State of Virginia

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	VA0043	A. BUILDING. _____ B. WING _____	C 04/16/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREENBRIER REGIONAL MEDICAL CENTER	1017 GEORGE WASHINGTON HIGHWAY NORTH CHESAPEAKE, VA 23323

(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) COMPLETE DATE
F 000	Initial Comments An unannounced biennial State Licensure Inspection was conducted 04/10/19 through 04/12/19 and 4/15/19 through 4/16/19. The facility was not in compliance with the Virginia Rules and Regulations for the Licensure of Nursing Facilities. 4 complaints were investigated during the survey. The census in this 120 licensed bed facility was 103 at the time of the survey. The survey sample consisted of 36 current Resident reviews and 8 closed record reviews.	F 000	000 This plan of correction is respectfully Submitted in response to deficiencies cited on 4/10/19 to 4/16/19. This plan of correction constitutes a written allegation of substantial compliance with the Federal Medicare and Medicaid requirements. The Submission of this plan of correction does not constitute an agreement that the deficiencies exists, nor is it an admission that they existed. It is an expression of the Facilities desire to fully comply with the Medicare and Medicaid requirements.	
F 001	Non Compliance The facility was out of compliance with the following state licensure requirements: This RULE: is not met as evidenced by: 12 VAC 5-371-150 (D). Resident Rights. Cross Reference to F-572. 12 VAC 5-371-150 (B)(1) Cross Reference To F-622, F-623, F-625. 12 VAC 5-371-250 B, C, D. Resident Assessment. Cross Reference to F640, F641. 12 VAC 5-371-220 C.1. Nursing Services. Cross Reference to F-684, F-686 12 VAC 5-371-220 D Nursing Services Cross Reference to F-687 12 VAC 5-371-200 (A). Nursing/Director of Nursing. Cross Reference to F-727. 12 VAC 5-371-310 B. Diagnostic Services. Cross Reference to F770.	F 001		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: ED / LNHA — (X6) DATE: 5/23/19

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F 001	Continued From page 1	F 001		

12-VAC 5-371-300 A. cross referenced at F-tag 755

12 VAC 5-371-220 C. Nursing Service. Cross Reference to F810.

12VAC5-371-180 Infection Control cross referenced to F-880.

12 VAC 5-371-380. Laundry Services. Cross Reference to F-880.

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E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 04/10/19 through 04/12/19 and 4/15/19-4/16/19. 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 004 SS=C	Develop EP Plan, Review and Update Annually CFR(s): 483.73(a) [The [facility] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility] must develop establish and maintain a comprehensive emergency preparedness program that meets the requirements of this section.] * [For hospitals at §482.15 and CAHs at §485.625(a):] The [hospital or CAH] must comply with all applicable Federal, State, and local emergency preparedness requirements. The [hospital or CAH] must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach. The emergency preparedness program must include, but not be limited to, the following elements:] (a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be [reviewed], and updated at least annually. * [For ESRD Facilities at §494.62(a):] Emergency Plan. The ESRD facility must develop and	E 004		

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y deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that ıer safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days owing 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 ys following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued ıgram participation.

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E 004	Continued From page 1 maintain an emergency preparedness plan that must be [evaluated], and updated at least annually. This REQUIREMENT is not met as evidenced by: Based on record review, and staff interview, the facility staff failed to have documentation of the facility's Emergency Preparedness Plan identified risk assessment. The findings included: During an interview on 4/11/19 at 2:58 P.M. with the Administrator, an onsite Administrator from a sister facility and the Maintenance Director, when asked for the Emergency Preparedness Program the facility staff failed to provide a comprehensive emergency preparedness program. The Administrator stated, "He had only been at the facility for five days prior to the survey. The Administrator from the sister facility stated, "He was there to provide support to the new Administrator." When asked for the Initial Emergency Preparedness Plan this surveyor was provided with a plan dated April 25, 2018. The provided document did not included how the facility would operate under potential interruptions and there were no contracts or arrangement to re-establish essential services during an emergency. The administrator stated the facility had not developed a emergency preparedness plan that identified how the facility would address the needs of the patients and continuity of operation. The facility staff failed to have documentation of identified needs of the facility and a continuity of operation during an actual emergency.	E 004	E 004 Develop the EP plan review and update annually. The Facility Administrator will develop the EEP plan for E 004. On how we would respond to an emergency and we will put the contracts in place to assist us in doing this during a disaster. He will in-service all staff on it and will review it annually. He will take it to the QAPI committee meeting for review and approval. This will be a permanent fix to this citation.	5/31/19

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E 007 E 007 SS=C	Continued From page 2 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 record review, and staff interview, the facility staff failed to have documentation of the facility's identified population at risk during an emergency. The findings included: During an interview on 04/11/19 at 3:10 P.M. with the Administrator, he was asked for documentation of the facility's identified population at risk during an emergency and delegation of authority during an emergency. The Administrator stated the facility had not conducted a risk assessment of it's resident population at risk during an emergency; nor did the facility have documentation of delegation of authority during an emergency. The facility staff failed to have documentation of	E 007 E 007	E 007 The Facility Administrator will develop documentation for the Facilities that will identify our at-risk population during an emergency. And the delegation of authority during an emergency / Disaster. If the Administrator is not present in the building. The Administrator will in-service all staff on these items and will also present them at our next Monthly QAPI committee meeting for review and approval. This will be a permanent fix to this citation.	5/31/19

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E 007	Continued From page 3 the facility's identified population at risk and documentation of delegation of authority during an emergency.	E 007		
E 009 SS=C	Local, State, Tribal Collaboration Process CFR(s): 483.73(a)(4) [(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:] (4) Include a process for cooperation and collaboration with local, tribal, regional, State, and Federal emergency preparedness officials' efforts to maintain an integrated response during a disaster or emergency situation, including documentation of the facility's efforts to contact such officials and, when applicable, of its participation in collaborative and cooperative planning efforts. * [For ESRD facilities only at §494.62(a)(4)]: (4) Include a process for cooperation and collaboration with local, tribal, regional, State, and Federal emergency preparedness officials' efforts to maintain an integrated response during a disaster or emergency situation, including documentation of the dialysis facility's efforts to contact such officials and, when applicable, of its participation in collaborative and cooperative planning efforts. The dialysis facility must contact the local emergency preparedness agency at least annually to confirm that the agency is aware of the dialysis facility's needs in the event of an emergency. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the	E 009	E 009 The Facility Administrator will develop and maintain an EPP that includes a process for cooperating and collaborating with local, tribal, regional, and State and Federal emergency preparedness officials. The Administrator will do an in-service for all staff and also take information to our QAPI committee meeting. This will be a permanent fix for this citation.	5/31/19

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E 009	Continued From page 4 facility staff failed to develop and maintain an emergency preparedness plan that include a process for cooperating and collaborating with local, tribal, regional, State and Federal emergency preparedness officials. The findings included: During an interview and review on 4/11/19 at 3:20 P.M. of the emergency preparedness plan with the Administrator he was asked for documentation of how the facility would maintain contact and cooperate with the local, tribal, regional, state and federal emergency preparedness officials. The administrator stated, the emergency preparedness plan did not have documentation of how to contact these officials. The facility staff failed to develop and maintain an emergency preparedness plan that included a process for cooperating and contacting the local, tribal, regional, State, and Federal emergency preparedness officials.	E 009		
E 013 SS=C	Development of EP Policies and Procedures CFR(s): 483.73(b) (b) Policies and procedures. [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. *Additional Requirements for PACE and ESRD Facilities:	E 013		

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E 013	Continued From page 5 *[For PACE at §460.84(b):] Policies and procedures. The PACE organization 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 address management of medical and nonmedical emergencies, including, but not limited to: Fire; equipment, power, or water failure; care-related emergencies; and natural disasters likely to threaten the health or safety of the participants, staff, or the public. The policies and procedures must be reviewed and updated at least annually. *[For ESRD Facilities at §494.62(b):] Policies and procedures. The dialysis facility 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. These emergencies include, but are not limited to, fire, equipment or power failures, care-related emergencies, water supply interruption, and natural disasters likely to occur in the facility's geographic area. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility staff failed to develop and implement emergency preparedness policies and procedures, based on the risk assessment and communication plan. The policies and procedures must be reviewed and updated at least annually.	E 013	E 013 the Facility Administrator cannot go back and meet the regulation of our plan meeting the November 2017 plan. What the Administrator will do is to develop an EPP plan that meets the requirements now. We will in-service all staff on that plan and will take it to our QAPI meeting for approval. We will develop policies and procedures annually and based on the facilities risk assessment and communication plan. This will be a permanent fix for this citation.	5/31/19

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E 013	Continued From page 6 The findings included; During an interview on 4/11/19 at 3:35 P.M. with the administrator he stated, the facility had not conducted an update to the emergency preparedness plan due to the facility's initial emergency preparedness plan was not implement until 4/25/18. A review of the documents presented included information from a different facility as well as information that described the current building as being a two story dwelling. The Administrator was reminded that the initial emergency preparedness plan process went into effect as of November 2017. The facility staff failed to develop and update policies and procedures annually and based on the facility's risk assessment and communication plan.	E 013		
E 015 SS=C	Subsistence Needs for Staff and Patients CFR(s): 483.73(b)(1) [(b) Policies and procedures. [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: (1) The provision of subsistence needs for staff and patients whether they evacuate or shelter in place, include, but are not limited to the following: (i) Food, water, medical and pharmaceutical supplies	E 015		

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E 015	Continued From page 7 (ii) Alternate sources of energy to maintain the following: (A) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions. (B) Emergency lighting. (C) Fire detection, extinguishing, and alarm systems. (D) Sewage and waste disposal. *[For inpatient Hospice at §418.113(b)(6)(iii):] Policies and procedures. (6) The following are additional requirements for hospice-operated inpatient care facilities only. The policies and procedures must address the following: (iii) The provision of subsistence needs for hospice employees and patients, whether they evacuate or shelter in place, include, but are not limited to the following: (A) Food, water, medical, and pharmaceutical supplies. (B) Alternate sources of energy to maintain the following: (1) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions. (2) Emergency lighting. (3) Fire detection, extinguishing, and alarm systems. (C) Sewage and waste disposal. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility staff failed to provide documentation that the emergency preparedness plan address sewage and waste disposal services. The findings included:	E 015	E 015 the Facility Administrator will develop an EPP plan that will include Sewage and waste disposal services for the building. The Facility has generator power and we have plans for (a) temperatures to protect patient's health and safety and for safe and sanitary storage of provisions. (b) Emergency lighting (c) Fire Detection, Extinguishing and alarm systems. (d) Sewage and waste disposal And for in=-patient Hospice we will obtain Food, Water, medical and Pharmacy supplies. We have alternate sources of energy to keep Temperatures to protect patient health and safety and sanitary storage or provisions. The Administrator will in-service all staff and will take this to the QAPI meeting for approval. This will be a permanent fix.	5/31/19

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E 015	Continued From page 8 The facility emergency preparedness plan failed to have documentation of procedures or agreements for the provision of sewage and waste disposal services during an emergency. During a review of the emergency preparedness plan with the administrator on 4/11/19 at 3:55 P.M. The administrator was asked for documentation for procedures or vendor contracts for sewage and waste disposal services. The administrator stated "He did not have documentation of the facility having contract agreements for sewage and waste disposal services." The facility staff failed to provide documentation of procedures for sewage and waste disposal services.	E 015		
E 018 SS=C	Procedures for Tracking of Staff and Patients CFR(s): 483.73(b)(2) [(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:] (2) A system to track the location of on-duty staff and sheltered patients in the [facility's] care during an emergency. If on-duty staff and sheltered patients are relocated during the emergency, the [facility] must document the specific name and	E 018		

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E 018	Continued From page 9 location of the receiving facility or other location. *[For PRTFs at §441.184(b), LTC at §483.73(b), ICF/IIDs at §483.475(b), PACE at §460.84(b):] Policies and procedures. (2) A system to track the location of on-duty staff and sheltered residents in the [PRTF's, LTC, ICF/IID or PACE] care during and after an emergency. If on-duty staff and sheltered residents are relocated during the emergency, the [PRTF's, LTC, ICF/IID or PACE] must document the specific name and location of the receiving facility or other location. *[For Inpatient Hospice at §418.113(b)(6):] Policies and procedures. (ii) Safe evacuation from the hospice, which includes consideration of care and treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s) and primary and alternate means of communication with external sources of assistance. (v) A system to track the location of hospice employees' on-duty and sheltered patients in the hospice's care during an emergency. If the on-duty employees or sheltered patients are relocated during the emergency, the hospice must document the specific name and location of the receiving facility or other location. *[For CMHCs at §485.920(b):] Policies and procedures. (2) Safe evacuation from the CMHC, which includes consideration of care and treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s); and primary and alternate means of communication with external sources of assistance.	E 018		

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E 018	Continued From page 10 *[For OPOs at § 486.360(b):] Policies and procedures. (2) A system of medical documentation that preserves potential and actual donor information, protects confidentiality of potential and actual donor information, and secures and maintains the availability of records. *[For ESRD at § 494.62(b):] Policies and procedures. (2) Safe evacuation from the dialysis facility, which includes staff responsibilities, and needs of the patients. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility staff failed to provide documentation for the location of residents at alternate sites. The facility failed to provide documentation that staff have been trained on the system to track the location of on-duty staff and sheltered patients who may be relocated during an emergency. The findings included: The facility failed to provide documentation that staff have been trained on the facility's tracking system. During review of the facility's emergency preparedness plan on 04/11/19 at 4:05 P.M. the administrator was asked to provide documentation that facility staff have been trained on the facility's system to track the location of on-duty staff and sheltered resident who are relocated during an emergency. The administrator stated, "We have not trained our staff on the tracking system." During interviews of nursing staff they were asked to describe the facility's tracking system used to track residents	E 018	E 018 The Facility Administrator will develop a EPP plan that will include Procedures for tracking of Staff and Patients. Especially if we have to evacuate the Facility. This tracking system will be for all patients that we serve, including Hospice. We will train the staff on Treatment needs of evacuees, staff responsibilities, transportation, identification of locations, and primary and alternative means of communication and external sources of assistance. This will be taking to the QAPI committee for review and approval. This is a permanent fix.	5/31/19

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	495330	A. BUILDING _____ B. WING _____	C 04/16/2019

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E 018	Continued From page 11 and staff during an emergency in the event residents are relocated. The staff stated, they had not received training. The facility staff failed to train staff on the system to track the location of on-duty staff and sheltered residents who are relocated during an emergency.	E 018		
E 020 SS=C	Policies for Evac. and Primary/Alt. Comm. CFR(s): 483.73(b)(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:] Safe evacuation from the [facility], which includes consideration of care and treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s); and primary and alternate means of communication with external sources of assistance. *[For RNHCs at §403.748(b)(3) and ASCs at §416.54(b)(2):] Safe evacuation from the [RNHCI or ASC] which includes the following: (i) Consideration of care needs of evacuees. (ii) Staff responsibilities. (iii) Transportation. (iv) Identification of evacuation location(s). (v) Primary and alternate means of	E 020		

