		
F 567 SS=E	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 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	F 567		4/26/19

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F 567	Continued From page 3 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 general observations, staff, resident and group interview, the facility staff failed to ensure the resident who have authorized the facility to manage their personal funds have ready and reasonable access to those funds. The findings include: On 3/21/19 at 11:30 a.m. a group interview was conducted with seven residents that represented the facility's units. When the standard group question was asked if they had access to their money seven days a week, it was a consensus of the group that responded they had access and knew they could get money Monday through Friday from 10:00 am to 2:00 p.m., but not on the weekends. The group stated they knew "by word of mouth" that 10:00 a.m. to 2:00 p.m. Monday through Friday were the only banking hours. The posting of the banking hours for the residents was located in the front lobby on a table sitting up in a 8 x 10 Plexiglas frame that read "Banking Hours Monday through Friday 10:00 a.m.-2:00 p.m. Saturday and Sunday request by 10:00 a.m. " Resident #86 stated, "I am barely up and finished breakfast before I can request money by 10:00 a.m. and on Sunday I am gone for church at that time. I get money during the week for the weekend." Resident #3 stated, "Where is that posting, I never go to the lobby. I never saw it, but does it say who to ask on the weekends?" Resident #47 stated he was not aware of the banking hours on the weekends and thought	F 567	1. The residents at facility have access to resident account funds 7 days per week. New signage was posted by Facility receptionist on each unit facility receptionist on 3/22/19. 2. All residents residing in a facility who have authorized the facility to manage their personal funds have the potential to be affected. 3. On 3/22/19 new banking hours went into effect. Signage was posted by in lobby and each nurse's station at wheelchair eye level utilizing bold, large font. On 4/3/19, the activities director addressed resident council and discussed banking hours. Business office associates have been educated on the Resident Trust Fund Accounting Policy by facility administrator on 4/5/19. On 4/9/19, the activities director provided each resident residing at facility a flyer with banking hours noted. The banking hours will be communicated to new admissions via admission packet starting 4/12/19. Nursing Staff will be educated by the DON or designee 4/10/19 on process for requesting funds to advise the residents as needed. 4. Business office manager will interview 6 residents a week for 12 weeks that they are aware of banking hours and have had no concerns about receiving money timely when requested. The results of the audits	

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F 567	Continued From page 4 there were no weekend banking hours. Resident #61, the resident council president stated, "We just want to get our money when we want it. For some of us by 10:00 a.m. may not work on the weekends. I would like to know if there are different people we ask on the weekend?" When taken to the table in the lobby, the resident had some difficulty locating the sign among the many brochures and other informational materials on the table. The sign had to be pointed out to her. There were no postings of banking hours on either of the three nursing units. On 3/22/19 at 11:00 a.m., the front lobby Receptionist #7 stated, when called, she and another person was able to provide banking on the weekends. She stated not all receptionists could provide banking services for residents on the weekends. She was not able to explain how the residents knew who to ask on the weekends. On 3/22/19 at 11:30 a.m., interviews were conducted with the Director of Nursing (DON), Assistant Director of Nursing (ADON), Corporate Clinical Nurse (CCN) #1, and CCN #2. The resident confusion about whether or not banking hours were provided on the weekends was brought to their attention. They reaffirmed the same information provided to this surveyor by Receptionist #7. On 3/22/19 at 2:30 p.m., the Chief Compliance Officer (CCO) stated she could not find anywhere in the federal regulation that stated there had to be a posting of banking hours, only that the funds had to be assessable. It was brought to her attention that one of the routine questions of the group interview posed to the residents asked the question about access to funds on the weekend,	F 567	will be reported by the facility administrator /designee at the Clinical Operations Review and the QA meetings for evaluation of compliance, ongoing monitoring for continuous improvement and to determine if any modifications to the action plans are necessary after the implementation.	

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F 567	Continued From page 5 to which they responded they thought there were no weekend banking hours or who to ask on the weekend. They were not aware of any postings that would inform them of this information. They were under the impression to date that their funds were not available on the weekend regardless of whether they did not bring this issue to anyone's attention before the question was asked in group meeting or that there may not be adequate posting in conspicuous areas that assisted the residents with the necessary information to access their funds. On 3/22/19 at 3:00 p.m., postings were observed being placed in conspicuous places on each nursing unit in very large bold print that read, "BANKING HOURS MONDAY-FRIDAY 10:00 AM-2 PM SATURDAY & SUNDAY 8:00 AM-10:00 AM PLEASE SEE RECEPTIONIST." This posting had been changed to reflect larger bold font, change in hours for the weekend and who to ask for banking services to include the weekend. On 3/22/19 at 3:15 p.m., the ADON stated they may even modify the weekend hours to be more accessible once they talk to the residents. On 3/22/19 at 4:00 p.m., a debriefing was conducted with the Administrator, the DON, ADON, CCO, CC1 and CC2. No further information was provided prior to survey exit. The facility's policy and procedures titled Resident Trust Fund Accounting dated as last revised 12/20/18 indicated "The resident must have access to their funds daily, at least two hours during normal business office hours and for some reasonable time on Saturday and Sunday."	F 567		
F 575	Required Postings	F 575		4/26/19

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F 575 SS=C	Continued From page 6 CFR(s): 483.10(g)(5)(i)(ii) §483.10(g)(5) The facility must post, in a form and manner accessible and understandable to residents, resident representatives: (i) A list of names, addresses (mailing and email), and telephone numbers of all pertinent State agencies and advocacy groups, such as the State Survey Agency, the State licensure office, adult protective services where state law provides for jurisdiction in long-term care facilities, the Office of the State Long-Term Care Ombudsman program, the protection and advocacy network, home and community based service programs, and the Medicaid Fraud Control Unit; and (ii) A statement that the resident may file a complaint with the State Survey Agency concerning any suspected violation of state or federal nursing facility regulation, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, and non-compliance with the advanced directives requirements (42 CFR part 489 subpart I) and requests for information regarding returning to the community. This REQUIREMENT is not met as evidenced by: Based on observations, resident, group and staff interviews the facility staff failed to have ensured that the names, addresses and telephones numbers of all State resident advocacy groups and the State survey agency were legible and posted in a conspicuous place and position accessible to the facility residents. Upon the State survey and certification agency's team entrance into the facility and during the orientation tour the posting of information on the advocacy groups and State survey agency was	F 575	1. On 3/22/19, new postings for state agencies and advocacy groups were re-posted facility receptionist, utilizing bold, large font and placed at w/c eye level in front lobby. 2. All residents residing in the facility have the potential to be affected. 3. On 4/3/19, the activities director addressed resident council and discussed required postings and locations. On 4/9/19 the activities director provided each resident residing at facility a flyer	

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F 575	Continued From page 7 noted to be illegible in small print and in a position on the wall and hallway inaccessible to the residents. The findings included: The State survey team entered the facility on 03/20/19 at approximately 11:00 AM. The front lobby was inspected for posting of information concerning advocacy groups and the State survey agency; it was located on a a bulletin board in a high position in very small illegible print. During an interview with 7 residents, identified as interviewable by the facility staff and representing the 'Resident Council', there were no residents out of 7 residents in the group meeting on 03/21/19 at 11:30 a.m. that acknowledged they knew the voluntary Ombudsman, that they were aware of how to contact the Ombudsman and/or the State survey agency, or were able to indicate where the advocacy group and State survey agency names, addressees and telephone numbers were posted. Resident #3, #59 and #86 represented all three units of the facility. After the group meeting these residents were taken to the lobby, at which time no one could locate the posting and when shown, they could not read the small print, nor was the posting at a level accessible to them in order to read the poster content. Each of these residents were also taken to the information bulletin board on each of their units. They were not able to locate the State Agency information because the print was either too small and illegible, or the postings were too high to access reading in a wheelchair position.	F 575	addressing required posting locations. The admissions director has added state agency and advocacy groups posting in the center admission packet. 4. The facility administrator will audit that resident state agency and advocacy postings remain accessible to residents once per week for 12 weeks. The results of the audits will be reported by the facility administrator /designee at the Clinical Operations Review and the QA meetings for evaluation of compliance, ongoing monitoring for continuous improvement and to determine if any modifications to the action plans are necessary after the implementation.	