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E 020	Continued From page 12 communication with external sources of assistance. * [For CORFs at §485.68(b)(1), Clinics, Rehabilitation Agencies, OPT/Speech at §485.727(b)(1), and ESRD Facilities at §494.62(b)(2):] Safe evacuation from the [CORF; Clinics, Rehabilitation Agencies, and Public Health Agencies as Providers of Outpatient Physical Therapy and Speech-Language Pathology Services; and ESRD Facilities], which includes staff responsibilities, and needs of the patients. * [For RHCs/FQHCs at §491.12(b)(1):] Safe evacuation from the RHC/FQHC, which includes appropriate placement of exit signs; staff responsibilities and needs of the patients. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility staff failed to have documentation that the emergency preparedness plan included policy and procedures for the safe evacuation from the facility. The findings included: During an interview on 4/11/19 at 11:15 A.M.. with the administrator, he was asked for documentation for the safe evacuation from the facility including care for the residents, transportation, identification of evacuation location and alternate means of communication with external resources and staff responsibilities. The administrator stated, he did not have documentation for the safe evacuation from the facility which included care for residents, transportation needs, communication with	E 020	E 020 The Facility will develop an EPP plan that will allow us to safely evacuate Residents along with staff in case we find it necessary to evacuate our Facility. This will include :consideration of care needs of evacuees, staff responsibilities, Transportation Identification of evacuation locations Identification of evacuation locations Primary and alternate means of communication and external sources of assistance. The staff will be trained in all of the above and we will take this for review and approval to our QAPI committee mtg. This will be a permanent fix.	5/31/19

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E 020	Continued From page 13 external resources and staff responsibilities. The facility staff failed to have documentation that the emergency preparedness plan included policy and procedures for the safe evacuation from the facility.	E 020		
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: Based on record review and staff interview, the facility staff failed to have documentation for	E 022	E 022 The Facility Administrator will develop an EPP that will address to protect the confidentiality of Patient information and maintain the availability of resident records to support the continuity of care for Residents during an emergency. All staff will be trained on the EPP plan and will be taken to our QAPI meeting for review and approval. This will be a permanent fix.	5/31/19

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E 022	Continued From page 14 sheltering in place. The findings included: During an interview with the administrator on 4/11/19 at 11:24 A.M. the administrator was asked for documentation for the process of sheltering in place for staff, volunteers and visitors. The administrator stated, he did not have documentation for sheltering in place for staff, volunteers and visitors. The facility staff failed to have procedure documentation for sheltering in place for staff, volunteers and visitors.	E 022		
E 023 SS=C	Policies/Procedures for Medical Documentation CFR(s): 483.73(b)(5) [(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:] (5) A system of medical documentation that preserves patient information, protects confidentiality of patient information, and secures and maintains availability of records. [(5) or (3),(4),(6)] A system of medical documentation that preserves patient information, protects confidentiality of patient information, and secures and maintains availability of records.	E 023		

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E 023	Continued From page 15 *[For RNHCIs at §403.748(b):] Policies and procedures. (5) A system of care documentation that does the following: (i) Preserves patient information. (ii) Protects confidentiality of patient information. (iii) Secures and maintains the availability of records. *[For OPOs at §486.360(b):] Policies and procedures. (2) A system of medical documentation that preserves potential and actual donor information, protects confidentiality of potential and actual donor information, and secures and maintains the availability of records. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility staff failed to have a documentation verification system for preserving patient information. The findings included: During an interview on 4/11/19 at 11:40 A.M. with the administrator, he was asked for documentation of the emergency preparedness plan to protect confidentiality of patient information and maintain the availability of resident records. The administrator stated, he did not have documentation to ensure patient records were secure and readily available to support the continuity of care for residents during an emergency. The facility staff failed to have verification for preserving resident information.	E 023	E 023 The Facility will develop an EPP plan that will secure our medical documentation that preserves patient information for our Residents during an evacuation of our Facility. The staff will be trained on this and we will take this for review and approval to our QAPI committee mtg. This will be a permanent fix.	5/31/19
E 024 SS=C	Policies/Procedures-Volunteers and Staffing CFR(s): 483.73(b)(6)	E 024		

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E 024	Continued From page 16 [(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 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 record review and staff interview, the facility staff failed to develop policies and procedures for the use of volunteers during an emergency.	E 024	E 024 The Facility will develop an EPP plan that will have Policies and Procedures as it pertains to Volunteers here at GRMC. We will provide training to the staff on the PnP's and will take it for review to our QAPI committee meeting for review and approval. This will be a permanent fix.	5/31/19

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E 024	Continued From page 17 The findings included: During an interview on 04/11/19 at 11:55 A.M. with the Administrator he stated, the facility have volunteers who assist residents daily, however, the facility had not developed policies and procedures for the use of volunteers during emergency preparedness activities. The facility failed to develop policies and procedures for the use of volunteers during an emergency.	E 024		
E 025 SS=C	Arrangement with Other Facilities CFR(s): 483.73(b)(7) [(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:] *[For Hospices at §418.113(b), PRFTs at §441.184,(b) Hospitals at §482.15(b), and LTC Facilities at §483.73(b):] Policies and procedures. (7) [or (5)] The development of arrangements with other [facilities] [and] other providers to receive patients in the event of limitations or cessation of operations to maintain the continuity of services to facility patients. *[For PACE at §460.84(b), ICF/IIDs at §483.475(b), CAHs at §486.625(b), CMHCs at §485.920(b) and ESRD Facilities at §494.62(b):]	E 025		

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E 025	Continued From page 18 Policies and procedures. (7) [or (6), (8)] The development of arrangements with other [facilities] [or] other providers to receive patients in the event of limitations or cessation of operations to maintain the continuity of services to facility patients. *[For RNHCIs at §403.748(b):] Policies and procedures. (7) The development of arrangements with other RNHCIs and other providers to receive patients in the event of limitations or cessation of operations to maintain the continuity of non-medical services to RNHCI patients. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility staff failed to have policies and procedures based on the emergency preparedness plan to make arrangements with other facility's and other providers. The findings included: During an interview on 04/11/19 at 12:05 P.M. with the administrator he was asked for policies and procedures for the arrangements with other facility's and providers to receive residents in the event of limited or cessation of operations. The administrator stated, he did not have policies and procedures, nor prearranged agreements with other facility's for the transfer or receiving of residents during an emergency should the need arise. The facility staff failed to have policy's and procedures for the prearrangement of transfer agreements to receive residents.	E 025	E 025 The Facility did Show that we had at One transfer agreement with a Sister Facility 2 hours away in Tappahannock VA. We will develop additional transfer agreements with local SNFs and others that are further away incase of hurricane or other disasters and we need to get our Residents to a safer location not in our immediate area. Staff will be trained on this as well. We will take it to our QAPI committee meeting for review and approval. This will be a permanent fix.	5/31/19

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E 026	Continued From page 19	E 026		
E 026	Roles Under a Waiver Declared by Secretary CFR(s): 483.73(b)(8) [(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 record review and staff interview the facility staff failed to have documentation describing the facilities role in providing care in an alternate care site. The findings included: During an interview with the administrator on 04/12/19 at 9:51 a.m., the administrator and the Regional Director of Operations were asked for	E 026	E 026 The Facility will develop the EPP plan that will have a clear understanding of our Staff providing care for our Residents if we have to evacuate and send staff to Facilities / alternate care sites in other locations. Staff will be trained on the policy and procedures for this and we will take it to our QAPI committee meeting for review and approval. This will be a permanent fix.	5/31/19

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E 026	Continued From page 20 documentation describing the facility's role in providing care at an alternate care site. The administrator stated, he did not have any documentation describing the facility's role or the care that would be provided at an alternate care site. Direct Care staff were interviewed on 4/11/19 at 2:30 P.M. and asked if they had been trained on providing care at an alternate care site and the staff response was, "No one trained them nor were they aware of providing care at an alternate care site in the event of an emergency and residents had to be moved." The facility staff failed to have documentation describing the facility's role in providing care in an alternate care site.	E 026		
E 029 SS=C	Development of Communication Plan CFR(s): 483.73(c) (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. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility staff failed to have all facility contact information in the communication plan. The findings included: During an interview on 4/12/19 at 11: 43 a.m. with the administrator, he was asked for names and contact information for all facility staff, as well as entities providing services under agreement during an emergency. A review of the communications plan did not include the names	E 029	E 029 The Facility did have a phone list which was shown the Surveyor, The Facility will continue to have a staff phone list and we will update it as needed with new staff numbers or staff that change their phone number as we are informed. The Administrator will develop the communication plan that will comply with Federal, State, and local laws and will be reviewed and updated at least annually. We will provide training to all Staff. We will take our communication plan to our QAPI meeting for review and approval. This will be a permanent fix.	6/1/19

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E 029	Continued From page 21 of all staff and their contact information; nor did the plan include vendors providing services to the facility during an emergency. The facility staff failed to have all facility contact information in the communication plan.	E 029		
E 030 SS=C	Names and Contact Information CFR(s): 483.73(c)(1) [(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:] (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians (iv) Other [facilities]. (v) Volunteers. *[For RNHCIs at §403.748(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Next of kin, guardian, or custodian. (iv) Other RNHCIs. (v) Volunteers. *[For ASCs at §416.45(c):] The communication plan must include all of the following: (1) Names and contact information for the	E 030		

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E 030	Continued From page 22 following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians. (iv) Volunteers. *[For Hospices at §418.113(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Hospice employees. (ii) Entities providing services under arrangement. (iii) Patients' physicians. (iv) Other hospices. *[For HHAs at §484.102(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians. (iv) Volunteers. *[For OPOs at §486.360(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Volunteers. (iv) Other OPOs. (v) Transplant and donor hospitals in the OPO's Donation Service Area (DSA). This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility staff failed to have all facility contact	E 030	E 030 The Facility did have a phone list which was shown the Surveyor, The Facility will continue to have a staff phone list and we will update it as needed with new staff numbers or staff that change their phone number as we are informed. The Administrator will develop the communication plan that will comply with Federal, State, and local laws and will be reviewed and updated at least annually. We will provide training to all Staff. Our communication plan will Include	

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	495330	A. BUILDING _____ B. WING _____	C 04/16/2019

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E 030	Continued From page 23 information in the communication plan. The findings included: During an interview on 04/12/19 at 10: 33 a.m. with the administrator, he was asked for names and contact information for all facility staff, as well as entities providing services under agreement during an emergency. A review of the communications plan did not include the name of all staff and their contact information. Nor did the plan include vendors providing services to the facility during an emergency. The facility staff failed to have all facility contact information in the communication plan.	E 030	1), Staff names and contract information Staff 2). Entities providing services under the arrangement 3), Patients Physicians 4). Other Facilities 5). Volunteers We will take our communication plan to our QAPI meeting for review and approval.	
E 031 SS=C	Emergency Officials Contact Information CFR(s): 483.73(c)(2) [(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: (2) Contact information for the following: (i) Federal, State, tribal, regional, and local emergency preparedness staff. (ii) Other sources of assistance. *[For LTC Facilities at §483.73(c):] (2) Contact information for the following: (i) Federal, State, tribal, regional, or local emergency preparedness staff. (ii) The State Licensing and Certification Agency. (iii) The Office of the State Long-Term Care Ombudsman.	E 031	This will be a permanent fix.	5/31/19

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E 031	Continued From page 24 (iv) Other sources of assistance. *[For ICF/IIDs at §483.475(c):] (2) Contact information for the following: (i) Federal, State, tribal, regional, and local emergency preparedness staff. (ii) Other sources of assistance. (iii) The State Licensing and Certification Agency. (iv) The State Protection and Advocacy Agency. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility staff failed to have all required contact information for sources of assistance in the communication plan. The findings included: During an interview on 04/12/19 at 10: 43 a.m. with the administrator, he was asked for names and contact information for entities providing services under agreement during an emergency. The administrator provided a list of local health department names and phone numbers for federal, state,tribal and local emergency preparedness staff, however the plan did the plan did not include vendors providing services to the facility during an emergency. The facility staff failed to have all facility contact information in the communication plan.	E 031	E 031 The Facility Administrator will develop an EPP plan communication plan that complies with Federal, State, and Local Laws and will be reviewed and updated at least annually. The Facilities communication plan will include a method for sharing information and medical documentation to maintain continuity of care. All staff will be trained on the communication and their roles in a disaster and the chain of command. The communication plan also will be taken to our QAPI meeting and reviewed and approved. This is a permanent fix.	5/31/19
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	E 033		

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E 033	Continued From page 25 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 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 record review and staff interview, the facility staff failed to have documentation that the communication plan included a method for sharing information and medical documentation	E 033		

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E 033	Continued From page 26 to maintain continuity of care. The findings included: During an interview on 04/12/19 at 10:48 a.m. with the administrator, he was asked for evidence that the facility had a method for sharing information and medical care for residents with other health care providers to maintain continuity of care. The administrator stated, he did not have documentation for sharing information and medical care needs for residents in an alternate care site. The facility staff failed to have documentation that the communication plan included methods for sharing information and medical care with other health care providers.	E 033		
E 034 SS=C	Information on Occupancy/Needs CFR(s): 483.73(c)(7) [(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: (7) [(5) or (6)] A means of providing information about the [facility's] occupancy, needs, and its ability to provide assistance, to the authority having jurisdiction, the Incident Command Center, or designee. *[For ASCs at 416.54(c)]: (7) A means of providing information about the ASC's needs, and its ability to provide assistance, to the authority having jurisdiction, the Incident Command	E 034	E. 034 The Facility Administrator will develop a EPP communication plan providing information about our Occupancy, needs, and its ability to provide assistance to the Authority having jurisdiction, the incident Command Center or Designee. We will train all Staff and take the plan to our QAPI meeting for review and approval. This is a permanent fix.	5/31/19

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E 034	Continued From page 27 Center, or designee. *[For Inpatient Hospice at §418.113:] (7) A means of providing information about the hospice's inpatient occupancy, needs, and its ability to provide assistance, to the authority having jurisdiction, the Incident Command Center, or designee. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility staff failed to have documentation about the facility's occupancy needs and its ability to provide assistance. The findings included: During an interview on 04/12/19 at 12:06 P.M. with the administrator, he was asked for documentation for identifying the needs of the facility, including the residents as well as the facility's ability to provide assistance to the Incident Command Center. The administrator stated, the facility had not identified the needs of the residents nor had the facility identified how the facility could provide assistance. The facility staff failed to provide documentation and have means of providing information about the facility's needs and its ability to provide assistance.	E 034		
E 035 SS=C	LTC and ICF/IID Sharing Plan with Patients CFR(s): 483.73(c)(8) [(c) The [LTC facility and ICF/IID] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and	E 035		

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E 035	Continued From page 28 updated at least annually.] The communication plan must include all of the following: (8) A method for sharing information from the emergency plan, that the facility has determined is appropriate, with residents [or clients] and their families or representatives. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility staff failed to have a method for sharing information of the Emergency Preparedness Plan with residents and families. The findings included: During an interview on 04/12/19 at 12:11 P.M. with the administrator, he was asked how the facility shared emergency preparedness information with residents and families. The administrator stated, the facility had sent out notices but could not produce a copy. When asked how did he know notices were sent out the administrator stated, he did not have any information to confirm that residents or families had been notified about the emergency preparedness plan. The facility staff failed to have a method to share information of the emergency preparedness plan with residents and families.	E 035	E 035 The Facility Administrator will develop an EPP plan that will develop a way that we can inform our Residents and their families about our EPP plan and how it will affect them. Notices were sent out and will be sent out again to meet this section of the Federal and State and Local Laws. Staff will be trained and the EPP plan for communicating with the Residents and Families will be taken to the QAPI meeting for review and approval. At least annually and updated. This will be a permanent fix	5/31/19
E 036 SS=C	EP Training and Testing CFR(s): 483.73(d) (d) Training and testing. The [facility] must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in	E 036		

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E 036	Continued From page 29 paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least annually. *[For ICF/IIDs at §483.475(d):] Training and testing. The ICF/IID must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least annually. The ICF/IID must meet the requirements for evacuation drills and training at §483.470(h). *[For ESRD Facilities at §494.62(d):] Training, testing, and orientation. The dialysis facility must develop and maintain an emergency preparedness training, testing and patient orientation program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training, testing and orientation program must be reviewed and updated at least annually. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility staff failed to have an emergency preparedness training and testing program.	E 036	E 036 The Facility Administrator will develop an EPP and maintain an EPP plan for training and testing program that is based on the EPP plan. This will be updated and reviewed at least annually. This training and testing plan will be taken to our QAPI meeting for review and approval. Staff will be trained with said plan. This is a permanent fix	5/31/19

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E 036	Continued From page 30 The findings included: During an interview on 04/12/19 at 12:17 P.M. with the administrator, he was asked for documentation of the facility's training and testing program. The administrator stated, the facility had not developed a training and testing program. The facility staff failed to have a training and testing program.	E 036		
E 037 SS=C	EP Training Program CFR(s): 483.73(d)(1) (1) Training program. The [facility, except CAHs, ASCs, PACE organizations, PRTFs, Hospices, and dialysis facilities] must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected role. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. *[For Hospitals at §482.15(d) and RHCs/FQHCs at §491.12:] (1) Training program. The [Hospital or RHC/FQHC] must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing on-site services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of the training.	E 037		

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E 037	Continued From page 31 (iv) Demonstrate staff knowledge of emergency procedures. *[For Hospices at §418.113(d):] (1) Training. The hospice must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing hospice employees, and individuals providing services under arrangement, consistent with their expected roles. (ii) Demonstrate staff knowledge of emergency procedures. (iii) Provide emergency preparedness training at least annually. (iv) Periodically review and rehearse its emergency preparedness plan with hospice employees (including nonemployee staff), with special emphasis placed on carrying out the procedures necessary to protect patients and others. *[For PRTFs at §441.184(d):] (1) Training program. The PRTF must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) After initial training, provide emergency preparedness training at least annually. (iii) Demonstrate staff knowledge of emergency procedures. (iv) Maintain documentation of all emergency preparedness training. *[For PACE at §460.84(d):] (1) The PACE organization must do all of the following: (i) Initial training in emergency preparedness	E 037		

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E 037	Continued From page 32 policies and procedures to all new and existing staff, individuals providing on-site services under arrangement, contractors, participants, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least annually. (iii) Demonstrate staff knowledge of emergency procedures, including informing participants of what to do, where to go, and whom to contact in case of an emergency. (iv) Maintain documentation of all training. *[For CORFs at §485.68(d):](1) Training. The CORF must do all of the following: (i) Provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. All new personnel must be oriented and assigned specific responsibilities regarding the CORF's emergency plan within 2 weeks of their first workday. The training program must include instruction in the location and use of alarm systems and signals and firefighting equipment. *[For CAHs at §485.625(d):] (1) Training program. The CAH must do all of the following: (i) Initial training in emergency preparedness policies and procedures, including prompt reporting and extinguishing of fires, protection, and where necessary, evacuation of patients, personnel, and guests, fire prevention, and	E 037		

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E 037	Continued From page 33 cooperation with firefighting and disaster authorities, to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. *[For CMHCs at §485.920(d):] (1) Training. The CMHC must provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles, and maintain documentation of the training. The CMHC must demonstrate staff knowledge of emergency procedures. Thereafter, the CMHC must provide emergency preparedness training at least annually. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility staff failed to have an initial emergency preparedness training and testing program. The findings included: During an interview on 04/12/19 at 12: 17 P.M. with the administrator, he was asked for documentation of the facilities training and testing program. The administrator stated, the facility had not developed a training and testing program. The facility staff failed to have an initial training and testing program.	E 037	E 037 The Facility Administrator will develop an EPP plan that maintains an EPP plan for training and testing program that is based upon EPP plan. This will be updated and reviewed annually. This training and testing plan will be taken to our QAPI meeting for review and approval. Staff will be trained with said plan. This will be a permanent fix.	5/31/19

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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 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.	E 039		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 039	Continued From page 35 *[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 record review and staff interview the facility staff failed to have documentation of the facility's emergency preparedness exercise analysis and response. The findings include: During an interview on 04/12/19 at 12:25 P.M. with the administrator, he was asked for documentation of the facility's table top exercise analyses and the revised emergency plan. The administrator stated, the facility staff did not conduct an analysis of the table top exercise nor did the facility staff revise the emergency preparedness plan as a result. The facility staff failed to have documentation of the facility's exercise analysis and response.	E 039	E 039 The Facility did have a table top exercise in August 2018 and will develop another one with the area EOC. This will be done in with local Fire department, EMS and other entities to comply with the requirements. This training will include staff as well. And we will take what we analysis what learned from this exercise and make adjustments to our EPP plan. This will a permanent fix	5/31/19

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	495330	A. BUILDING _____ B. WING _____	C 04/16/2019

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E 041	Continued From page 36	E 041		
E 041 SS=C	Hospital CAH and LTC Emergency Power CFR(s): 483.73(e) (e) Emergency and standby power systems. The hospital must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section and in the policies and procedures plan set forth in paragraphs (b)(1)(i) and (ii) of this section. §483.73(e), §485.625(e) (e) Emergency and standby power systems. The [LTC facility and the CAH] must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section. §482.15(e)(1), §483.73(e)(1), §485.625(e)(1) Emergency generator location. The generator must be located in accordance with the location requirements found in the Health Care Facilities Code (NFPA 99 and Tentative Interim Amendments TIA 12-2, TIA 12-3, TIA 12-4, TIA 12-5, and TIA 12-6), Life Safety Code (NFPA 101 and Tentative Interim Amendments TIA 12-1, TIA 12-2, TIA 12-3, and TIA 12-4), and NFPA 110, when a new structure is built or when an existing structure or building is renovated. 482.15(e)(2), §483.73(e)(2), §485.625(e)(2) Emergency generator inspection and testing. The [hospital, CAH and LTC facility] must implement the emergency power system inspection, testing, and maintenance requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code. 482.15(e)(3), §483.73(e)(3), §485.625(e)(3)	E 041		

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E 041	Continued From page 37 Emergency generator fuel. [Hospitals, CAHs and LTC facilities] that maintain an onsite fuel source to power emergency generators must have a plan for how it will keep emergency power systems operational during the emergency, unless it evacuates. *[For hospitals at §482.15(h), LTC at §483.73(g), and CAHs §485.625(g):] The standards incorporated by reference in this section are approved for incorporation by reference by the Director of the Office of the Federal Register in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. You may obtain the material from the sources listed below. You may inspect a copy at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html. If any changes in this edition of the Code are incorporated by reference, CMS will publish a document in the Federal Register to announce the changes. (1) National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02169, www.nfpa.org, 1.617.770.3000. (i) NFPA 99, Health Care Facilities Code, 2012 edition, issued August 11, 2011. (ii) Technical interim amendment (TIA) 12-2 to NFPA 99, issued August 11, 2011. (iii) TIA 12-3 to NFPA 99, issued August 9, 2012. (iv) TIA 12-4 to NFPA 99, issued March 7, 2013. (v) TIA 12-5 to NFPA 99, issued August 1, 2013.	E 041		

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E 041	Continued From page 38 (vi) TIA 12-6 to NFPA 99, issued March 3, 2014. (vii) NFPA 101, Life Safety Code, 2012 edition, issued August 11, 2011. (viii) TIA 12-1 to NFPA 101, issued August 11, 2011. (ix) TIA 12-2 to NFPA 101, issued October 30, 2012. (x) TIA 12-3 to NFPA 101, issued October 22, 2013. (xi) TIA 12-4 to NFPA 101, issued October 22, 2013. (xiii) NFPA 110, Standard for Emergency and Standby Power Systems, 2010 edition, including TIAs to chapter 7, issued August 6, 2009. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility staff failed to have documentation of how the facility will keep the generator functional and/or written agreement with an outside fuel source vendor during the emergency. The findings included: During an interview on 04/12/19 at 12:33 P.M. with the administrator he was asked for documentation of how the generator would be kept operational during an emergency and/or for written agreement with an outside fuel vendor for emergencies. The administrator was not able to provide a written contract for an outside fuel vendor.	E 041	E 041 The Facility has a generator on premises. We have a generator company that services our unit and a fuel company that will provide us fuel. In the event of a disaster we would pre plan and get the generator topped off with fuel and have spare fuel in the event that our fuel source could not make it out to our Facility. We will have fuel that will last us up to 96 hours. We will put copies of our agreements in the EPP book and have them for proof of having them. This is permanent fix.	5/31/19
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 04/10/19 through 04/12/19 and 4/15/19 through 4/16/19. Corrections are required for compliance with 42 CFR Part 483	F 000		

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F 000	Continued From page 39 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. Four complaints were investigated during the survey. The census in this 120 certified bed facility was 103 at the time of the survey. The survey sample consisted of 36 current Resident reviews and 8 closed record reviews.	F 000	000 This plan of correction is respectfully Submitted in response to deficiencies cited on 4/10/19 to 4/16/19. This plan of correction constitutes a written allegation of substantial compliance with the Federal Medicare and Medicaid requirements. The Submission of this plan of correction does not constitute an agreement that the deficiencies exists, nor is it an admission that they existed. It is an expression of the Facilities desire to fully comply with the Medicare and Medicaid requirements.	
F 582 SS=D	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	F 582		

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F 582	Continued From page 40 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 clinical record review, staff interviews and facility documentation review, the facility staff failed to ensure Medicare Beneficiary Notices in accordance with applicable Federal regulations, were issued to 2 of 3 discharged residents (Resident #38 and #94) in the survey sample. 1. The facility staff failed to issue an Advanced Beneficiary Notice (ABN) letter to Resident #38 who was discharged from skilled services with Medicare days remaining.	F 582	2. All Medicare Part A covered residents have the potential to be affected. All upcoming Medicare Part A discharges will be discussed in the morning meetings. Two days prior to discharge an ABN letter will be issued by the Social Worker. In the absence of the Social Worker, the Administrator will designate who will issue the ABN letter. 3. The members of the IDT team will be in-serviced on ABN letters and when to issue them. 4. Weekly audits will be conducted X 4 weeks and then on a quarterly basis. Results of all reviews and audits will be incorporated into the center's QAPI process to ensure compliance is achieved and sustained.	

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F 582	Continued From page 41 2. The facility staff failed to issue an Advanced Beneficiary Notice (ABN) letter to Resident #94 who was discharged from skilled services with Medicare days remaining. The findings included: 1. Resident #38 was re-admitted to the nursing facility on 12/06/18. Diagnosis for Resident #38 included but not limited to Muscle Weakness. Resident #38's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) date of 02/14/19 coded Resident #38 a 15 out of a possible score of 15 on the Brief Interview for Mental Status (BIMS) that indicated no cognitive impairment. On review of the Beneficiary Notification Checklist provided by the facility to the surveyor it was noted that Resident #38 was not listed for having been issued the SNF ABN (Skilled Nursing Facility-Advanced Beneficiary Notice, form CMS-10055). The resident had received a NOMNC (Notice of Medicare Provider Non-Coverage-form CMS-10123), however no copies of the SNF ABN (CMS-10055) were provided. Resident #38 started a Medicare Part A stay on 12/06/18 and the last covered day of this stay was 01/18/19. Resident #38 was discharged from Medicare Part A services when benefit days were not exhausted and should have been issued a SNF ABN (CMS-10055) and an NOMNC (CMS-10123). Resident #38 had only used 44 days of her Medicare Part A services. Only an NOMNC was issued, with written notification to Resident #38 on 01/16/19.	F 582		

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F 582	Continued From page 42 An interview was conducted with the Assistant Social Worker on 04/09/19 at approximately 4:00 p.m., stated, "I did not starting issuing the cut letters until January 19, 2019 and before then it was the Social Worker who is no longer here. The Assistant Social Worker stated, "I was unable to locate an ABN letter for Resident #38; I really have no idea what an ABN letter is." 2. Resident #94 was admitted to the nursing facility on 03/15/19. Diagnosis for Resident #94 included but not limited to Respiratory Failure. Resident #94's Minimum Data Set (MDS) with an (ARD) date of 03/22/19 coded Resident #94 a 09 out of a possible score of 15 on the Brief Interview for Mental Status (BIMS) that indicated moderate cognitive impairment. On review of the Beneficiary Notification Checklist provided by the facility to surveyor was noted that Resident #94 was not listed for having been issued the SNF ABN (Skilled Nursing Facility-Advanced Beneficiary Notice, form CMS-10055). The resident had received a NOMNC (Notice of Medicare Provider Non-Coverage-form CMS-10123), however no copies of the SNF ABN (CMS-10055) were provided. Resident #94 started a Medicare Part A stay on 03/15/19, and the last covered day of this stay was 04/03/19. Resident #94 was discharged from Medicare Part A services when benefit days were not exhausted and should have been issued a SNF ABN (CMS-10055) and an NOMNC (CMS-10123). Resident #94 only used 20 days of his Medicare Part A services. Only an NOMNC was issued, with written notification to Resident #94 on 04/01/19.	F 582		

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F 582	Continued From page 43 An interview was conducted with the Assistant Social Worker on 04/09/19 at approximately 5:00 p.m., stated, "I did not starting issuing the cut letters until January 19, 2019 and before then it was the Social Worker who is no longer here. The Assistant Social Worker stated, "I was unable to locate an ABN letter for Resident #94; I really have no idea what an ABN letter is." A briefing was conducted via phone with the Administrator and Interim Director of Nursing (IDON) on 04/11/19 at approximately 4:55 p.m. The facility did not present any further information about the findings. The facility's policy titled Advanced Beneficiary Notice with a revision date of 01/04/18. Policy: It is the policy of this facility to provide timely notices regarding Medicare eligibility and coverage. Policy Explanation and Compliance Guidelines included but not limited to: -4. The facility shall inform Medicare beneficiaries of his or her potential liability for payment. -b. For Part A items and services, the facility shall use the Skilled Facility Advanced Beneficiary Notice (SNF/ABN), Form CMS-10055. -6. To ensure that the resident, or representative, has enough time to make a decision whether or not to receive the services in question and assume financial responsibility, the notice shall be provided within two days of the last anticipated covered day.	F 582		

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F 622 SS=E	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	F622 Transfer and Discharge Requirements 1. Resident #21, #31, #22, #35 and #41 have had their care plans updated as of 5-7-19. 2. All residents have the potential to be affected. Review of Resident transferred out of the facility over last 30 days were reviewed and update as indicated. 3. A list of items needed for resident transfers out of the facility will be given to the nursing staff and posted at the nurses' stations. Nurses will be in-serviced on all documentation including Care Plan Goals that are to be sent with residents who are transferred out of the facility.	5/31 2019

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F 622	Continued From page 45 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	F 622	4. Each resident who is transferred out of the facility will be reviewed by the management staff by the following day. If any documents are found not to have been sent, they will be immediately sent to the receiving facility. Results and reviews will be incorporated into the facilities QAPI process to ensure compliance is achieved and sustained.	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREENBRIER REGIONAL MEDICAL CENTER	1017 GEORGE WASHINGTON HIGHWAY NORTH CHESAPEAKE, VA 23323

(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 622	Continued From page 46 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 documentation (including care plan goals) was sent with the resident during a facility-initiated transfer to the hospital for 5 of 44 residents in the survey sample, Resident #21, 31, 22, 35, 41. 1. For Resident #21, facility staff failed to evidence that care plan goals were sent with the resident during a transfer to the hospital on 1/13/19. 2. For Resident #31, facility staff failed to evidence that care plan goals were sent with the resident during a transfer to the hospital on 1/18/19. 3. For Resident #22, facility staff failed to evidence that care plan goals were sent with the resident during a transfer to the hospital on 3/4/19. 4. The facility staff failed to convey to the receiving provider, Resident #35's Plan of Care Summary upon transfer to the hospital 12/18/18. 5. The facility staff failed to send care plan goals upon Resident #41's discharge to the hospital on	F 622		