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F 575	Continued From page 8 On 3/22/19 at 11:20 a.m., the aforementioned issue was brought the the attention of Corporate Consultant (CC) #1 and CC#2, as well as the Assistant Director of Nursing (ADON). They were shown the postings at this time. The Director of Maintenance joined and stated most of the posters and postings were at a high level and he would adjust them to be 37 inches from the floor which would adapt to wheelchair height. The CC #1 and CC #2 as well as the ADON said they would make sure the print/font were enlarged, legible and at a height on the bulletin boards accessible to the residents. On 3/22/19 at 4:00 p.m., a debriefing was conducted with the Administrator, the Director of Nursing (DON), ADON, the Chief Compliance Officer (CCO), CC1 and CC2. No further information was provided prior to survey exit.	F 575		
F 577 SS=C	Right to Survey Results/Advocate Agency Info CFR(s): 483.10(g)(10)(11) §483.10(g)(10) The resident has the right to- (i) Examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility; and (ii) Receive information from agencies acting as client advocates, and be afforded the opportunity to contact these agencies. §483.10(g)(11) The facility must-- (i) Post in a place readily accessible to residents, and family members and legal representatives of residents, the results of the most recent survey of the facility. (ii) Have reports with respect to any surveys,	F 577		4/26/19

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F 577	Continued From page 9 certifications, and complaint investigations made respecting the facility during the 3 preceding years, and any plan of correction in effect with respect to the facility, available for any individual to review upon request; and (iii) Post notice of the availability of such reports in areas of the facility that are prominent and accessible to the public. (iv) The facility shall not make available identifying information about complainants or residents. This REQUIREMENT is not met as evidenced by: Based on observations, resident, group and staff interviews it was determined that the facility staff failed to post a notice that indicated where the survey results were located for their examination without having to ask someone. The facility staff failed to ensure survey results were easily available to the resident without having to ask. The findings include: On 3/20/09 at 11:00 AM, three binders was observed in separate metal holders high up on the wall by the receptionist desk. The posting above these binders read "State Survey Results...Please see receptionist for assistance or call (a phone number and extension)." During an interview with residents, identified as interviewable by the facility staff and representing the 'Resident Council', there were no residents out of 7 residents in the group meeting on 03/21/19 at 11:30 a.m. that acknowledged they knew where the survey results were available for their review.	F 577	1. On 3/22/19, the survey binders were removed from the metal holders on the wall by reception desk and moved to the credenza in lobby allowing easy access for w/c bound residents or family by facility maintenance director. New signs were also posted that did not state to ask for assistance 2. All residents residing in a facility have the potential to be affected. 3. On 4/3/19, the activities director addressed resident council and discussed survey result locations. On 4/9/19, the activity director provided each resident residing at facility a flyer with notification of survey result location. 4. The facility administrator/designee will audit that the past 3 years of survey information is accessible to residents once per week for 12 weeks. The results of the audits will be reported by the facility administrator /designee at the Clinical Operations Review and the QA meetings for evaluation of compliance, ongoing monitoring for continuous improvement and to determine if any modifications to the action plans are necessary after the	

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F 577	Continued From page 10 Resident #3, #59 and #86 represented all three units of the facility. After the group meeting these resident were taken to the lobby, at which time they located the binders and stated there was no way they could get them out of the metal holders, nor could they reach them due the height of the holders. They all stated they would have to ask someone to take them down and take them somewhere to read it, in an office or a table in the dining room. On 3/22/19 at 11:20 a.m., the aforementioned issue was brought the the attention of Corporate Consultant (CC) #1 and CC#2, as well as the Assistant Director of Nursing (ADON). They were shown the binders and told what the resident's said about having to ask to have them removed from the holders and taken somewhere to read the survey findings. The Director of Maintenance joined and measured that the 2.5 inches (") wide by 11.5" by 10" diameter binders were 46.5" high from the floor and too high for the residents to reach, as well as to large and awkward to handle them. The receptionist stated it would be a good idea to take them off the wall and place them down on a table with a sign that did not require he to access any of them for residents. The CC #1 and CC #2 as well as the ADON said they would find a suitable place for the binders that did not require receptionist assistance and would change the signage. On 3/22/19 at 4:00 p.m., a debriefing was conducted with the Administrator, the Director of Nursing (DON), ADON, the Chief Compliance Officer (CCO), CC1 and CC2. No further information was provided prior to survey exit.	F 577	implementation.	
F 607	Develop/Implement Abuse/Neglect Policies	F 607		4/26/19

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F 607 SS=D	Continued From page 11 CFR(s): 483.12(b)(1)-(3) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, and facility document review, it was determined that facility staff failed to implement abuse policies and report an allegation of abuse to the appropriate state agencies for one of 38 residents in the survey sample, Resident #75. For Resident #75, facility staff failed to implement abuse policies and report an allegation of verbal abuse reported to the administrator on 3/20/19 to the appropriate state agencies. The findings include: Resident #75 was admitted to the facility on 12/26/13 with diagnoses that included, but were not limited to, dementia without behavioral disturbance, depressive disorder, diabetes mellitus, seizures, and muscle weakness. Resident #75's most recent MDS (minimum data set) assessment was an annual assessment with an ARD (assessment reference date) of 9/11/18. Resident #75 was coded as being moderately	F 607	1. The facility reported the allegation involving resident # 75 on 3/22/19. 2. All residents who reside at the center have the potential to be affected. 3. Facility staff and leadership have been re-educated on the centers policy titled abuse prevention and management by Clinical Educator or designee on 4/5/19. The facility will report all allegations of abuse immediately, but not later than 2 hours after the allegation is made. 4. Facility administrator and/or designee will interview 6 staff for 12 weeks regarding their knowledge of reporting allegations of abuse. The facility administrator and/or designee will maintain a daily tracking log of all allegations of abuse and validate proper implementation of abuse policy. The results of the interviews and tracking log will be reported by the Administrator/designee at the Clinical	

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	495308	A. BUILDING _____ B. WING _____	C 03/22/2019