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F 622	Continued From page 47 1/18/19. The findings include: 1. For Resident #21, facility staff failed to evidence that care plan goals were sent with the resident during a transfer to the hospital on 1/13/19. Resident #21 was admitted to the facility on 11/3/17 and readmitted on 1/21/19 with diagnoses that included but were not limited to, high blood pressure, dementia, and diabetes. Resident #21's most recent MDS (minimum data set) assessment was a significant change assessment with an ARD (assessment reference date) of 1/28/19. Resident #21 was coded as being severely impaired in cognitive function on the Staff Assessment for Mental Status Exam. Review of Resident #21's nursing notes, revealed that she had been transferred to the hospital on 1/13/19. The following note was written: "reported from am nurse that resident had episode of emesis in the shift. v/s (vital signs) 102.3 (temp) 98 (pulse), 22 (respirations), 146/55 (blood pressure). Notified long term of (physician) on call and received New (sic) order to send to ER (emergency room) for evaluation and treatment. Responsible party (Son) notified, DON (Director of Nursing) notified by this nurse leaving message on phone. Report called into (Name of ER (emergency room)." Review of Resident #21's Nursing Home to Hospital Transfer Form (INTERACT) dated 1/13/19, failed to evidence that care plan goals were sent with the resident upon transfer to the hospital.	F 622		

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F 622	Continued From page 48 On 4/12/19 at 9:57 A.M., an interview was conducted with ASM (administrative staff member) #2, the ADON (assistant director of nursing). When asked what paperwork was sent with residents at time of a transfer to the hospital, ASM #2 stated that nurses will fill out and send an INTERACT tool form, an SBAR (situation, background, assessment, recommendation) form, the residents history and physical, bed hold policy, and any pertinent labs, orders etc. When asked if the care plan was sent with the resident upon transfer to the hospital, ASM #2 stated that the care plan goals should be able to be pulled through to the INTERACT form electronically. ASM #2 stated that nursing started pulling the care plan goals to the INTERACT form in June of 2018. ASM #2 stated that the nurses do not document in a note what items were sent with the resident to the hospital. ASM #2 confirmed that she did not see the care plan goals on Resident #21's INTERACT form. ASM #2 stated that if it was not documented then it was not done. On 4/12/19 at 1:32 p.m., ASM (administrative staff member) #1, the administrator and ASM #4, the DON (Director of Nursing) were made aware of the above concerns. 2. For Resident #31, facility staff failed to evidence that care plan goals were sent with the resident during a transfer to the hospital on 1/18/19. Resident #31 was admitted to the facility on 1/10/19 and readmitted on 1/22/19 with diagnoses that included but were not limited to Alzheimer's Disease, type one diabetes, high blood pressure and psychotic disorder. Resident	F 622		

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F 622	Continued From page 49 #31's most recent MDS (minimum data set) assessment was a significant change assessment with an ARD (assessment reference date) of 2/3/19. Resident #31 was coded as being severely impaired in cognitive function on the Staff Assessment for Mental Status Exam. Review of Resident #31's nursing notes, revealed that she had been transferred to the hospital on 1/18/19. The following note was written: "v/s (vital signs) 99.7, 64 (pulse), 16 (respirations), 103/66 (blood pressure) Resident had 2 episodes of vomiting this eve (evening) shift. On call NP (nurse practitioner) called and a new order was given for Zofran (1) 4 mg (milligrams) po (by mouth) q (every) six hours prn (as needed) for nausea and vomitting, STAT (immediate) *KUB (2) labs to draw CBC (complete blood count) (3), CMP (complete metabolic panel) (4), amylase (5) ans (sic) lipase (6) levels. Cont (continue) on PO (by mouth) abt (antibiotics) with no adverse reactions noted. KUB done this shift, awaiting results." Review of the KUB results documented the following: "Mild Paralytic ileus (6)." The next note dated 1/18/19 documented the following: "Resident sent to ER (emergency room) for evaluation to KUB results. RP (responsible party) aware." Review of Resident #31's Nursing Home to Hospital Transfer Form (INTERACT) dated 1/13/19, failed to evidence that care plan goals were sent with the resident upon transfer to the hospital. On 4/12/19 at 9:57 A.M., an interview was conducted with ASM (administrative staff member) #2, the ADON (assistant director of	F 622		

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F 622	Continued From page 50 nursing). When asked what paperwork was sent with residents at time of a transfer to the hospital, ASM #2 stated that nurses will fill out and send an INTERACT tool form, an SBAR (situation, background, assessment, recommendation) form, the residents history and physical, bed hold policy, and any pertinent labs, orders etc. When asked if the care plan was sent with the resident upon transfer to the hospital, ASM #2 stated that the care plan goals should be able to be pulled through to the INTERACT form electronically. ASM #2 stated that nursing started pulling the care plan goals to the INTERACT form in June of 2018. ASM #2 stated that the nurses do not document in a note what items were sent with the resident to the hospital. ASM #2 confirmed that she did not see the care plan goals on Resident #31's INTERACT form. ASM #2 stated that if it was not documented then it was not done. On 4/12/19 at 1:32 p.m., ASM (administrative staff member) #1, the administrator and ASM #4, the DON (Director of Nursing) were made aware of the above concerns. (1) Zofran is indicated for the prevention of nausea and vomiting. This information was obtained from The National Institutes of Health. https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=555f81bc-4ce0-4f77-b394-b974838c4440. (2) KUB (Kidneys, Ureters, Bladder) radiographic examination of abdomen providing information about the kidneys, ureters, bladder. This information was obtained from The National Institutes of Health. https://www.ncbi.nlm.nih.gov/pubmed/3537252. (3) CBC -Your blood contains red blood cells (RBC), white blood cells (WBC), and platelets.	F 622		

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F 622	Continued From page 51 Blood count tests measure the number and types of cells in your blood. This helps doctors check on your overall health. The tests can also help to diagnose diseases and conditions such as anemia, infections, clotting problems, blood cancers, and immune system disorders. This information was obtained from The National Institutes of Health. https://www.ncbi.nlm.nih.gov/pubmed/3537252. (4) CMP-A group of blood tests that measures several parameters, including blood sugar (glucose), proteins, electrolytes (such as sodium and potassium), waste products (such as blood urea nitrogen [BUN] and creatinine), and enzymes. The comprehensive metabolic panel (CMP) is used to assess overall health and to diagnose and guide treatment of numerous diseases. This information was obtained from The National Institutes of Health. https://aidsinfo.nih.gov/understanding-hiv-aids/glossary/2992/comprehensive-metabolic-panel. (5) Amyalse and Lipase- The diagnosis of acute pancreatitis requires the presence of at least two of the three diagnostic criteria - characteristic abdominal pain, elevated serum amylase or lipase, and radiological evidence of pancreatitis. This information was obtained from The National Institutes of Health. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4653980/. (6) Mild Paralytic ileus is a condition in which the muscles of the intestines do not allow food to pass through, resulting in a blocked intestine. Paralytic ileus may be caused by surgery, inflammation, and certain drugs. This information was obtained from The National Institutes of Health. https://www.cancer.gov/publications/dictionaries/cancer-terms/def/paralytic-ileus.	F 622		

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F 622	Continued From page 52 3. For Resident #22, facility staff failed to evidence that care plan goals were sent with the resident during a transfer to the hospital on 3/4/19. Resident #22 was admitted to the facility on 1/13/17 and readmitted on 3/6/19 with diagnoses that included but were not limited to, anxiety disorder, severe panic disorder, muscle weakness, Hepatitis C, protein-calorie malnutrition and diabetes (type two). Resident #22's most recent MDS (minimum data set) assessment was a quarterly assessment with an ARD (assessment reference date of 1/31/19. Resident #22 was coded as being moderately impaired in cognitive function scoring 11 out of 15 on the BIMS (Brief Interview for Mental Status) exam. Review of Resident #22's nursing notes, revealed that she had been transferred to the hospital on 3/4/19. The following was documented: "Labs (Laboratory) results call in to LTC (long term care-physician) regarding Glucose (sugar) Critical Value. ...On call nurse (Name of On call nurse) made aware, awaiting call back." The next note dated 3/4/19 documented the following: "Send Resident to ER for evaluation of Critical lab/glucose level." Review of Resident #22's Nursing Home to Hospital Transfer Form (INTERACT) dated 3/4/19, failed to evidence that care plan goals were sent with the resident upon transfer to the hospital. On 4/12/19 at 9:57 A.M., an interview was	F 622		

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F 622	Continued From page 53 conducted with ASM (administrative staff member) #2, the ADON (assistant director of nursing). When asked what paperwork was sent with residents at time of a transfer to the hospital, ASM #2 stated that nurses will fill out and send an INTERACT tool form, an SBAR (situation, background, assessment, recommendation) form, the residents history and physical, bed hold policy, and any pertinent labs, orders etc. When asked if the care plan was sent with the resident upon transfer to the hospital, ASM #2 stated that the care plan goals should be able to be pulled through to the INTERACT form electronically. ASM #2 stated that nursing started pulling the care plan goals to the INTERACT form in June of 2018. ASM #2 stated that the nurses do not document in a note what items were sent with the resident to the hospital. ASM #2 confirmed that she did not see the care plan goals on Resident #22's INTERACT form. ASM #2 stated that if it was not documented then it was not done. On 4/12/19 at 1:32 p.m., ASM (administrative staff member) #1, the administrator and ASM #4, the DON (Director of Nursing) were made aware of the above concerns. 4. Resident #35 was originally admitted to the facility 10/4/15, and was readmitted to the facility 12/31/18, after an acute care hospital stay. The current diagnoses included: diabetes, hemiparesis, GERD and Alzheimer's disease. The quarterly Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 2/7/19, coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 2 out of 15. This indicated Resident #35's daily decision making abilities	F 622		

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F 622	Continued From page 54 were severely impaired. In section "G" (Physical functioning) the resident was coded as requiring extensive assistance of one with bed mobility, total care of two with transfers, total care of one with eating, locomotion dressing, personal hygiene, toileting and bathing. Review of the discharge MDS assessment dated 12/18/18, revealed Resident #35 was discharged-return not anticipated. Review of the clinical record revealed a nurse's note dated 12/18/18, at 7:55 p.m., which stated Resident #35 was assessed at 5:35 p.m., in a deep sleep and abnormal vital signs. Tylenol was administered for temperature and the on-call physician was made aware of the resident's condition/abnormal vital signs. A nebulizer treatment was administered for wheezing and wasn't successful therefore the physician was notified again. The physician gave an order to transfer the resident to the local acute care hospital for evaluation and treatment. 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. The above findings were shared with the Administrator, Director of Nursing and the Corporate Consultant on 4/16/19 at approximately 1:40 p.m. The facility staff provided no additional information. 5. The facility staff failed to send care plan goals upon Resident #41's discharge to the hospital on 1/18/19.	F 622		

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F 622	Continued From page 55 Resident #41 was a 84 year old admitted to the facility originally on 4/6/15 and readmitted on 1/22/19 with diagnoses to include but not limited to Dysphagia (difficulty swallowing), Major Depressive Disorder, Type 2 Diabetes Mellitus and Dementia. The most recent Minimum Data Set (MDS) assessment was a Significant Change with an Assessment Reference Date (ARD) of 1/29/19. The Brief Interview for Mental Status (BIMS) was a 4 out of a possible 15, indicating Resident #41 has severe cognitive impairment. Resident #41's MDS submit history was also reviewed and is documented in part, as follows: 1. Unplanned Hospital Discharge Return Anticipated Assessment with ARD of 1/18/19. 2. Facility Entry Assessment with ARD of 1/22/19. Resident #41's Progress Notes were reviewed and are documented in part, as follows: 1/18/19 4:31 AM: resident vomiting large amounts of beige colored phlegm, emesis X3, diminished lung sounds right side upper lobes, nasal congestion. resident transported via 911 to Name (hospital) at 4:30 am. 1/18/19 14:37 (2:37) PM: resident admitted to Name (hospital) with diagnosis of Hypoxia. Resident #41's Care Plan that were last revised on 3/19/19 were reviewed and are documented in part, as follows: Potential for alteration in dietary intake related to	F 622		

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F 622	Continued From page 56 poor appetite with history of weight loss. The resident has an ADL (activities of daily living) self care performance deficit with history of hemiplegia. The resident has a behavior problem (getting angry). The resident uses snuff. The resident has hypertension. The resident has diabetes mellitus. The resident is at risk for falls. The resident has pain related to arthritis. On 4/12/19 at approximately 1:30 P.M. the Assistant Director of Nursing (ADON) was asked if Resident #41's Care Plan Goals had been sent with the resident upon discharge to the hospital on 1/18/19. The ADON stated, " No we have not been sending the care plan goals with the residents upon discharge to the hospital." Upon request the facility was unable to provide a policy for Care Plan Goals to be sent upon discharge to the hospital for their residents. On 4/16/19 at 1:25 P.M. a pre-exit debriefing was held with the Administrator, the Director of Nursing and the Regional Director of Operations were the above information was shared. Prior to exit no further information was shared.	F 622		
F 623 SS=E	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and	F 623		

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F 623	Continued From page 57 the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:	F 623	F 623 Notice Requirements Before Transfer/ Discharge 1. The Ombudsman will be notified of the resident's discharges for Resident #21 who discharged on 1-31-19, Resident #31 who discharged on 1-18-19, Resident #22 who discharged on 3-4-19, Resident #35 who discharged on 12-18-18, Resident #41 who discharged on 1-18-19, Resident #17 who discharged on 4-8-19, Resident # 57 who discharged on 8-19-18, and Resident #103 who discharged on 11-24-18. 2. All residents have the potential to be affected. 3. At the end of each month a list of resident discharges with the date of discharge will be faxed to the Office of the State Long-Term Care Ombudsman by the Social worker or a person designated by the Administrator in his/her absents. A record of these list will be maintained in the Social Worker's office. Management staff will be in-serviced on the process.	5/31 2019

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F 623	Continued From page 58 (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available.	F 623	4. The Administrator or his designee will check the binder each month to ensure all discharges were reported. Results of all reviews and audits will be incorporated into the Center's QAPI process to ensure compliance is achieved and sustained.	

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	495330	A. BUILDING _____ B. WING _____	C 04/16/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 623	Continued From page 59 §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, and clinical record review, it was determined that facility staff failed to provide written documentation that the ombudsman was notified of a resident transfer for 8 of 44 residents in the survey sample, Resident #21, #31, #22, 35, 41, 17, 57, and 103. 1. For Resident #21, facility staff failed to provide written documentation that the Office of the State Long-Term Care Ombudsman was notified of her transfer to the hospital on 1/13/19. 2. For Resident #31, facility staff failed to provide written documentation that the Office of the State Long-Term Care Ombudsman was notified of his transfer to the hospital on 1/18/19. 3. For Resident #22, facility staff failed to provide written documentation that the Office of the State Long-Term Care Ombudsman was notified of his transfer to the hospital on 3/4/19. 4. The facility staff failed to notify the Office of the State Long-Term Care Ombudsman of Resident #35's transfer to the local acute care hospital 12/18/18.	F 623		

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F 623	Continued From page 60 5. The facility staff failed to notify the Office of the State Long-Term Care Ombudsman of Resident #41's discharge to the hospital on 1/18/19. 6. The facility staff failed to provide a notice of discharge and send a copy to the Office of the State Long-Term Care Ombudsman for Residents #57. 7. The facility staff failed to provide Resident #17 with a hospital notice of discharge and send a copy to the Office of the State Long-Term Care Ombudsman. 8. The facility staff failed to provide Resident #103 with a hospital notice of discharge and send a copy to the Office of the State Long-Term Care Ombudsman. The findings include: 1. Resident #21 was admitted to the facility on 11/3/17 and readmitted on 1/21/19 with diagnoses that included but were not limited to high blood pressure, dementia, and diabetes. Resident #21's most recent MDS (minimum data set) assessment was a significant change assessment with an ARD (assessment reference date) of 1/28/19. Resident #21 was coded as being severely impaired in cognitive function on the Staff Assessment for Mental Status Exam. Review of Resident #21's nursing notes, revealed that she had been transferred to the hospital on 1/13/19. The following note was written: "reported from am nurse that resident had episode of emesis in the shift. v/s (vital signs) 102.3 (temp)	F 623		

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F 623	Continued From page 61 98 (pulse), 22 (respirations), 146/55 (blood pressure). Notified long term of Virginia on call and received New (sic) order to send to ER (emergency room) for evaluation and treatment. Responsible party (Son) notified, DON (Director of Nursing) notified by this nurse leaving message on phone. Report called into (Name of ER (emergency room)." There was no further evidence in the clinical record that the ombudsman was made aware of this transfer. On 4/12/19 at 11:20 a.m., an interview was conducted with OSM (other staff member) #2, the social worker assistant. OSM #2 stated that she had no role when a resident was sent to the hospital. OSM #2 stated that she was not sure of the social worker had notified the ombudsman for hospital transfers in the past. OSM #2 stated that the social worker had left the facility in January of 2019 and was no longer employed. OSM #2 stated that she was never told to notify the ombudsman for hospital transfers. On 4/12/19 at 1:32 p.m., ASM (administrative staff member) #1, the administrator and ASM #4, the DON (Director of Nursing) were made aware of the above concerns. 2. For Resident #31, facility staff failed to provide written documentation that the ombudsman was notified for his transfer to the hospital on 1/18/19. Review of Resident #31's nursing notes, revealed that she had been transferred to the hospital on 1/18/19. The following note was written: "v/s (vital signs) 99.7, 64 (pulse), 16 (respirations), 103/66 (blood pressure) Resident had 2 episodes of	F 623		

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F 623	Continued From page 62 vomiting this eve (evening) shift. On call NP (nurse practitioner) called and a new order was given for Zofran 4 mg (milligrams) po (by mouth) q (every) six hours prn (as needed) for nausea and vomiting, STAT (immediate) KUB (kidney, ureters, bladder) labs to draw CBC (complete blood count), CMP (complete metabolic panel), amylase ans (sic) lipase levels. Cont (continue) on PO (by mouth) abt (antibiotics) with no adverse reactions noted. KUB done this shift, awaiting results." Review of the KUB (kidney ureter bladder) results documented the following: "Mild Paralytic ileus." The next note dated 1/18/19 documented the following: "Resident sent to ER (emergency room) for evaluation to KUB results. RP (responsible party) aware." There was no further evidence in the clinical record that the ombudsman was made aware of this transfer. On 4/12/19 at 11:20 a.m., an interview was conducted with OSM (other staff member) #2, the social worker assistant. OSM #2 stated that she had no role when a resident was sent to the hospital. OSM #2 stated that she was not sure of the social worker had notified the ombudsman for hospital transfers in the past. OSM #2 stated that the social worker had left the facility in January of 2019 and was no longer employed. OSM #2 stated that she was never told to notify the ombudsman for hospital transfers. On 4/12/19 at 1:32 p.m., ASM (administrative staff member) #1, the administrator and ASM #?, the DON (Director of Nursing) were made aware of the above concerns.	F 623		

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F 623	Continued From page 63	F 623		

3. For Resident #22, facility staff failed to provide written documentation that the ombudsman was notified for his transfer to the hospital on 3/4/19.

Resident #22 was admitted to the facility on 1/13/17 and readmitted on 3/6/19 with diagnoses that included but were not limited to anxiety disorder, severe panic disorder, muscle weakness, Hepatitis C, protein-calorie malnutrition and diabetes (type two). Resident #22's most recent MDS (minimum data set) assessment was a quarterly assessment with an ARD (assessment reference date of 1/31/19. Resident #22 was coded as being moderately impaired in cognitive function scoring 11 out of 15 on the BIMS (Brief Interview for Mental Status) exam.

Review of Resident #22's nursing notes, revealed that she had been transferred to the hospital on 3/4/19. The following was documented: "Labs (Laboratory) results call in to LTC (long term care-physician) regarding Glucose (sugar) Critical Value. ...On call nurse (Name of On call nurse) made aware, awaiting call back."

The next note dated 3/4/19 documented the following: "Send Resident to ER for evaluation of Critical lab/glucose level."

There was no further evidence in the clinical record that the ombudsman was made aware of this transfer.

On 4/12/19 at 11:20 a.m., an interview was conducted with OSM (other staff member) #2, the social worker assistant. OSM #2 stated that she

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F 623	Continued From page 64 had no role when a resident was sent to the hospital. OSM #2 stated that she was not sure of the social worker had notified the ombudsman for hospital transfers in the past. OSM #2 stated that the social worker had left the facility in January of 2019 and was no longer employed. OSM #2 stated that she was never told to notify the ombudsman for hospital transfers. On 4/12/19 at 1:32 p.m., ASM (administrative staff member) #1, the administrator and ASM #4, the DON (Director of Nursing) were made aware of the above concerns. 4. Resident #35 was originally admitted to the facility 10/4/15, and was readmitted to the facility 12/31/18, after an acute care hospital stay. The current diagnoses included; diabetes, hemiparesis, GERD and Alzheimer's disease. The quarterly Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 2/7/19, coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 2 out of 15. This indicated Resident #35's daily decision making abilities were severely impaired. In section "G" (Physical functioning) the resident was coded as requiring extensive assistance of one with bed mobility, total care of two with transfers, total care of one with eating, locomotion dressing, personal hygiene, toileting and bathing. Review of the discharge MDS assessment dated 12/18/18, revealed Resident #35 was discharged - return not anticipated. Review of the clinical record revealed a nurse's	F 623		

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F 623	Continued From page 65 note dated 12/18/18, at 7:55 p.m., which stated Resident #35 was assessed at 5:35 p.m., in a deep sleep and abnormal vital signs. Tylenol was administered for temperature and the on-call physician was made aware of the resident's condition/abnormal vital signs. A nebulizer treatment was administered for wheezing and wasn't successful therefore the physician was notified again. The physician gave an order to transfer the resident to the local acute care hospital for evaluation and treatment. An interview was conducted with the Social Worker Assistant 4/11/19, at approximately 3:49 p.m. The Social Worker Assistant stated she had never notified the Ombudsman of discharges to the hospital but it could have been a responsibility of the Social Worker Director but she wasn't instructed to do so. The above findings were shared with the Administrator, Director of Nursing and the Corporate Consultant on 4/16/19 at approximately 1:40 p.m., the Director of Nursing stated at the time of Resident 35's hospital transfer the facility staff was not aware of the requirement to notify the Long-Term Care Ombudsman but in late February or early March she had in-serviced the facility's staff of the requirement and how they would meet the requirements using the Interact form. 5. Resident #41 was a 84 year old admitted to the facility originally on 4/6/15 and readmitted on 1/22/19 with diagnoses to include but not limited to *Dysphagia (difficulty swallowing), *Major Depressive Disorder, *Type 2 Diabetes Mellitus and *Dementia. The most recent Minimum Data Set (MDS)	F 623		

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F 623	Continued From page 66 assessment was a Significant Change with an Assessment Reference Date (ARD) of 1/29/19. The Brief Interview for Mental Status (BIMS) was a 4 out of a possible 15, indicating Resident #41 has severe cognitive impairment. Resident #41's MDS submit history was also reviewed and is documented in part, as follows: 1. Unplanned Hospital Discharge Return Anticipated Assessment with ARD of 1/18/19. 2. Facility Entry Assessment with ARD of 1/22/19. Resident #41's Progress Notes were reviewed and are documented in part, as follows: 1/18/19 4:31 AM: resident vomiting large amounts of beige colored phlegm, emesis X3, diminished lung sounds right side upper lobes, nasal congestion. resident transported via 911 to Name (hospital) at 4:30 am. 1/18/19 14:37 (2:37) PM: resident admitted to Name (hospital) with diagnosis of Hypoxia. On 4/15/19 at approximately 2:39 P.M. an interview was conducted with the Assistant Social Worker regarding ombudsman notification of resident discharges. The Assistant Social Worker stated, "I didn't sent it to the ombudsman for her when she (Resident #41) was discharged. The other Social Worker was doing it but she left in the middle of January and I didn't know it had to be done. I know now to do it and will do it if they discharge." The facility policy titled "Transfer or Discharge Notice" last revised on 12/2016 was reviewed and is documented in part, as follows:	F 623		

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F 623	Continued From page 67 3. A copy of the notice will be sent to the Office of the State Long-Term Care Ombudsman. On 4/16/19 at 1:25 P.M. a pre-exit debriefing was held with the Administrator, the Director of Nursing and the Regional Director of Operations were the above information was shared. Prior to exit no further information was presented by facility staff. 6. Resident #57 was re-admitted to the facility on 1/28/19 with diagnoses which included a history of sepsis due to Escherichia coli (E.Coli) esophagitis, muscle weakness, dysphagia, abnormalities of gait, hypertension, COPD, depression, diabetes, cardiovascular disease, hyperlipidemia, and contractures of left hand. The facility staff failed to provide Resident #57 with a notice of discharge and send a copy to the office of the Ombudsman. A Re-entry Minimum Data Set (MDS) dated 2/25/19 assessed this resident as having no difficulties in the area of hearing, speech, vision or understanding and the ability to be understood. In the area of Cognitive Patterns this resident was assessed for a brief Interview for mental Status (BIMS) and scored a (13). This resident was assessed in the area of Activities of Daily Living (ADL'S) as requiring supervision and one person set-up in the area of bed mobility, transfers, and locomotion on unit. This resident was assessed as requiring extensive assistance with one person set-up in the area of dressing and personal hygiene. In the area of Pain Management this resident was assessed as having pain within the last 5 days. This resident was assessed as	F 623		

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F 623	Continued From page 68 having frequent pain. This resident was assessed as having pain which made it difficult to sleep at night. In the area of Pain Intensity this resident rated pain in the last 5 days as a (10) on a scale from 0 to 10. A Nursing note dated 8/19/18 at 18:44 (6:44 P.M.) indicated: "Pt complaining of groin pain. Pt is in tears. Pt. stated that the pain has been off and on all week but pt has failed to report the pain. Pt does have Foley that is patent and flowing yellow urine. Foley was flushed with NS (normal saline) with increased pain noted by pt. Pt stated that he has been down to decrease pain with no relief. Pt requested to be sent out to ER for eval an if I don't that he will. Pt is self responsible, on call NP (Nurse Practitioner) notified. Resident transported by fast track medical to hospital. During an interview with the social worker on 4/11/19 at 2:55 P.M. she stated, Resident #57 was not provided with a notice of discharge nor was a copy sent to the Ombudsman. The facility staff to provide Resident #57 with a hospital notice of discharge and send a copy to the office of the Ombudsman. 7. Resident #17 was admitted to the facility on 1/15/18 with diagnoses of hypertension, cardiovascular disease, epilepsy, anxiety, and dementia. The facility staff failed to provide Resident #17 with a hospital notice of discharge and send a copy to the office of the Ombudsman. An Annual MDS dated 1/22/19 assessed this resident as having no hearing, or speech difficulty. Resident #17 was assessed as needing glasses. In the area of Cognitive Patterns this	F 623		

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F 623	Continued From page 69 resident was assessed as having a BIMS score of 15 which indicated no cognitive impairment. A Nursing Note dated 4/8/19 at 22:45 (10:45 P.M.) indicated: "CNA (certified nursing assistant) came and got this nurse to go into the residents room because something was wrong. When walking into the residents room the resident was sitting up in the chair slummed over with vomit all over her chest and her mouth was over to the side and her eyes were open. This nurse kept calling out the residents name the resident did not respond but just looked at this nurse but did not say anything. Got nurse from the unit to help. When calling the residents name the resident still did not respond to her name, she just looked and moved around. We then repositioned the resident on her with HOB elevated to about 65 degrees. CNA got vitals within normal range the residents skin was cold and clammy, blood sugar was checked read at 186. Supervisor was brought to the room to see the condition of the resident. 911 was called. All responsible parties were called and notified." During an interview with the social worker on 4/11/19 at 2:55 P.M. she stated, Resident #17 was not provided with a notice of discharge nor was a copy sent to the Ombudsman. The facility staff failed to provide Resident #17 with a hospital notice of discharge and send a copy to the office of the Ombudsman. 8. Resident #103 was admitted to the facility on 4/26/18 with diagnoses of hypertension, diabetes mellitus, dysphagia, cardiovascular accident, neuropathy, and over active bladder. The facility staff failed to provide Resident #103 with a	F 623		

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F 623	Continued From page 70 hospital notice of discharge and send a copy to the office of the Ombudsman. A 2/20/19 MDS assessed this resident in the area of Cognitive Status as having scored a 10 on the BIMS assessment which indicated . A Nursing Note dated 11/24/18 at 23:36 (11:36 P.M.) indicated: "Resident was admitted to hospital daughter was notified of his status. DON (Director of Nursing) was informed." During an interview with the social worker on 4/11/19 at 2:55 P.M. she stated, Resident #103 was not provided with a notice of discharge nor was a copy sent to the Ombudsman. The facility staff failed to provide Resident #103 with a hospital notice of discharge and send a copy to the office of the Ombudsman.	F 623		5/31
F 625 SS=E	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	F 625	F 625 Notice of Bed Hold policy and return 1. Resident # 21, # 31, # 22, # 35, # 41, #17, # 57 and # 103 Written notification of the bed hold policy has been provided to the resident/and or Responsible party, Began on 4/16/2019 by the Admission Director.	2019

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	495330	A. BUILDING _____ B. WING _____	C 04/16/2019

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F 625	Continued From page 71 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 staff interview, facility document review, and clinical record review, it was determined that facility staff failed to provide written notification of the bed hold policy at the time of a facility-initiated transfer for 8 of 44 residents in the survey sample, Resident #21, 31, 22, , 35, 41, 17, 57, and 103. 1. The facility staff failed to provide Resident #21 or the resident's representative written notification of the bed hold policy when the resident was transferred to the hospital on 1/13/19. 2. The facility staff failed to provide Resident #31 or the resident's representative written notification of the bed hold policy when the resident was transferred to the hospital on 1/18/19. 3. The facility staff failed to provide Resident #22 or the resident's representative written notification of the bed hold policy when the resident was transferred to the hospital on 3/4/19. 4. The facility failed to provide Resident #35 with	F 625	2. Resident who have transferred from the facility to the hospital have a potential to be affected. Review of resident discharge/ transfer to the hospital over last 3 months to ensure a written bed hold policy has been given on or before 5-30-19 3. On 4/17/2019 Re-Inservice began to Licensee on bed hold policy, process of notification at the time of the transfer and bed hold policy reviewed with resident/POA and hospital by the Regional Director of Clinical Operations. On 5/14/2019 Re-training on Bed hold policy will be conducted for License nurses, Admission Director and Social service department by the Regional Director of Clinical Operations.	