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F 607	Continued From page 12 impaired in cognitive function scoring 10 out of possible 15 on the BIMS (Brief Interview for Mental Status) exam. Resident #75 was coded in section G (Functional Status) as needing supervision with one staff member for meals. On 3/20/19 at 12:30 p.m., observation of the dining room was conducted. A CNA (certified nursing assistant) was observed assisting Resident #75 with her lunch. This writer was a few feet away from the resident. This CNA then left the dining room for approximately ten minutes to assist another resident. At approximately 12:40 p.m. this CNA entered the dining room and walked over to Resident #75. The CNA stated in an abrasive tone: "Mrs. (Name of Resident) you are falling asleep. You need to sit up. Sit up! Here, I'll help you." The CNA began to help Resident #75 to sit up in her chair and stated, "Aw, Mrs (Name of resident), don't cry." Resident #75's back was facing this writer. This writer did not see the resident cry but overhead the above statement. On 3/20/19 at approximately 1:00 p.m., an attempt was made to interview Resident #75. Resident #75 was up in the day room doing an activity with facility staff. On 3/20/19 at 1:38 p.m., this incident was reported to ASM (administrative staff member) #1, the administrator. It was reported that the CNA used an abrasive tone with the resident and that the resident must have started crying because of what the CNA had stated. ASM #1 stated that he would look into the events. On 3/21/19 at 9:56 a.m., an interview was conducted with Resident #75. Resident #75 could	F 607	Operations Review and the QA meetings for evaluation of compliance, ongoing monitoring for continuous improvement and to determine if any modifications to the action plans are necessary after the implementation.	

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F 607	Continued From page 13	F 607		

not recall any verbal abuse from staff. Resident #75 stated that she did not fear anyone at the facility. When asked if she could recall falling asleep at lunch, Resident #75 stated, "I did?"

On 3/21/19 at approximately 5:00 p.m., the investigation was requested by administrative staff to be seen in the morning.

On 3/22/19 at 8:48 a.m., ASM #1 presented the investigation. ASM #1 stated that he conducted interviews with the staff, a resident in the dining area at the time of alleged events and Resident #75. ASM #1 stated that based on these interviews, it was determined that the CNA was not loud or rude. ASM #1 stated that Resident #75 denied that anyone was abusive to her. ASM #1 stated that Resident #75 stated that if anyone was abusive, that she wouldn't "pay them any attention." ASM #1 stated that he interviewed the gentleman (another resident) in the dining room and the resident stated that the CNA was trying to encourage Resident #75 to eat and that Resident #75 did not seem to be upset or tearful. This resident stated that maybe the CNA was a little loud but not abusive. ASM #1 stated that he went over customer service with the CNA and stated that administration did not feel it was abuse. When asked if they had reported this allegation to the appropriate state agencies, ASM #1 stated, "The way you presented it to me was that she wasn't rude. You said abrasive."When asked what abrasive meant to him, ASM #1 stated that this surveyor did not present the above allegation like it was an allegation of verbal abuse. ASM #1 repeated that this surveyor did not use the word harsh or rude, that this surveyor said abrasive. ASM #1 stated, "I don't know what else you wanted me to do." ASM #1 also stated that this

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F 607	Continued From page 14	F 607		

writer witnessed the resident cry when the resident did not cry. It was clarified that this writer did not see the resident cry, but overheard the CNA state, "Aw, (Name of Resident) don't cry."

On 3/22/19 at 10:53 a.m., an interview was conducted with ASM #2, the DON (Director of Nursing). When asked the process if a resident, family member or staff member reported an allegation of physical abuse to her, ASM #2 stated that she would remove the resident from the situation and start an investigation immediately and talk to the patient it concerns first. ASM #2 stated that she would conduct interviews immediately so that the staff/patient can recall the events. ASM #2 stated that if the patient denies any abuse, she would put the incident on a grievance report. ASM #2 stated she may send a FRI (facility reported incident) if she cannot conduct her investigation in time to determine if abuse occurred. ASM #2 stated if she has talked to everyone within the window to report abuse, and abuse wasn't founded, she would put the event on a grievance form. ASM #2 stated that if she witnessed abuse, she would remove the resident from the situation and report the incident to APS (adult protective services), the OLC (office of licensure and certification) and the police within 2 hours.

Review of facility's investigation revealed that they had completed a thorough investigation on the above incident.

A facility reported incident (FRI) was not completed and sent to the appropriate state agencies regarding the above allegation.

On 3/22/19 at approximately 3:45 p.m., ASM

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F 607	Continued From page 15 (administrative staff member) #1, the administrator, ASM #2, the DON (Director of Nursing), ASM #3, the ADON (assistant director of nursing) and ASM #4, the chief compliance officer were made aware of the above concerns. On 3/22/19 at approximately 5:00 p.m., ASM #2, the DON presented a FRI that they had faxed to the appropriate state agencies on 3/22/19, after the concern was brought to their attention. Facility policy titled, "Abuse Prevention and Management," documents in part, the following: "The organization will maintain systems to ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility, or his or her designee, and to other officials (including to the State Survey Agency and adult protective services where state law provides jurisdiction in long term care facilities) in accordance with State law through established procedures."	F 607		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations	F 609		4/26/19

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F 609	Continued From page 16 involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, and facility document review, it was determined that facility staff failed to report an allegation of abuse to the appropriate state agencies for one of 38 residents in the survey sample, Resident #75. For Resident #75, facility staff failed to report an allegation of verbal abuse reported to the administrator on 3/20/19 to the appropriate state agencies. The findings include:	F 609	1. The facility reported the allegation involving resident # 75 on 3/22/19. 2. All residents who reside at the center have the potential to be affected. 3. Facility staff and leadership have been re-educated on the centers policy titled abuse prevention and management by the clinical educator or designee 4/5/19. The facility will report all allegations of abuse immediately, but not later than 2 hours after the allegation is made. 4. Facility administrator and/or designee will interview 6 staff for 12 weeks	

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F 609	Continued From page 17 Resident #75 was admitted to the facility on 12/26/13 with diagnoses that included but were not limited to dementia without behavioral disturbance, depressive disorder, diabetes mellitus, seizures, and muscle weakness. Resident #75's most recent MDS (minimum data set) assessment was an annual assessment with an ARD (assessment reference date) of 9/11/18. Resident #75 was coded as being moderately impaired in cognitive function scoring 10 out of possible 15 on the BIMS (Brief Interview for Mental Status) exam. Resident #75 was coded in section G (Functional Status) as needing supervision with one staff member for meals. On 3/20/19 at 12:30 p.m., observation of the dining room was conducted. A CNA (certified nursing assistant) was observed assisting Resident #75 with her lunch. This writer was a few feet away from the resident. This CNA then left the dining room for approximately ten minutes to assist another resident. At approximately 12:40 p.m. this CNA entered the dining room and walked over to Resident #75. The CNA stated in an abrasive tone: "Mrs. (Name of Resident) you are falling asleep. You need to sit up. Sit up! Here, I'll help you." The CNA began to help Resident #75 to sit up in her chair and stated, "Aw, Mrs (Name of resident), don't cry." Resident #75's back was facing this writer. This writer did not see the resident cry but overhead the above statement. On 3/20/19 at approximately 1:00 p.m., an attempt was made to interview Resident #75. Resident #75 was up in the day room doing an activity with facility staff. On 3/20/19 at 1:38 p.m., this incident was	F 609	regarding their knowledge of reporting allegations of abuse. The facility administrator and/or designee will maintain a daily log and validate timely reporting with any allegation of abuse. The results of the interviews and tracking log will be reported by the Administrator/designee at the Clinical Operations Review and the QA meetings for evaluation of compliance, ongoing monitoring for continuous improvement and to determine if any modifications to the action plans are necessary after the implementation.	