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F 625	Continued From page 72 a written notice of the facility's Bed-Hold Policy upon transfer to the hospital 12/18/18. 5. The facility staff failed to provide a Bed-Hold Notice to Resident #41 upon discharge to the hospital on 1/18/19. 6. The facility staff failed to provide a notice of bed hold to Resident #57 who was transferred to the hospital. 7. The facility staff failed to provide a notice of bed hold to Resident #17 who was transferred to the hospital. 8. The facility staff failed to provide a notice of bed hold prior to Resident #103 who was transferred to the hospital. The findings include: 1. Resident #21 was admitted to the facility on 11/3/17 and readmitted on 1/21/19 with diagnoses that included but were not limited to high blood pressure, dementia, and diabetes. Resident #21's most recent MDS (minimum data set) assessment was a significant change assessment with an ARD (assessment reference date) of 1/28/19. Resident #21 was coded as being severely impaired in cognitive function on the Staff Assessment for Mental Status Exam. Review of Resident #21's nursing notes, revealed that she had been transferred to the hospital on 1/13/19. The following note was written: "reported from am nurse that resident had episode of emesis in the shift. v/s (vital signs) 102.3 (temp) 98 (pulse), 22 (respirations), 146/55 (blood pressure). Notified long term (physician) on call	F 625	4. Bed hold audit will be conducted 1 x week x 4 weeks, then 1 x month by DON/Administrator/designed The audits will be documented and maintained in the Administrator's office Results of the training and audits will be presented Monthly to the QAPI committee by The Administrator and/or DON	

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F 625	Continued From page 73 and received New (sic) order to send to ER (emergency room) for evaluation and treatment. Responsible party (Son) notified, DON (Director of Nursing) notified by this nurse leaving message on phone. Report called into (Name of ER (emergency room)." Review of Resident #21's clinical record failed to evidence that the bed hold policy was sent with the resident at the time of transfer to the hospital. On 4/12/19 at 9:57 A.M., an interview was conducted with ASM (administrative staff member) #2, the ADON (assistant director of nursing). When asked what paperwork was sent with residents at time of a transfer to the hospital, ASM #2 stated that nurses will fill out and send an INTERACT tool form, an SBAR (situation, background, assessment, recommendation) form, the residents history and physical, bed hold policy, and any pertinent labs, orders etc. When asked how we would know that the bed hold policy was sent with the resident upon transfer to the hospital, ASM #2 stated that nurses should be documenting in the clinical record that the bed hold policy was sent with the resident. ASM #2 stated that if it was not documented anywhere in the clinical record that the bed hold policy was sent with the resident, then it was not done. On 4/12/19 at 1:32 p.m., ASM (administrative staff member) #1, the administrator and ASM #4, the DON (Director of Nursing) were made aware of the above concerns. 2. The facility staff failed to provide Resident #31 or the resident's representative written notification of the bed hold policy when the resident was transferred to the hospital on 1/18/19.	F 625		

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F 625	Continued From page 74 Resident #31 was admitted to the facility on 1/10/19 and readmitted on 1/22/19 with diagnoses that included but were not limited to Alzheimer's Disease, type one diabetes, high blood pressure and psychotic disorder. Resident #31's most recent MDS (minimum data set) assessment was a significant change assessment with an ARD (assessment reference date) of 2/3/19. Resident #31 was coded as being severely impaired in cognitive function on the Staff Assessment for Mental Status Exam. Review of Resident #31's nursing notes, revealed that she had been transferred to the hospital on 1/18/19. The following note was written: "v/s (vital signs) 99.7, 64 (pulse), 16 (respirations), 103/66 (blood pressure) Resident had 2 episodes of vomiting this eve (evening) shift. On call NP (nurse practitioner) called and a new order was given for Zofran (1) 4 mg (milligrams) po (by mouth) q (every) six hours prn (as needed) for nausea and vomiting, STAT (immediate) KUB (2) labs to draw CBC (complete blood count) (3), CMP (complete metabolic panel) (4), amylase (5) ans (sic) lipase (6) levels. Cont (continue) on PO (by mouth) abt (antibiotics) with no adverse reactions noted. KUB done this shift, awaiting results." Review of the KUB results documented the following: "Mild Paralytic ileus (6)." The next note dated 1/18/19 documented the following: "Resident sent to ER (emergency room) for evaluation to KUB results. RP (responsible party) aware." Review of Resident #31's clinical record failed to	F 625		

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F 625	Continued From page 75 evidence that the bed hold policy was sent with the resident at the time of transfer to the hospital. On 4/12/19 at 9:57 A.M., an interview was conducted with ASM (administrative staff member) #2, the ADON (assistant director of nursing). When asked what paperwork was sent with residents at time of a transfer to the hospital, ASM #2 stated that nurses will fill out and send an INTERACT tool form, an SBAR (situation, background, assessment, recommendation) form, the residents history and physical, bed hold policy, and any pertinent labs, orders etc. When asked how we would know that the bed hold policy was sent with the resident upon transfer to the hospital, ASM #2 stated that nurses should be documenting in the clinical record that the bed hold policy was sent with the resident. ASM #2 stated that if it was not documented anywhere in the clinical record that the bed hold policy was sent with the resident, then it was not done. On 4/12/19 at 1:32 p.m., ASM (administrative staff member) #1, the administrator and ASM #4, the DON (Director of Nursing) were made aware of the above concerns. (1) Zofran is indicated for the prevention of nausea and vomiting. This information was obtained from The National Insitutes of Health. https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=555f81bc-4ce0-4f77-b394-b974838c4440. (2) KUB (Kidneys, Ureters, Bladder) radiographic examination of abdomen providing information about the kidneys, urterers, bladder. This information was obtained from The National Institutes of Health. https://www.ncbi.nlm.nih.gov/pubmed/3537252.	F 625		

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F 625	Continued From page 76 (3) CBC -Your blood contains red blood cells (RBC), white blood cells (WBC), and platelets. Blood count tests measure the number and types of cells in your blood. This helps doctors check on your overall health. The tests can also help to diagnose diseases and conditions such as anemia, infections, clotting problems, blood cancers, and immune system disorders. This information was obtained from The National Institutes of Health. https://www.ncbi.nlm.nih.gov/pubmed/3537252. (4) CMP-A group of blood tests that measures several parameters, including blood sugar (glucose), proteins, electrolytes (such as sodium and potassium), waste products (such as blood urea nitrogen [BUN] and creatinine), and enzymes. The comprehensive metabolic panel (CMP) is used to assess overall health and to diagnose and guide treatment of numerous diseases. This information was obtained from The National Institutes of Health. https://aidsinfo.nih.gov/understanding-hiv-aids/glossary/2992/comprehensive-metabolic-panel. (5) Amyalse and Lipase- The diagnosis of acute pancreatitis requires the presence of at least two of the three diagnostic criteria - characteristic abdominal pain, elevated serum amylase or lipase, and radiological evidence of pancreatitis. This information was obtained from The National Institutes of Health. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4653980/. (6) Mild Paralytic ileus is a condition in which the muscles of the intestines do not allow food to pass through, resulting in a blocked intestine. Paralytic ileus may be caused by surgery, inflammation, and certain drugs. This information was obtained from The National Institutes of Health.	F 625		

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F 625	Continued From page 77 https://www.cancer.gov/publications/dictionaries/cancer-terms/def/paralytic-ileus. 3. The facility staff failed to provide Resident #22 or the resident's representative written notification of the bed hold policy when the resident was transferred to the hospital on 3/4/19. Resident #22 was admitted to the facility on 1/13/17 and readmitted on 3/6/19 with diagnoses that included but were not limited to anxiety disorder, severe panic disorder, muscle weakness, Hepatitis C, protein-calorie malnutrition and diabetes (type two). Resident #22's most recent MDS (minimum data set) assessment was a quarterly assessment with an ARD (assessment reference date of 1/31/19. Resident #22 was coded as being moderately impaired in cognitive function scoring 11 out of 15 on the BIMS (Brief Interview for Mental Status) exam. Review of Resident #22's nursing notes, revealed that she had been transferred to the hospital on 3/4/19. The following was documented: "Labs (Laboratory) results call in to LTC (long term care-physician) regarding Glucose (sugar) Critical Value. ...On call nurse (Name of On call nurse) made aware, awaiting call back." The next note dated 3/4/19 documented the following: "Send Resident to ER for evaluation of Critical lab/glucose level." Review of Resident #22's clinical record failed to evidence that the bed hold policy was sent with the resident at the time of transfer to the hospital. On 4/12/19 at 9:57 A.M., an interview was	F 625		

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F 625	Continued From page 78 conducted with ASM (administrative staff member) #2, the ADON (assistant director of nursing). When asked what paperwork was sent with residents at time of a transfer to the hospital, ASM #2 stated that nurses will fill out and send an INTERACT tool form, an SBAR (situation, background, assessment, recommendation) form, the residents history and physical, bed hold policy, and any pertinent labs, orders etc. When asked how we would know that the bed hold policy was sent with the resident upon transfer to the hospital, ASM #2 stated that nurses should be documenting in the clinical record that the bed hold policy was sent with the resident. ASM #2 stated that if it was not documented anywhere in the clinical record that the bed hold policy was sent with the resident, then it was not done. On 4/12/19 at 1:32 p.m., ASM (administrative staff member) #1, the administrator and ASM #4, the DON (Director of Nursing) were made aware of the above concerns. 4. Resident #35 was originally admitted to the facility 10/4/15, and was readmitted to the facility 12/31/18, after an acute care hospital stay. The current diagnoses included; diabetes, hemiparesis, GERD and Alzheimer's disease. The quarterly Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 2/7/19, coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 2 out of 15. This indicated Resident #35's daily decision making abilities were severely impaired. In section "G" (Physical functioning) the resident was coded as requiring extensive assistance of one with bed mobility, total care of two with	F 625		

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F 625	Continued From page 79 transfers, total care of one with eating, locomotion dressing, personal hygiene, toileting and bathing. Review of the discharge MDS assessment dated 12/18/18, revealed Resident #35 was discharged-return not anticipated. Review of the clinical record revealed a nurse's note dated 12/18/18, at 7:55 p.m., which stated Resident #35 was assessed at 5:35 p.m., in a deep sleep and abnormal vital signs. Tylenol was administered for temperature and the on-call physician was made aware of the resident's condition/abnormal vital signs. A nebulizer treatment was administered for wheezing and wasn't successful therefore the physician was notified again. The physician gave an order to transfer the resident to the local acute care hospital for evaluation and treatment. The above findings were shared with the Administrator, Director of Nursing and the Corporate Consultant on 4/16/19 at approximately 1:40 p.m., the Director of Nursing stated at the time of Resident 35's hospital transfer the facility staff was not aware of the requirement to provide written information to the resident and/or resident representative of the facility's bed-hold policy but; in late February or early March she had in-serviced the facility's staff of the requirement and how they would meet the requirements. 5. The facility staff failed to provide a Bed-Hold Notice to Resident #41 upon discharge to the hospital on 1/18/19. Resident #41 was a 84 year old admitted to the facility originally on 4/6/15 and readmitted on 1/22/19 with diagnoses to include but not limited	F 625		

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F 625	Continued From page 80 to Dysphagia (difficulty swallowing), Major Depressive Disorder, Type 2 Diabetes Mellitus and Dementia. The most recent Minimum Data Set (MDS) assessment was a Significant Change with an Assessment Reference Date (ARD) of 1/29/19. The Brief Interview for Mental Status (BIMS) was a 4 out of a possible 15, indicating Resident #41 has severe cognitive impairment. Resident #41's MDS submit history was also reviewed and is documented in part, as follows: 1. Unplanned Hospital Discharge Return Anticipated Assessment with ARD of 1/18/19. 2. Facility Entry Assessment with ARD of 1/22/19. Resident #41's Progress Notes were reviewed and are documented in part, as follows: 1/18/19 4:31 AM: resident vomiting large amounts of beige colored phlegm, emesis X3, diminished lung sounds right side upper lobes, nasal congestion. resident transported via 911 to Name (hospital) at 4:30 am. 1/18/19 14:37 (2:37) PM: resident admitted to Name (hospital) with diagnosis of Hypoxia. On 4/12/19 at approximately 1:30 P.M. the Assistant Director of Nursing (ADON) was asked if a Bed-Hold Notice had been sent with the resident upon discharge to the hospital on 1/18/19. The ADON stated, " I can't find any documentation that the bed-hold notice was sent." The facility policy titled "Bed-Holds and Returns"	F 625		

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F 625	Continued From page 81 last revised on 3/2017 was reviewed and is documented in part, as follows: Policy Statement: Prior to transfers and therapeutic leaves, residents or resident representatives will be informed in writing of the bed-hold policy and return policy. 3. Prior to a transfer, written information will be given to the residents and the resident representatives that explain in detail: a. The rights and limitations of the resident regarding bed-holds; b. The reserve bed payment policy as indicated by the state plan (Medicaid residents); c. The facility per diem rate required to hold a bed , or to hold a bed beyond the state bed-hold period, and d. The details of the transfer. On 4/16/19 at 1:25 P.M. a pre-exit debriefing was held with the Administrator, the Director of Nursing and the Regional Director of Operations were the above information was shared. Prior to exit no further information was presented by facility staff. 6. Resident #57 was re-admitted to the facility on 1/28/19 with diagnoses which included a history of sepsis due to Escherichia coli (E.Coli) esophagitis, muscle weakness, dysphagia, abnormalities of gait, hypertension, COPD, depression, diabetes, cardiovascular disease, hyperlipidemia, and contractures of left hand. The facility staff failed to provide Resident #57 with a notice of bed hold policy prior to transfer to a hospital.	F 625		

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F 625	Continued From page 82 A re-entry Minimum Data Set (MDS) dated 2/25/19 assessed this resident as having no difficulties in the area of hearing, speech, vision or understanding and the ability to be understood. In the area of Cognitive Patterns this resident was assessed for a brief Interview for mental Status (BIMS) and scored a (13). A Nursing note dated 8/19/18 at 18:44 (6:44 P.M.) indicated: "Pt complaining of groin pain. Pt is in tears. Pt. stated that the pain has been off and on all week but pt has failed to report the pain. Pt does have Foley that is patent and flowing yellow urine. Foley was flushed with NS with increased pain noted by pt. Pt stated that he has been down to decrease pain with no relief. Pt requested to be sent out to ER for eval an if I don't that he will. Pt is self responsible, on call NP (Nurse Practitioner) notified. Resident transported by fast track medical to hospital. During an interview with the social worker on 4/11/19 at 2:55 P.M. she stated, Resident #57 was not provided with a notice of bed policy prior to a discharge to the hospital. The facility staff to provide Resident #57 with a notice of bed hold policy. 7. Resident #17 was admitted to the facility on 1/15/18 with diagnoses of hypertension, cardiovascular disease, epilepsy, anxiety, and dementia. The facility staff failed to provide Resident #17 with a notice of bed hold policy. An Annual MDS dated 1/22/19 assessed this resident as having no hearing, or speech difficulty. Resident #17 was assessed as needing glasses. In the area of Cognitive Patterns this	F 625		