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F 609	Continued From page 18	F 609		

reported to ASM (administrative staff member) #1, the administrator. It was reported that the CNA used an abrasive tone with the resident and that the resident must have started crying because of what the CNA had stated. ASM #1 stated that he would look into the events.

On 3/21/19 at 9:56 a.m., an interview was conducted with Resident #75. Resident #75 could not recall any verbal abuse from staff. Resident #75 stated that she did not fear anyone at the facility. When asked if she could recall falling asleep at lunch, Resident #75 stated, "I did?"

On 3/21/19 at approximately 5:00 p.m., the investigation was requested by administrative staff to be seen in the morning.

On 3/22/19 at 8:48 a.m., ASM #1 presented the investigation. ASM #1 stated that he conducted interviews with the staff, a resident in the dining area at the time of alleged events and Resident #75. ASM #1 stated that based on these interviews, it was determined that the CNA was not loud or rude. ASM #1 stated that Resident #75 denied that anyone was abusive to her. ASM #1 stated that Resident #75 stated that if anyone was abusive, that she wouldn't "pay them any attention." ASM #1 stated that he interviewed the gentleman (another resident) in the dining room and the resident stated that the CNA was trying to encourage Resident #75 to eat and that Resident #75 did not seem to be upset or tearful. This resident stated that maybe the CNA was a little loud but not abusive. ASM #1 stated that he went over customer service with the CNA and stated that administration did not feel it was abuse. When asked if they had reported this allegation to the appropriate state agencies, ASM #1 stated,

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"The way you presented it to me was that she wasn't rude. You said abrasive." When asked what abrasive meant to him, ASM #1 stated that this surveyor did not present the above allegation like it was an allegation of verbal abuse. ASM #1 repeated that this surveyor did not use the word harsh or rude, that this surveyor said abrasive. ASM #1 stated, "I don't know what else you wanted me to do." ASM #1 also stated that this writer witnessed the resident cry when the resident did not cry. It was clarified that this writer did not see the resident cry, but overheard the CNA state, "Aw, (Name of Resident) don't cry."

On 3/22/19 at 10:53 a.m., an interview was conducted with ASM #2, the DON (Director of Nursing). When asked the process if a resident, family member or staff member reported an allegation of physical abuse to her, ASM #2 stated that she would remove the resident from the situation and start an investigation immediately and talk to the patient it concerns first. ASM #2 stated that she would conduct interviews immediately so that the staff/patient can recall the events. ASM #2 stated that if the patient denies any abuse, she would put the incident on a grievance report. ASM #2 stated she may send a FRI (facility reported incident) if she cannot conduct her investigation in time to determine if abuse occurred. ASM #2 stated if she has talked to everyone within the window to report abuse, and abuse wasn't founded, she would put the event on a grievance form. ASM #2 stated that if she witnessed abuse, she would remove the resident from the situation and report the incident to APS (adult protective services), the OLC (office of licensure and certification) and the police within 2 hours.

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Review of facility's investigation revealed that they had completed a thorough investigation on the above incident.

A facility reported incident (FRI) was not completed and sent to the appropriate state agencies regarding the above allegation.

On 3/22/19 at approximately 3:45 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the DON (Director of Nursing), ASM #3, the ADON (assistant director of nursing) and ASM #4, the chief compliance officer were made aware of the above concerns.

On 3/22/19 at approximately 5:00 p.m., ASM #2, the DON presented a FRI that they had faxed to the appropriate state agencies on 3/22/19, after the concern was brought to their attention.

Facility policy titled, "Abuse Prevention and Management," documents in part, the following: "The organization will maintain systems to ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility, or his or her designee, and to other officials (including to the State Survey Agency and adult protective services where state law provides jurisdiction in long term care facilities) in accordance with State law through established procedures."

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F 622 SS=D	Transfer and Discharge Requirements CFR(s): 483.15(c)(1)(i)(ii)(2)(i)-(iii) §483.15(c) Transfer and discharge- §483.15(c)(1) Facility requirements- (i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless- (A) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility; (B) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility; (C) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident; (D) The health of individuals in the facility would otherwise be endangered; (E) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or (F) The facility ceases to operate. (ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health	F 622		4/26/19

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or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose.

§483.15(c)(2) Documentation.
When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider.
(i) Documentation in the resident's medical record must include:
(A) The basis for the transfer per paragraph (c)(1)(i) of this section.
(B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s).
(ii) The documentation required by paragraph (c)(2)(i) of this section must be made by-
(A) The resident's physician when transfer or discharge is necessary under paragraph (c) (1) (A) or (B) of this section; and
(B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section.
(iii) Information provided to the receiving provider must include a minimum of the following:
(A) Contact information of the practitioner responsible for the care of the resident.
(B) Resident representative information including contact information
(C) Advance Directive information
(D) All special instructions or precautions for

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F 622	Continued From page 23 ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, and clinical record review, it was determined that facility staff failed to evidence that all the required information was provided to the receiving provider for a facility-initiated transfer for 3 of 38 residents in the survey sample; Resident #82, #60, and #28. 1. For Resident #82, facility staff failed to send care plan goals at the time of a facility-initiated transfer to the hospital on 2/26/19. 2. The facility staff failed to ensure that Resident #60's Plan of Care Summary Goals were sent upon discharge to the hospital on 12/15/18, 2/6/18, and 3/2/19. 3. The facility staff failed to convey Resident #28's Individual Plan of Care summary upon discharge to the local acute care hospital on 12/19/18 The findings include: 1. Resident #82 was admitted to the facility on 12/13/18 and readmitted on 2/27/19 with diagnoses that included, but were not limited to, anemia, high blood pressure, alcoholic cirrhosis, and oral (mouth) cancer. Resident #82's most recent MDS (minimum data set) assessment was	F 622	1. Residents # 82, # 60 and # 28 have all been returned to the facility post-acute hospital stay. Their current care plans are current at the facility. 2. All residents who are in the hospital as of 4/8/19 had their Plan of Care Summary sent to the hospital so the acute care hospital has the required information. 3. Licensed nurses and IDT have been educated by the Clinical Educator or designee on the discharge process that meets the regulatory requirements for information provided to receiving provider/healthcare institution 3/27/19. 4. A transfer/discharge audit form has been developed and will be updated daily as needed by on-site facility supervisor and/or designee to validate the Plan of Care Summary has been sent with transferring resident to receiving healthcare institution. Unit Manager or designee will audit all hospital discharges for 12 weeks to ensure the Plan of Care Summary was provided to the hospital. The results of the audits will be reported by the DON/designee at the Clinical Operations Review and the QA meetings for evaluation of compliance, ongoing monitoring for continuous improvement and to determine if any modifications to	

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F 622	Continued From page 24 a quarterly assessment with an ARD (assessment reference date) of 3/5/19. Resident #82 was coded as being cognitively intact in the ability to make daily decisions scoring 15 out of possible 15 on the BIMS (Brief Interview for Mental Status) exam. Review of Resident #82's clinical record revealed that she had been transferred to the hospital on 2/26/19. The following note was documented: "Dr. (Name of physician) gave orders for resident to be sent out to the emergency room for evaluation and treatment due to elevated blood pressure and temperature, and tongue swelling. Transportation services was called to schedule a non-emergent transport to (Name of ED (Emergency department)...Resident is her own RP (responsible party) and she gave consent to be sent out for further evaluation." The next note dated 2/26/19 documented in part, the following: "...Face-sheet along with SBAR (situation, background, assessment, resident evaluation) and medication list was given to transportation services personnel." Review of the SBAR form dated 2/26/19 failed to evidence that care plan goals were sent with the resident at the time of the facility-initiated transfer. There was no evidence in the clinical record that a hospital/transfer discharge form was completed for Resident #82. On 2/21/19 at approximately 2:40 p.m., an interview was conducted with LPN (licensed practical nurse) #9 regarding documents that are sent with residents when they are discharged to the hospital. LPN #9 stated, "We send the hospital transfer interact form, copy of the bed	F 622	the action plans are necessary after the implementation.	

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F 622	Continued From page 25	F 622		

hold, the Transfer/Discharge Notice and we call report to the receiving facility. LPN #9 was asked if they send any information about the resident's care plan when they are discharged. LPN #9 stated, "No we don't send the care plan."

On 3/22/19 at 9:50 a.m., an interview was conducted with the Staff Development Coordinator (OSM (other staff member) #1), regarding what documents the nurses are instructed to send to the hospital when a resident is discharged to the hospital. The Staff Development Coordinator stated, "The nurses send the medication administration record, the treatment administration record, a copy of the bed hold, face sheet, immediate discharge/transfer sheet, and a list of medications." The Staff Development Coordinator was asked if the resident's care plan goals were sent with the above documents she just mentioned. The Staff Development Coordinator stated, "No, we send all the other stuff but not the care plan when the resident is discharged to the hospital."

On 3/22/19 1:33 p.m., an interview was conducted with the Director of Nursing (ASM (administrative staff member) #2) regarding care plan goals being sent with residents when discharged to the hospital and what she would have expected. The Director of Nursing stated, "I expected if there is an area on the hospital transfer form for the care plan to be included for it to be inserted by the nurses when the resident discharges."

On 3/22/19 at approximately 3:45 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the DON (Director of Nursing), ASM #3, the ADON (assistant director

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of nursing) and ASM #4, the chief compliance officer were made aware of the above concerns.

Facility policy titled, "Discharge/Transfer of Resident," did not address sending care plan goals for a facility initiated transfer to the hospital.

No further information was presented prior to exit.

2. Resident #60 was a 67 year old originally admitted on 6/6/14 and readmitted on 12/31/18, 2/12/19 and 3/12/19 with diagnoses to include but not limited to *Cerebral Palsy, *Diabetes Mellitus, and *Hypertension.

The most recent Minimum Data Set (MDS) assessment was a Quarterly with an Assessment Reference Date (ARD) pf 2/19/19. Resident #60's Brief Interview for Mental Status (BIMS) was a 13 out of a possible 15 which indicated the resident is cognitively intact and capable of daily decision making. Resident #60's MDS submit history was also reviewed and is documented in part, as follows:

1. Unplanned Hospital Discharge Return Anticipated Assessment with ARD of 12/15/18.
2. Facility Entry Assessment with ARD of 12/31/18.
3. Unplanned Hospital Discharge Return Anticipated Assessment with ARD of 2/6/19.
4. Facility Entry Assessment with ARD of 2/12/19.
5. Unplanned Hospital Discharge Return Anticipated Assessment with ARD of 3/2/19.
6. Facility Entry Assessment with ARD of 3/12/19.

Resident #60's Comprehensive Care Plan was

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reviewed and included the following facility identified problems which included goals and interventions for the resident: Extensive assist for activities of daily living, Full Code, anticoagulant use, alteration in cardiac output, risk of constipation, history of falls, urinary incontinence, risk for urinary tract infection, potential for pain, risk for impaired skin integrity, impaired vision, depression, nutritional risk mechanically altered diet, and potential for infection.

Resident #60's Nursing Home to Hospital Transfer Forms were reviewed and are documented in part, as follows:

Date of Transfer: 12/15/18
Reason for Transfer: Abnormalities of Breathing
Primary Goals of Care at Time of Transfer: (fill in box) Empty

Date of Transfer: 2/6/19
Reason for Transfer: Change in Mental Status
Primary Goals of Care at Time of Transfer: (fill in box) Empty

There was no Nursing Home to Hospital Transfer Form for Resident #60's 3/2/19 discharge to the hospital. There was a note dated 3/2/19 at 3:26 PM with the which is documented in part, as follows:

Dr. (Doctor) is the on call physician for Name (facility). She is sending a 67 year old female to the ED (emergency department) for evaluation of hypotension and arm pain. Possible mild changes in mental status.

On 3/21/19 at 2:30 PM an interview was conducted with the Assistant Director of Nursing

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regarding the area on the Nursing Home to Hospital Transfer form titled "Primary Goals of Care at Time of Transfer" as to if the area had been completed on Resident #60's three hospital discharges and if not should it had had been completed. The Assistant Director of Nursing stated, "No I don't see where it was done on the discharges. We should be sending that information so the other facility knows the plan of care for the resident."

On 2/21/19 at approximately 2:40 PM an interview was conducted with LPN (Licensed Practical Nurse) #9 regarding documents that are sent with residents when they are discharged to the hospital. LPN #9 stated, "We send the hospital transfer interact form, copy of the bed hold, the Transfer/Discharge Notice and we call report to the receiving facility. LPN #9 was asked if they send any information about the resident's care plan when they are discharged. LPN #9 stated, "No, we don't send the care plan."

On 3/22/19 at 9:50 AM an interview was conducted with the Staff Development Coordinator regarding what documents the nurses are instructed to send to the hospital when a resident is discharged to the hospital. The Staff Development Coordinator stated, " We have a LOA (leave of absence) Process. The nurses send the medication administration record, the treatment administration record, a copy of the bed hold, face sheet, immediate discharge/transfer sheet, and a list of medications." The Staff Development Coordinator was asked if the resident's care plan goals were sent with the above documents she just mentioned. The Staff Development Coordinator stated, "No, we send all the other stuff but not the care plan when the

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resident is discharged to the hospital."

On 3/22/19 at 9:52 AM an interview was conducted with LPN #1 and was asked asked if nurses fill out the care plan goals section of the hospital interact form. LPN #1 stated, "The nurses completed that section only if their care plan goals pertained to the reason why they were transferring out."

On 03/22/19 01:33 PM an interview was conducted with the Director of Nursing regarding care plan goals being sent with residents when discharged to the hospital and what she would have expected. The Director of Nursing stated, "I expected if there is an area on the hospital transfer form for the care plan to be included for it to be inserted by the nurses when the resident discharges."

On 3/22/19 at 3:45 PM a pre-exit conference was held with the Administrator, The Director of Nursing, The Assistant Director Of Nursing and the Compliance Officer were the above information was shared. The Compliance Officer stated that the facility has no policy for sending care plans upon resident hospital discharges but they have a process which is to send the Nursing Home to Hospital Transfer Form and to fill in the Primary Goals of Care at Time of Transfer section. No further information was provided prior to exit.

3. Resident #28 was originally admitted to the facility 7/29/16, and was readmitted to the facility 12/28/18, after an acute care hospital stay. The current diagnoses included; diabetes, chronic kidney disease and malnourishment.

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The quarterly Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 1/15/19, coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 15 out of 15. This indicated Resident #28's daily decision making abilities were intact.