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F 625	Continued From page 83 resident was assessed as having a BIMS score of 15. A Nursing Note dated 4/8/19 at 22:45 (10:45 P.M.) indicated: "CNA (certified nursing assistant) came and got this nurse to go into the residents room because something was wrong. When walking into the residents room the resident was sitting up in the chair slummed over with vomit all over her chest and her mouth was over to the side and her eyes were open. This nurse kept calling out the residents name the resident did not respond but just looked at this nurse but did not say anything. Got nurse from the unit to help. When calling the residents name the resident still did not respond to her name, she just looked and moved around. We then repositioned the resident on her with HOB elevated to about 65 degrees. CNA got vitals within normal range the residents skin was cold and clammy, blood sugar was checked read at 186. Supervisor was brought to the room to see the condition of the resident. 911 was called. All responsible parties were called and notified." During an interview with the social worker on 4/11/19 at 2:55 P.M. she stated, Resident #17 was not provided with a notice of be hold policy prior to a hospital transfer. The facility staff failed to provide Resident #17 with a bed hold policy prior to a hospital transfer. 8. Resident #103 was admitted to the facility on 4/26/18 with diagnoses of hypertension, diabetes mellitus, dysphagia, cardiovascular accident, neuropathy, and over active bladder. The facility staff failed to provide Resident #103 with a bed hold policy prior to a hospital transfer.	F 625		

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F 625	Continued From page 84 A 2/20/19 MDS assessed this resident in the area of Cognitive Status as having scored a 10 on the BIMS assessment. A Nursing Note dated 11/24/18 at 23:36 (11:36 P.M.) indicated: " Resident was admitted to hospital daughter was notified of his status. DON (Director of Nursing) was informed." During an interview with the social worker on 4/11/19 at 2:55 P.M. she stated, Resident #103 was not provided with a bed hold policy prior to being transferred to a hospital. The facility staff failed to provide Resident #103 with a bed hold policy prior to being transferred to a hospital.	F 625		
F 640 SS=B	Encoding/Transmitting Resident Assessments CFR(s): 483.20(f)(1)-(4) §483.20(f) Automated data processing requirement- §483.20(f)(1) Encoding data. Within 7 days after a facility completes a resident's assessment, a facility must encode the following information for each resident in the facility: (i) Admission assessment. (ii) Annual assessment updates. (iii) Significant change in status assessments. (iv) Quarterly review assessments. (v) A subset of items upon a resident's transfer, reentry, discharge, and death. (vi) Background (face-sheet) information, if there is no admission assessment. §483.20(f)(2) Transmitting data. Within 7 days after a facility completes a resident's assessment,	F 640		

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F 640	Continued From page 85 a facility must be capable of transmitting to the CMS System information for each resident contained in the MDS in a format that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by CMS and the State. §483.20(f)(3) Transmittal requirements. Within 14 days after a facility completes a resident's assessment, a facility must electronically transmit encoded, accurate, and complete MDS data to the CMS System, including the following: (i)Admission assessment. (ii) Annual assessment. (iii) Significant change in status assessment. (iv) Significant correction of prior full assessment. (v) Significant correction of prior quarterly assessment. (vi) Quarterly review. (vii) A subset of items upon a resident's transfer, reentry, discharge, and death. (viii) Background (face-sheet) information, for an initial transmission of MDS data on resident that does not have an admission assessment. §483.20(f)(4) Data format. The facility must transmit data in the format specified by CMS or, for a State which has an alternate RAI approved by CMS, in the format specified by the State and approved by CMS. 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 electronically transmit encoded and complete Minimum Data Set (MDS), data to the Centers for Medicare/Medicaid System, for 1 of 44 residents (Resident #1), in the survey sample of 44 residents.	F 640	F 640 Encoding/ Transmitting Residents Assessments 1. Resident #1's 1/25/2019 Annual Minimum Data Set (MDS) Assessment was reviewed and correctly transmitted encoded to the Centers for Medicare/ Medicaid system on 4/12/2019 by the MDS coordinator. 2. All residents have the potential to be affected. 3. MDS Coordinators will be in-serviced on transmitting the MDS within 7 days of completion of the MDS 4. Twice a week the DON will audit to ensure MDSs are completed in a timely manner and that they are transmitted within 7 days of completion. Results of the training and audits will be presented monthly to the QAPI committee by the Administrator and/ or DON 5. Completion Date 5/31/2019	

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F 640	Continued From page 86 The facility's staff failed to transmit Resident #1's encoded 1/25/19, annual Minimum Data Set (MDS) assessment. The findings included: Resident #1 was originally admitted to the facility 11/25/16 and was discharged from the facility to an acute care facility 7/3/17, and returned to the facility 7/7/17. The current diagnoses schizophrenia and high blood pressure. The quarterly MDS assessment with an assessment reference date (ARD) of 10/25/18, coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 15 out of a possible 15. This indicates Resident #1's cognitive abilities for daily decision making were intact. In section "G" (Physical functioning) the resident was coded as independent with all activities of daily living. During the Resident Assessment review Resident #1 triggered for not having a MDS assessment completed in greater than 120 days (the prior MDS assessment accepted in the CMS databank was dated 10/25/18), therefore an interview was conducted with the MDS Coordinator on 4/11/19, at approximately 2:10 p.m. The MDS Coordinator stated Resident #1's annual MDS assessment with an ARD of 1/25/19, was in the computer, it was completed 2/7/19, and showed it had been exported (batched to send). The MDS Coordinator stated she was unable to locate the validation report from the CMS databank indicating the 1/25/19, assessment was accepted or rejected. The MDS	F 640		

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F 640	Continued From page 87 Coordinator stated she had reached out to their software company to aid her in unlocking the 1/25/19, MDS assessment so she could attempt to transmit it the CMS databank. On 4/12/19, at approximately 11:15 a.m., the MDS Coordinator present Resident #1's submitted 1/25/19, annual MDS assessment and the CMS validation report revealing it had been accepted. The above findings were shared with the Administrator, Director of Nursing and the Corporate Consultant on 4/16/19 at approximately 1:40 p.m. The facility staff provided no additional information. The facility's policy titled "Electronic Transmission of the MDS" dated 9/2010, read at #5; MDS electronic submissions shall be conducted in accordance with current Omnibus Budget Reconciliation Act regulations governing the transmission of such data.	F 640		
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 observations, clinical record review, staff interviews, and review of the facility's policy the facility staff failed to assure Minimum Data Set (MDS) assessments accurately reflected the resident's status at the time of the assessment for 2 of 44 residents (Resident #11 and #41), in the survey sample. 1. The facility staff failed to assure Resident #11's	F 641		

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F 641	Continued From page 88 1/14/19, quarterly MDS assessment was accurately coded at section "P0100" (Physical Restraints). 2. The facility staff failed to ensure that Resident #41's Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 2/8/19 was accurately coded under Section "P" (Restraints and Alarms). The findings included: 1. Resident #11 was originally admitted to the facility 3/12/15 and readmitted 4/12/17 after an acute care hospital stay. The current diagnoses included; intellectual disability, right hemiparesis and cerebral palsy. The quarterly Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 1/14/19, coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 15 out of a possible 15. This indicates Resident #11's cognitive abilities for daily decision making are intact. In section "G" (Physical functioning) the resident was coded as requiring supervision of one person with eating, extensive assistance of one person with bed mobility, transfers, locomotion, dressing, and personal hygiene and total care with toileting, and bathing. On the 1/14/19, MDS assessment in section "P0100" (Physical Restraints), Resident #11 was coded as utilizing a limb restraint daily. On 4/11/19 at 12:30 p.m., the resident was observed in the dining room during lunch; the resident presented with right upper extremity hemiparesis, no type of restraint was observed in use. Again on 4/12/19 at approximately 12:15	F 641	F 641 Accuracy of Assessments 1. Resident #11's Quarterly MDS assessment 1/14/2019 coding under Physical Restraints was corrected on 4/16/2019. Resident #41 Quarterly MDS with an ARD date of 2/8/2019 coding under Restraints and alarms was corrected on 4/16/2019 2. All residents have the potential to be affected. 3. On 5/3/2019 training was provided to the MDS Coordinator by the Regional RAI Consultant on Accuracy of MDS coding on 4-16-2019 4. MDS accuracy audits will be conducted by the Regional RAI Director 1 x week x 4 weeks then 1 x monthly x 4 months then quarterly. The audits will be documented and maintained in the Administrator's office, Results of the training and audits will be presented monthly to the QAPI committee by the Administrator and / or DON 5. Completion Date 5/31/2019	

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F 641	Continued From page 89 p.m., resident #11 was observed in the dining room during the lunch meal, use of a restraint was not observed. Review of the April 2019, physician order summary revealed orders for a right hand palm protector at bedtime to be donned/doffed by nursing staff. Review of the care plan revealed a problem dated 9/20/18, which read; the resident has an ADL self-care performance deficit related to intellectual ability and history of stroke. The goal read; the resident will demonstrate the appropriate use of adaptive to increase ability in ADL functional care through the review date 3/17/19. The approaches included: splint/brace program #1. An interview was conducted with the MDS Coordinator on 4/15/19 at approximately 1:30 p.m. The MDS Coordinator stated the coding for physical restraints used daily was incorrect for the palm protector and the pommel cushion are not restraints therefore the MDS assessment would be modified. On 4/16/19 at approximately 10:30 a.m. the modified 1/14/19 MDS assessment was present and it no longer was coded that resident #11 required use of a limb restraint daily. The above findings were shared with the Administrator, Director of Nursing and the Corporate Consultant on 4/16/19 at approximately 1:40 p.m. The facility staff provided no additional information. The facility's policy titled "Certifying Accuracy of the Resident Assessment" dated 12/2009 read; all personnel who complete any portion of the	F 641		

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F 641	Continued From page 90 Resident Assessment (MDS) must sign and certify the accuracy of that portion of the assessment. 2. Resident #41 was a 84 year old admitted to the facility originally on 4/6/15 and readmitted on 1/22/19 with diagnoses to include but not limited to Dysphagia (difficulty swallowing), Major Depressive Disorder, Type 2 Diabetes Mellitus and Dementia. Resident #41 was triggered for Restraints under MDS (Minimum Date Set) Indicators. The most recent Minimum Data Set assessment was a Significant Change with an Assessment Reference Date (ARD) of 1/29/19. The Brief Interview for Mental Status(BIMS) was a 4 out of a possible 15, indicating Resident #41 has severe cognitive impairment. Resident #41's Quarterly MDS with an ARD of 2/8/19 was reviewed and is documented in part, as follows: Section P Restraints and Alarms P0100 Physical Restraints c. Limb Restraint: 1-Used less than daily. On 4/11/19 at 4:00 P.M. an interview was conducted with the MDS Coordinator regarding Resident #41 being coded for a restraint on the 2/8/19 Quarterly MDS. The MDS Coordinator stated, "A MDS Coordinator from another facility that help us prn (as needed) did that assessment. That is an error on the MDS for the restraint she was never restrained. I will have to modify the assessment." The Modified Quarterly MDS for 2/8/19 was completed on 4/11/19. Under Section P	F 641		

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F 641	Continued From page 91 Restraints and Alarms, P0100 Physical Restraints Resident #41 was coded as 0-Not Used. The facility policy titled "Certifying Accuracy of the Resident Assessment" revised 12/2009 was reviewed and is documented in part, as follows" Policy Statement: All personnel who complete any portion of the Resident Assessment (MDS) must sign and certify the accuracy of that portion of the assessment. 2.. All personnel who complete any portion of the MDS assessment, tracking form, or correction request form must sign a hard copy of such assessment certifying the accuracy of that portion of that assessment. On 4/16/19 at 1:25 P.M. a pre-exit debriefing was held with the Administrator, the Director of Nursing and the Regional Director of Operations were the above information was shared. Prior to exit no further information was shared by facility staff.	F 641		
F 645 SS=E	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	F 645		

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F 645	Continued From page 92 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- (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	F 645	F 645 PASARR Screening for MD & MI 1. Resident # 104 Level 1 PASSAR screen will be completed and submitted for determination on or before 5-30-19 Resident # 68 Level 1 PASSAR will be completed and submitted for determination on or before 5-30-19 Resident # 83 Level 1 PASARR will be completed and submitted for determination on or before 5-30-19 2. Review of resident admitted to the facility for Level 1 PASSAR began on 4/22/2019 by the DON/ADON. All residents could be affected.	5/31 2019

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F 645	Continued From page 93 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: 2. Resident #104 was admitted to the facility on 03/15/19 with diagnoses of schizophrenia, diabetes mellitus, Non-Alzheimer's Dementia, hemiplegia and seizure disorder. The facility staff failed to provide a (Preadmission Screening and Resident Review) (PASARR) to assess the need of Resident #104 for a mental disorder or intellectual disability prior to admission. An Initial Minimum Data Set (MDS) dated 03/29/19 assessed Resident #104 in the area of hearing, speech and vision as having no difficulty's. In the area of Cognitive Patterns this resident had a BIMS score of 3. In the area of Functional Status Activities of Daily Living (ADL'S) this resident was assessed in the areas of bed mobility, transfer, dressing, eating toilet use and personal hygiene as requiring extensive assistance of one person physical assist. A Care Plan dated 3/19/19 indicated:	F 645	3. On 5/3/2019 In-service Training provided to the Interdisciplinary team to include the Social Service assistant and Admission Director on PASARR pre-admission screening, Level 1 PASSAR Admission requirements. 4. PASSAR Audit completed 1 x week x 4 weeks then 1 x month by the DON/ Administrator. The audits will be documented and maintained in the Administrator's office Results of the training and audits will be presented Monthly to the QAPI committee by The Administrator and/or DON	

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F 645	Continued From page 94 Problem/Need- Resident #104 has little or no activity involvement r/t new admit to facility needs time for adjustment. Resident has history of schizophrenia. Goal- Resident to participate in activities of choice. Approaches/tasks - Encourage the resident's participation by friendly visits with reminders. Focus- The resident has a behavior problem drinking water from o2 concentrator; Goal- The resident will have fewer episodes of inappropriate behaviors through the review date. Approaches/ Tasks - Administer medications as ordered. Monitor/document for side effects and effectiveness. During an interview on 4/11/19 at 2:50 P.M. with the facility Social Worker, she stated, Resident #104 was not provided with a Level I PASARR screening prior to admissions. The facility staff failed to provide Resident #104 with a Level I PASARR screening prior to admissions. 3. Resident # 68 was a 67 year old admitted to the facility on 2/28/19 with diagnosis to include but not limited to Bipolar Disorder, Major Depressive Disorder, Anxiety Disorder and Schizoaffective Disorder. The most recent Minimum Data Set (MDS) assessment was a 60 day with an Assessment Reference Date (ARD) of 2/8/19. The Brief Interview for Mental Status (BIMS) was a 15 out of a possible 15 which indicated Resident #68 is cognitively intact and capable of daily decision making. Resident #68's Comprehensive Care Plan last revised 4/11/19 was reviewed and is documented in part, as follows:	F 645		

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F 645	Continued From page 95 Focus: The resident has little of no activity involvement related to Depression, Disinterest, resident wishes not to participate. History of Schizoaffective, Bipolar, prefers own leisure time.. The facility policy titled "Admission Criteria" version 2.1 was reviewed and is documented in part, as follows: Policy Statement: Our facility admits only residents whose medical and nursing care needs can be met. 9. All new admissions and readmissions are screened for mental disorders (MD), intellectual disabilities (ID) or related disorders(RD) per the Medicaid Pre-Admission Screening and Resident Review (PASARR) process. a. The facility conducts a Level I PASARR screen for all potential admissions, regardless of payer source, to determine if the individual meets criteria for a MD, ID or RD. b. If the level I screen indicates that the individual may meet the criteria for a MD, ID, or RD, he or she is referred to the state PASARR representative for the Level II (evaluation and determination) screening process. On 4/11/19 at 2:30 P.M. and interview was conducted with the Marketing Director who also oversees the Admission Department. The Marketing Director stated, " We do not have a Level I PASARR for (Name) Resident #68." The Marketing Director was asked what was the facility process for obtaining Level I PASARR's. The Marketing Director stated, "Earlier this week I spoke with the hospital case managers and asked them if PASARR's (Level I's) were being	F 645		