In section "G" (Physical functioning) the resident was coded as requiring extensive assistance of one person with bed mobility, transfers, dressing, toileting, personal hygiene and bathing and limited assistance of one with eating.

Review of the discharge MDS assessment dated 12/19/18, revealed Resident #28 was discharged-return anticipated.

Review of the clinical record revealed a nurse's note dated 12/19/18, at 11:55 a.m., which stated Resident #28 was transferred to the local acute care hospital for stent replacements.

No documentation was included which stated the facility staff conveyed to the receiving providers the resident's summary of the comprehensive care plan goals at the time of discharge or as soon as possible to the actual time of transfer.

On 3/21/19 at approximately 2:30 p.m., the Clinical Consultant stated at the time of Resident 28's hospital transfer the facility staff was not aware of the requirement to provide a copy of the resident's care plan summary to the receiving provider.

On 3/22/18, at approximately 4:00 p.m. the above findings were shared with the Administrator, the Director of Nursing and the Corporate consultant.

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F 622	Continued From page 31 An opportunity was given for the facility to provide additional information but no further information was provided.	F 622		
F 625 SS=D	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on clinical record review, staff interviews, and facility document review the facility staff failed	F 625	1. Resident # 28 has been readmitted to the facility, to the same room and has had	4/26/19

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F 625	Continued From page 32 to issue bed-hold notices and policy at the time of discharge for 1 of 38 residents (Resident #28) in the survey sample. The facility's staff failed to provide written information to the resident or resident representative which specifies the duration of the bed-hold policy upon transfer to the local acute care hospital on 12/19/18 for Resident #28. The findings included: Resident #28 was originally admitted to the facility 7/29/16, and was readmitted to the facility 12/28/18, after an acute care hospital stay. The current diagnoses included; diabetes, chronic kidney disease and malnourishment. The quarterly Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 1/15/19, coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 15 out of 15. This indicated Resident #28's daily decision making abilities were intact. In section "G" (Physical functioning) the resident was coded as requiring extensive assistance of one person with bed mobility, transfers, dressing, toileting, personal hygiene and bathing and limited assistance of one with eating. Review of the discharge MDS assessment dated 12/19/18, revealed Resident #28 was discharged-return anticipated. Review of the clinical record revealed a nurse's note dated 12/19/18, at 11:55 a.m., which stated Resident #28 was transferred to the local acute	F 625	no further discharges. 2. All residents who are in the hospital as of 4/8/19 have been audited by admissions coordinator/designee for issuance of bed hold notice to resident and resident representative. Any identified that had not received the bed hold had the bed hold documentation provided on 4/8/19. 3. Licensed nurses and IDT have been educated by the clinical educator or designee on the requirements for notice of bed hold and the process in the EMR to complete this task. Facility administrator provided education to the business office staff concerning bed hold requirements and the process for issuing and confirming a bed hold. The Business Office Manager/designee will check each business day to ensure that its bed hold policy was appropriately issued to each resident and resident representatives by the discharging nurse or designee starting 4/10/19. 4. A transfer/discharge audit form has been developed and will be updated daily as needed by on-site facility supervisor and/or designee to validate the bed hold has been provided to the transferring resident and that resident representative has been notified. BOM or designee will audit all hospital discharges for 12 weeks to ensure the bed hold notice was appropriately issued. The results of the audits will be reported by the DON/designee at the Clinical Operations Review and the QA meetings for evaluation of compliance, ongoing monitoring for continuous improvement	

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F 625	Continued From page 33 care hospital for stent replacements. On 3/21/19 at approximately 2:30 p.m., the Clinical Consultant stated at the time of Resident #28's hospital transfer the facility staff was not aware of the requirement to provide written information to the resident or resident representative of the facility's bed-hold policy therefore, notification was not provided. On 3/22/18, at approximately 4:00 p.m. the above findings were shared with the Administrator, the Director of Nursing and the Corporate consultant. An opportunity was given for the facility to provide additional information but they did not.	F 625	and to determine if any modifications to the action plans are necessary after the implementation.	
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on clinical record review, staff interview and review of the facility's policy, the facility staff failed to accurately code the Minimum Data Set (MDS) assessment for 1 of 38 residents (Residents #21), in the survey sample. The facility staff failed to accurately code Resident #21's quarterly Minimum Data Set (MDS) assessment dated 01/8/19, at section "N0350" (Insulin Injections). The findings included; Resident #21 was originally admitted to the facility 2/1/11 and was readmitted to the facility 10/4/18,	F 641	1. The MDS Coordinator modified resident # 21's MDS on 3/21/19. 2. A 100% audit of all current residents on insulin will have their MDS for N0350 audited for accuracy. This was completed by the MDS coordinator by 4/8/19. All inaccuracies noted in N0350 coding have had modifications completed. 3. MDS nurse was educated on coding for insulin of the MDS by DON on 4/8/19. 4. The Director of Clinical Reimbursement or designee will audit 6 MDS's per week for 4 weeks and then 3 MDS's for 8 weeks to validate accuracy of N0350. The results of the audits will be	4/26/19

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F 641	Continued From page 34 after an acute care hospital stay. The current diagnoses included; diabetes. The quarterly Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 1/8/19, coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 1 out of 15. This indicated Resident #21's daily decision making abilities were severely impaired. In section "G" (Physical functioning) the resident was coded as requiring total care two people with transfers, personal hygiene, bathing, dressing and toileting total care of one person with eating, extensive assistance of two people with bed mobility. In section "N0350" (Insulin Injections), the resident was zero; indicating the number of days the resident received insulin injections over the seven day period 1/2/19-1/8/19. Review of the Medication Administration Record revealed from 1/2/19-1/8/19, the resident received Lantus insulin and Kwik-pen subcutaneous injections daily. An interview was conducted with the MDS Coordinator 3/21/19, at approximately 3:50 p.m. The MDS Coordinator stated the 1/8/19 MDS assessment was not coded correctly at section "N0350" and a modification would be made. At approximately 4:00 p.m., the MDS Coordinator presented a copy of the modified MDS assessment. It coded "N0350" as seven. On 3/22/19, at approximately 4:00 p.m., the above findings were shared with the Administrator, Director of Nursing and a corporate consultant.	F 641	reported by the MDS Coordinator or designee at the Clinical Operations Review and the QA meetings for evaluation of compliance, ongoing monitoring for continuous improvement and to determine if any modifications to the action plans are necessary after the implementation	

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F 641	Continued From page 35 The facility's policy/procedure titled Resident Assessment Instrument Process with a revision date of 10/14 stated the facility will follow the most current CMS RAI Version 3.0 manual.	F 641		
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 and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, and clinical record review, it was	F 657	1. Resident # 98 no longer resides at the center.	4/26/19

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F 657	Continued From page 36 determined that facility staff failed to review and revise the care plan for one of 38 residents in the survey sample, Resident #98. For Resident #98, facility staff failed to revise the care plan when his code status changed to DNR (Do Not Resuscitate) and was ordered for comfort care measures. The findings include: Resident #98 was admitted to the facility on 12/2/16 with diagnoses that included, but were not limited to, muscle weakness, hypoxic ischemic encephalopathy (1), fractured femur and pelvis post motor vehicle accident, and psychosis. Resident #98's most recent comprehensive MDS (minimum data set) assessment was a quarterly assessment with an ARD (assessment reference date) of 7/10/18. Resident #98 was coded as being severely impaired in cognitive function scoring 00 out of possible 15 on the BIMS (Brief Interview for Mental Status) exam. Resident #98 passed away in the facility on 12/22/18. Review of Resident #98's clinical record revealed that his code status had changed from Full Code to DNR on 11/28/18. Further review of Resident #98's most recent physician order summary, revealed that Resident #98 was put on comfort care measures on 11/28/18. Review of Resident #98's most recent comprehensive care plan dated 12/13/16 and revised 11/6/18 failed to evidence a DNR and comfort measures care plan. The following was	F 657	2. All residents who reside at the center have the potential to be affected. 100 % of resident records were reviewed and audited on 3/27/19 to validate code status order consistent with care plan and accurate. No other conflicting data noted. 3. Licensed staff / IDT have been educated by DON/designee on care plan revisions pertaining to code status changes on 4/9/19. 4. New order report in EMR will be pulled daily for 12 weeks and reviewed by the DON/designee to note new code status orders and then log and validate accuracy of care plan. The results of the audits will be reported by the DON/designee at the Clinical Operations Review and the QA meetings for evaluation of compliance, ongoing monitoring for continuous improvement and to determine if any modifications to the action plans are necessary after the implementation	

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F 657	Continued From page 37	F 657		

documented on Resident #98's care plan: "RESIDENT IS A FULL CODE STATUS: Active (Current)."

On 3/22/19 at 1:28 p.m., an interview was conducted with LPN (licensed practical nurse) #1. When asked the purpose of the care plan, LPN #1 stated that the purpose of the care plan was to plan out the care for each resident. LPN #1 stated that the care plan allowed nursing to measure progress of their goals. When asked if the care plan should be accurate, LPN #1 stated, "Absolutely." When asked when the care plan was revised, LPN #1 stated that the care plan was revised with status changes such as new orders. When asked if the care plan was updated if the resident becomes a DNR or is placed on comfort measures, LPN #1 stated that it was. When asked the type of interventions she would expect to see for a resident on comfort measures, LPN #1 stated she would expect to see interventions for pain (medications) and non-pharmacological interventions such "cool cloths." When asked who was responsible for updating care plans, LPN #1 stated that she would have to ask. LPN #1 then stopped ASM (administrative staff member) #2, the DON (Director of Nursing) and asked who was responsible for updating care plans. ASM #2 stated that the unit managers were responsible for updating care plans. When asked if LPN #1 could find where Resident #98's care plan was updated after he his code status had changed and he was put on comfort measures, LPN #1 looked through his care plan and stated, "I see Full Code right here. You are correct. I do not see it."

On 3/22/19 at approximately 3:45 p.m., ASM

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F 657	Continued From page 38 (administrative staff member) #1, the administrator, ASM #2, the DON (Director of Nursing), ASM #3, the ADON (assistant director of nursing) and ASM #4, the chief compliance officer were made aware of the above concerns. A policy on care plans was requested. A policy was not presented to this surveyor. No further information was presented prior to exit. (1) "Hypoxic ischemic encephalopathy is a severe consequence of cerebral ischemia (lack of blood flow to the brain) due to cardiac arrest or other causes (e.g. hanging, strangulation, poisoning with carbon monoxide or near-drowning). Cardiac diseases are the main cause of cardiac arrests and subsequent brain damage." This information was obtained from The National Institutes of Health. https://search.nih.gov/search?utf8=%E2%9C%93&affiliate=nih&query=cerebral+ischemia+.	F 657		
F 687 SS=D	Foot Care CFR(s): 483.25(b)(2)(i)(ii) §483.25(b)(2) Foot care. To ensure that residents receive proper treatment and care to maintain mobility and good foot health, the facility must: (i) Provide foot care and treatment, in accordance with professional standards of practice, including to prevent complications from the resident's medical condition(s) and (ii) If necessary, assist the resident in making appointments with a qualified person, and arranging for transportation to and from such appointments. This REQUIREMENT is not met as evidenced by:	F 687		4/26/19

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F 687	Continued From page 39 Based on observations, resident interview, clinical record review, and staff interviews, the facility staff failed to ensure residents received necessary foot care to maintain good foot health, for 1 of 38 residents (Residents #76), in the survey sample. The facility staff failed to ensure Resident #76's toe nails were not overgrown, thick and discolored. The findings included: Resident #76 was originally admitted to the facility 11/30/18 and has never been discharged from the facility. The current diagnoses included; stroke, hemiparesis venous insufficiency and diabetes. The quarterly Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 2/26/19, coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 15 out of 15. This indicated Resident #76's daily decision making abilities were intact. In section "G" (Physical functioning) the resident was coded as requiring total care of one person with bathing, extensive assistance of two people with bed mobility and transfers, extensive assistance of one person with personal hygiene, toileting, and dressing. The current care plan dated 12/13/18, had a problem which read; requires assistance with activities of daily living (ADL), related to osteoarthritis, gout, Parkinson's, and paraplegia. The goal read: Resident will be clean and dressed appropriately for the facility's activities. The interventions included bathing: assist resident in ADL's as needed.	F 687	1. The center ensures residents receive proper foot care to maintain good foot health in accordance with professional standards. On 3/21/19, resident # 76 had his nails cut by the ADON. 2. The ADON/designee completed a 100% facility wide foot care audit on 3/27/19. ADON trimmed all nails as needed and appropriate. Those resident requiring podiatry services was either seen or have pending appointment. 3. Licensed nursing staff have been educated by Clinical Educator or designee on 4/8/19 on noting podiatry needs during weekly skin assessment and placing those individuals on podiatry list. Nursing assistants have been educated by Clinical Educator or designee on 4/8/19 to use the INTERACT stop and watch tool to note podiatry needs. 4. DON/ADON or designee will assess/audit 6 resident's feet weekly for 4 weeks, then 3 residents weekly for 8 weeks to validate compliance with professional standard concerning foot care. The results of the audits will be reported by the DON/designee at the Clinical Operations Review and the QA meetings for evaluation of compliance, ongoing monitoring for continuous improvement and to determine if any modifications to the action plans are necessary after the implementation	

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Resident #76 finger nails were observed to be long, broken and jagged therefore, an interview was conducted with him on 3/20/19 at approximately 12:35 p.m. Resident #76 stated his toenails were in worst shape than his finger nails and he had repetitively asked the nurses to cut them.

Review of the resident's clinical record didn't reveal a podiatry visit therefore, Licensed Practical Nurse (LPN) #7 was asked to assist with observation of Resident #76's toe nails. Observation of his toe nails revealed all were long, thick and discolored. The resident voiced they were also uncomfortable and needed to be cut.

Resident #76 was observed sitting in the day room, wearing sneakers; he stated they cut everyone's toe nails in here last night and now I can wear shoes.

On 3/22/19, at approximately 4:00 p.m., the above findings were shared with the Administrator, Director of Nursing and a corporate consultant. The Director of Nursing stated licensed nurses are permitted to cut most resident's toe nails and those who need their toe nails cut is determined by observations during daily care and weekly skin assessment.

The facility provided a skills document from Point of Care titled, published 7/2018; Nails and Foot Care. It read: do not cut the nails of a patient who has diabetes mellitus, impaired peripheral circulation, or an increased risk of bleeding. Refer the resident to a podiatrist or other appropriate health care professional.

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F 814 SS=D	Dispose Garbage and Refuse Properly CFR(s): 483.60(i)(4) §483.60(i)(4)- Dispose of garbage and refuse properly. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview it was determined that facility staff failed to dispose garbage and refuse properly for one of three facility dumpsters, the third facility dumpster. Facility staff failed to ensure one of three facility dumpsters was free from surrounding debris. The findings include: On 3/22/19 at 11:15 a.m., an observation of the facility dumpster area, located outside the building behind the kitchen, was conducted with OSM (other staff member) #4, the Dietary Manager. Three used gloves were observed on the ground in close proximity to the third facility dumpster. OSM #4 was then asked which department was responsible for ensuring the dumpster area was clean. OSM #4 stated that it was a shared responsibility between dietary and the environmental department. When asked how long the gloves were on the ground, OSM #4 stated that he was not sure but that he did not want his staff picking up the gloves with their bare hands. OSM #4 stated that the environmental department had a device they used to clean up debris (gloves) around the dumpsters. When asked how often the dumpsters were checked for surrounding debris, OSM #4 stated that maintenance will come around once a day around 12:30 to 1:00 p.m. OSM #4 stated that he will also clean the area if he has extra time.	F 814	1. The center ensures garbage and refuse are disposed of correctly around trash dumpsters. The 3 gloves outside the dumpster were immediately disposed of on 3/22/19 by maintenance director. 2. All residents who reside at the center have the potential to be affected by improperly disposed trash. 3. Facility staff were educated by the Clinical Educator on 4/8/19 on proper disposal of trash into the dumpster, and paying attention to reduce the risk of blown or loose trash around dumpster. The process for removing night shift trash to the dumpsters has been adjusted. A pick-up tool is available to staff to pick up debris. 4. Maintenance Director/designee will audit the area surrounding the trash dumpster for trash debris and document findings 5 days per week for 12 weeks. The Administrator or designee will note results of audits 5 days per week for 4 weeks and weekly for 8 weeks. The results of the audits will be reported by the facility administrator /designee at the Clinical Operations Review and the QA meetings for evaluation of compliance, ongoing monitoring for continuous improvement and to determine if any modifications to the action plans are necessary after the implementation	4/26/19

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F 814	Continued From page 42 On 3/22/19 at 11:14 a.m., an interview was conducted with OSM (other staff member) #6, the Maintenance Director. When asked who was responsible for maintaining the facility dumpster, OSM #6 also stated that it was a shared responsibility between maintenance and dietary. When asked how often dumpsters were checked for surrounding debris, OSM #6 stated "Daily." OSM #6 stated that staff should also be picking up garbage when they see it on the ground. On 3/22/19 at approximately 3:45 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the DON (Director of Nursing), ASM #3, the ADON (assistant director of nursing) and ASM #4, the chief compliance officer were made aware of the above concerns. A policy could not be provided on maintaining the dumpster in a sanitary manner. No further information was presented prior to exit.	F 814		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:	F 880		4/26/19

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F 880	Continued From page 43 §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents	F 880		

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F 880	Continued From page 44 identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and clinical record review the facility staff failed to ensure infection control measures were utilized to prevent the spread of infections, illnesses and diseases for 1 of 38 residents in the survey sample, Resident #51. Licensed Practical Nurse (LPN) #6 failed to don (to put on) gloves and gown (PPE/Personal Protective Equipment) before entering a contact precaution room and failed to perform proper hand hygiene after completing wound care on Resident #51. The findings included: Resident #51 was originally admitted to the facility on 01/10/17, discharged from the facility to an acute hospital on 10/12/17 and returned to the facility on 10/17/17. The current diagnoses included; cancer, hypertension, thyroid disorder, seizure disorder, depression and (VRE) Vancomycin Resistant Enterococcus. The Quarterly Review Minimum Data Set (MDS) assessment with an assessment reference date	F 880	1. On 3/21/19 LPN #6 was provided education on handwashing and isolation procedures by Clinical Educator. Resident # 51 had no complications noted from the failure to ensure infection control measures. 2. All residents who reside at the center have the potential to be affected. 3. Facility staff were educated by Clinical Educator/designee on 4/8/19 for proper handwashing technique and isolation procedures. 4. The Clinical Educator/designee will audit 6 employee handwashing techniques weekly for 4 weeks and then 3 per week for 8 weeks to validate compliance with proper procedure. The Clinical Educator/designee will also observe 3 employees use of PPE weekly for 12 weeks. The auditor will focus on isolation rooms if our resident population has individuals on isolation for review during validation period. The results of the audits will be reported by the Clinical Educator/designee at the Clinical Operations Review and the QA meetings	

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F 880	Continued From page 45 (ARD) of 02/12/19 coded Resident # 51's cognitive abilities for daily decision making as moderately impaired. On 03/21/19 at approximately 12:38 PM LPN #6 (Licensed Practical Nurse) was observed entering an isolation precaution room without wearing PPE (Personal Protective Equipment) to retrieve Resident #51's bedside table. LPN #6 retrieved the bedside table and rolled the bedside table between the doorway of Resident #51's room. After placing the bedside table between the doorway, LPN #6 applied hand sanitizer, donned gloves and sanitized the bedside table. Once the table was completely dry she removed her gloves, sanitized her hands and placed on PPE (consisting of putting on gloves and gown). LPN #6 then began to drape the bedside table adding necessary supplies in preparation for wound care. After wound care was completed LPN #6 discarded items on table, removed her PPE and proceeded to wash her hands in the following order: Applied soap, ran hands under the water and rubbed her hands together. Because she ran her hands under the water after and not before applying the soap, a lather did not form. On 03/22/19 at approximately 10:00 AM the Staff Development Coordinator was informed of the above observation. She stated that there should never be a time when a staff member enters an isolation room that they shouldn't wear PPE. On 03/22/19 received the following policies from Staff Development Coordinator (Other Staff #1). PROCEDURE TITLED - Contact Precaution Procedure, Last Date of Review-12/26/17. PURPOSE: Contact Isolation is used to prevent transmission of epidemiologically important	F 880	for evaluation of compliance, ongoing monitoring for continuous improvement and to determine if any modifications to the action plans are necessary after the implementation	

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organisms from an infected or colonized patient through direct (touching the patient) or indirect (touching surfaces or objects in the patient's environment) contact -i.e., multi-drug resistant organisms (MRSA, VRE, Acinetobacter, ESBL, or C. difficile). PERFORMED BY: All employees and or visitors when indicated. PROCEDURE: 1. Place "contact Precaution" sign inside the first drawer of isolation cart for staff to review instructions before entering the room. 2. Gloves and Hand Hygiene: A. Wear gloves and gown when entering the room. B. During the course of providing care, change gloves after having contact with infective material that may contain high concentrations of microorganisms (fecal material and wound drainage). C. Remove gloves, and gowns before leaving the resident's room and wash hands immediately and or use a waterless antiseptic agent.

POLICY TITLED - Handwashing Policy, Last review Date-06/01/18. POLICY STATEMENT: It is the policy of this facility that handwashing be regarded as the single most important means of preventing the spread of infections. Hands should be washed: Before and after each procedure, before and after physical contact with each resident and after removing gloves, gowns or masks.

On 03/22/19 at approximately, 3:09 PM the administrator and Director of Nursing were made aware of the above concerns.