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F 645	Continued From page 96 done. They said that they have just starting being asked for them by facilities. The Marketing Director was asked if the facility had been receiving completed Level I PASARR's or completing Level I PASARR's prior to talking to the hospital earlier this week. The Marketing Director stated, "No we have not been receiving them or doing them here for the residents. On 4/16/19 at 1:25 P.M. a pre-exit debriefing was held with the Administrator, the Director of Nursing and the Regional Director of Operations were the above information was shared. The Regional Director of Operations stated, "We have hired a new social worker who will be starting soon and if the Level I PASARR's are not received from the hospital the social worker will be able to complete them." Prior to exit no further information was shared by the facility staff. Based on record review, staff interviews and review of the facility's policy the facility staff failed to ensure a Level I PASARR (Preadmission Screening and Resident Review) a pre-admission screening for a mental disorder (MD) or intellectual disability was completed prior to admission for 3 of 44 residents (Resident #83,	F 645		

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F 645	Continued From page 97 #104 and #68), in the survey sample. 1. The facility staff failed to ensure Resident #83's Level I PASARR was completed prior to admission to the nursing facility. 2. The facility staff failed to ensure Resident #104's Level I PASARR was completed prior to admission to the nursing facility. 3. The facility staff failed to ensure a Level 1 PASARR was completed prior to admission to the nursing facility for Resident #68. The findings included; 1. Resident #83 was originally admitted to the facility 1/17/17 and the resident has never been discharged from the facility. The current diagnoses included; dementia, traumatic brain injury, hemiparesis, psychotic disorder, depression and an anxiety disorder. The quarterly Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 3/15/19 coded the resident as completing the Brief Interview for Mental Status (BIMS), and scoring 9 out of a possible 15. This indicated Resident #83's cognitive abilities for daily decision making was moderately impaired. An interview was conducted with the Social Worker Assistant 4/11/19, at approximately 3:49 p.m. The Social Worker Assistant stated it wasn't something she took care of for she was not the Social Service Director. The Admission's Coordinator stated on 4/11/19, at approximately 4:30 p.m., that it wasn't something she asked for during the admission process and review of the	F 645		

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F 645	Continued From page 98 resident's record didn't reveal the document. On 4/16/18, at 1:40 p.m., the above findings were shared with the Administrator, Director of Nursing, and the Corporate Consultant. No additional information was provided.	F 645		
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:	F 657	F 657 Care plan Timing Revision 1. Resident # 27 care plan was updated on 5-8-19 to reflect care plan problem of seizure activity, goals and Interventions by the MDS coordinator. 2. All residents have the potential to be affected	5/31/19

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F 657	Continued From page 99 Based on record review, individual and staff interviews the facility staff failed to develop a care plan for seizures for one resident (Resident #27) in the survey sample of 44 residents. The findings included: Resident #27 was admitted to the facility on 03/13/18 and re-admitted on 07/13/18 with diagnoses which included seizures, depression, anxiety, bipolar disorder, hypertension, contractures of left hand, COPD, hypokalemia, dementia and cardiovascular disease. The facility staff failed to care plan seizure activity for Resident #27. A Quarterly Minimum Data Set dated 2/8/19 assessed this resident in the area of Hearing, Speech, and Vision as makes himself understood and usually understands. This resident was assessed as having impaired vision. In the area of Cognitive Patterns this resident was assessed as scoring a 12 on the Brief Interview for Mental Status. In the area of Behavior this resident was assessed as having behaviors directed towards others, verbal behaviors directed towards other, and other behavioral symptoms not directed towards others. In the area of Activities of Daily Living (ADL'S) this resident was assessed as requiring extensive assistance of one person in the areas of transfer, bed mobility, dressing, toilet use and personal hygiene. In the area of activity diagnoses this resident was coded as having a diagnoses of seizure disorder or epilepsy. A review of the Medication Administration Record dated April 2019 indicated: Keppra tablet 750 MG give two times a day related to unspecified convulsions.	F 657	3. On 5/3/2019 Inservice began on Care plan creation and updating to License nurses by the Regional Director of Clinical Operations. On 5/3/2019 Re-training provide to the MDS coordinator on Timely creation, revision and updating of care plans by the Regional RAI Director 4. Care Plan Audit will be conducted by the Regional RAI director/MDS coordinator 1x week x 4 then 1 x monthly. The audits will be documented and maintained in the Administrator's office Results of the training and audits will be presented Monthly to the QAPI committee by The Administrator and/or DON	

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F 657	Continued From page 100 A review of a revised Care Plan dated 03/27/19 did not included goals and needs for this resident's seizures. A nursing note dated 4/11/19 at 08:01:04 (8:01 A.M.) indicated: Seizure activity noted at approximate 6:55 am, resident noted with tremors lasting 30 seconds the started snoring and went to sleep. V/S 97.9-87-18-129/87. Physician answering service notified, message left to return call. HOB (head of bed) elevated SR (side rails) up X 2. Resident noted with eye contact but non-verbal at this time." During an interview on 4/11/19 at 6:15 P.M. with Resident #27 he stated, he was feeling much better, had a rough morning but got plenty of sleep, felt much better. During an interview on 4/12/19 with the Care Plan Coordinator she was asked about Resident #27 not having a care plan to address his seizure activity and she stated, "We must have missed it." The facility staff failed to develop a care plan to address the goals and needs of Resident #27's seizure activity.	F 657		
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	F 684		

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F 684	Continued From page 101 practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on complaint investigations, staff interviews, facility document review, and clinical record review the facility staff failed to ensure that one (1) of 44 residents in the survey sample received treatment and care in accordance with professional standards of practice, Resident # 22. The facility staff failed to administer five consecutive doses of scheduled Ativan. The findings included: Resident #22 was admitted to the facility on 1/13/17 and readmitted on 3/6/19 with diagnoses that included but were not limited to anxiety disorder, hyponatremia (low sodium), severe panic disorder, muscle weakness, Hepatitis C, protein-calorie malnutrition and diabetes (type two). Resident #22's most recent MDS (minimum data set) assessment was a quarterly assessment with an ARD (assessment reference date of 1/31/19. Resident #22 was coded as being moderately impaired in cognitive function scoring 11 out of 15 on the BIMS (Brief Interview for Mental Status) exam. Review of Resident #22's clinical record revealed the following order for Ativan on his December 2017 physician order summary: "Ativan 2 MG (milligrams): 1 tablet by mouth three times a day daily." Review of Resident #22's December 2017 MAR (Medication Administration Record) revealed that he missed five consecutive doses of his	F 684	F 684 Quality of Care 1. On 4/12/2019 Resident #22 Medical Doctor was notified of the 5 doses (2) days of Ativan not administered to the resident #22 on 12/9/2017 and 12/10/2017 by the Regional Director of Clinical Operations. The Pharmacy Director was notified on 4/12/2019 by the Regional Director of Clinical Operations. 2. All residents have the potential to be affected. 3. Nursing Staff will be in-serviced on ordering medications 3-7 days before medications run out. Nursing staff will be in-serviced to notify the physician of any medications not available and to use the medications from the CUBEX system or emergency box both which are provided by the pharmacy.	

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F 684	Continued From page 102 scheduled Ativan 2 mg on the following dates and times: 12/9/17 at 2 p.m., 12/9/17 at 10 p.m., 12/10/17 at 6 a.m., 12/10/17 at 2 p.m. and 12/10/17 at 10 p.m. The back of the December 2017 MAR documented the following: "12/9/17 2:00 p.m. Ativan 2 mg Medication not available/pharmacy contacted. 12/9/17 10:00 p.m. Ativan 2 mg Medication not available. 12/10/17 at 6:00 a.m. Ativan 2 mg 6 a.m. Not in from pharmacy, pharmacy contacted. 12/10/17 at 2 p.m. Ativan 2 mg Medication not available. 12/10/17 at 10 p.m. Ativan 2 mg Medication not available." Review of Resident #22's clinical record revealed a script for his Ativan was not signed and dated by the physician until 12/10/17. Review of the December 2017 Ativan narcotic logs revealed that his Ativan did not arrive to the facility until 12/11/17. Further review of the December 2017 narcotic logs confirmed that the did not receive Ativan on the above dates and times. Review of the facility's emergency STAT box list revealed that Ativan 0.5 mg was in the emergency STAT box. Review of Resident #22's nursing notes revealed that was sent out to the hospital on 12/11/17. The following nursing note was written: "12/11/17 4:46	F 684	4. Medication Administration Compliance Audit 5 x week x 4weeks then 3 x week x 4 weeks then 1 x week by the DON/ADON/ designee. Narcotic/ Controlled substance audit 3 x week x 4 weeks then 1 x week by the DON/ADON/ designee. Admission Medication reconciliation audit/ review of new admission medications to include controlled substances by DON/ADON/ UM 5x week. The audits will be documented and maintained in the Administrator's office. Results of the training and audits will be presented monthly to the QAPI committee by the Administrator and/ or DON 5. Completion Date 5/31/2019	

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F 684	Continued From page 103 AM VS (vital signs) 96.2 (temperature), 106 (pulse), 30 (respirations), 175/95 (blood pressure), 02 sats 95% (percent) ORA (on room air) Resident observed at about 12:56 am presenting with seizure activity which lasted about 2 minutes long, resident came around but unable to communicate with staff resident, (sic) observed with a blank stare bleeding from mouth unable to assess residents (sic) mouth safely after seizure activity, resident not responding so 911 contacted to transfer resident to (Name of Emergency Room) for eval (evaluation) and treatment, resident LOA (leave of absence) to ER at 115 am via 911 stretcher, oncall (sic) MD (medical doctor) made aware, RP (responsible party) made aware, supervisor made aware, DON (Director of Nursing) aware will (sic) pass onto oncoming shift residents whereabouts..." Review of the hospital course stay summary dated 12/15/17, documented the following: "Patient is a 64 yo (year old) with liver cirrhosis, quit alcohol 2 years ago, hep C, hyponatremia, chronic benzodiazepine use, comes in with seizure...Patient takes ativan TID (three times a day) but has not had it in three days. Tonight he had witnessed seizure with mouth bleeding. He was brought to ER (emergency room), altered mental status. Patient had another seizure in the ER. he (sic) vomited several times and was coughing with suspicion for aspiration. Patient is awake but not providing any history which according to his sister not his baseline. She last saw him three days ago. Hospital course by problem: New onset seizures due to benzo withdrawal and hyponatremia. Severe hyponatremia, symptomatic. Continues to improve steadily...Resolving with Na (Sodium) 134. Suspect benzo withdrawal. Continue home	F 684		

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F 684	Continued From page 104 dose of Ativan...Plan: Neurochecks and seizure precaution...I will recommend treatment of hyponatremia but avoid rapid correction...Continue symptomatic treatment for seizures with Ativan 2 mg IV (intravenous) as needed...Continue other medical management including the treatment of possible benzodiazepine withdrawal as per admitting hospitalist." Further review of the hospital records, revealed that his sodium level was 119 in the ER on 12/11/17. Review of Resident #22's hospital history and physical from the physician dated 12/11/17 documented the following:"...He does not have a history of...seizure disorder...Impression: 1. Recurrent generalized seizure, most likely secondary to severe hyponatremia and Ativan withdrawal." Review of Resident #22's clinical record revealed that he had a history of low sodium but did not have a history of seizures. The most recent ordered CMP (complete metabolic panel) (a test that would have shown sodium levels) (2) prior to his hospitalization was on 7/6/18. There was no evidence that this CMP was drawn. Staff could not provide this result. Further review of Resident #22's clinical record revealed that Resident #22 was on fluid restrictions for his hyponatremia and was non-compliant with these restrictions. Review of the facility's Drug Guide for Nurses p. 700- 701, documents the following under adverse/toxic reactions for Ativan: "Abrupt or too rapid withdrawal may result in pronounced restlessness, irritability, insomnia, hand tremor,	F 684		

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F 684	Continued From page 105 abdominal cramping, muscle cramps, diaphoresis (excessive sweating), vomiting and seizures." Further review of the clinical record revealed that Resident #22 returned to the facility on 12/15/17 with the following changed order from the hospital: "Ativan 2 mg Take 1 tablet by mouth every (8) hours PRN (as needed) for anxiety." A physician's note could not be found regarding Resident #22's transfer to the hospital on 12/11/17. On 4/11/19 at 3:51 p.m., an interview was conducted with a floor nurse, LPN (Licensed Practical Nurse) #1. When asked the process if she were to administer Ativan but it wasn't in the medication cart, LPN #1 stated that if Ativan was not available in the medication cart, she would check the PIXIS (STAT box) to see if it was in there. LPN #1 stated that pharmacy has to be called to receive a code to retrieve the Ativan from the PIXIS. LPN #1 stated that a script was still needed for Ativan to be pulled from PIXIS. LPN #1 stated that if the Ativan needed a new prescription from the doctor, that she would have to send that to pharmacy before she could take out Ativan from PIXIS. LPN #1 stated in that situation, she would call the physician or on-call physician to obtain a script. On 4/12/19 at 8:51 a.m., an interview was conducted with OSM (other staff member) #1, the pharmacy director. When asked if she could track what was going on with Resident #22's Ativan on 12/9/17 through 12/11/17, OSM #1 stated that pharmacy had sent them a fax that his Ativan needed a new script on 12/5/17. OSM #1 stated that the facility did not fax over a script until	F 684		

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F 684	Continued From page 106 12/10/17 at 8:59 p.m. OSM #1 stated that the night run for pharmacy usually leaves around 8:30 p.m. and that the pharmacy was two hours away from the facility. OSM #1 stated that pharmacy could not send narcotics without a hard script. When asked if Ativan was in the STAT box, OSM #1 stated that Ativan 0.5 mg was in PIXIS. OSM #1 stated that facility staff could have called the MD to get a new one time order for Ativan 0.5 mg, 4 tabs to equal the 2 mg after a script was sent over. On 4/12/19 at 9:26 a.m., an interview was conducted with LPN #2, the LPN who documented on most occasions that Resident #22's Ativan was not available. When asked the process if she were to administer Ativan and it wasn't available on the medication cart, LPN #2 stated that she would contact pharmacy and if pharmacy states that she needs a hard script, she would call the physician and ask him to send a script to pharmacy. LPN #2 stated that she could also ask the physician for an alternative medication for the time being that is in the facility STAT box. When asked if Ativan was in the facility STAT box, LPN #2 stated that she was not sure because she has never had to go into the STAT box. When asked if she would call the physician right away to obtain a script, LPN #2 stated that she would call before she shift ended and that was not a task she would pass onto the next shift nurse because it would be a delay in treatment. When asked the negative outcomes for a resident who misses five consecutive doses of Ativan, LPN #2 stated that the resident could go into withdrawal or have an increase in behaviors. When asked if she could recall what had happened with Resident #22's Ativan on 12/9/17 through 12/10/17, LPN #2 stated that she could	F 684		

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F 684	Continued From page 107 not remember. LPN #2 stated, "It probably wasn't there and I notified pharmacy. Maybe it needed a hard script or maybe it was on its way. I think we need to have our pharmacy closer." When asked if she was working the day Resident #22 went into a seizure, LPN #2 stated that she was not on shift that morning. LPN #2 could not recall what had happened to his Ativan. LPN #2 stated there should have been a nursing note. When asked of you could get Ativan from the PIXIS system without a had script, LPN #2 stated that you could not get narcotics from PIXIS if a hard script is needed. When asked if pharmacy notifies the facility if a medication needs a new script, LPN #2 stated that pharmacy will put a pink slip around the medication card alerting staff that the prescription needs to be filled for the next time the narcotic is ordered. On 4/12/19 at 9:33 a.m., further interview was conducted with OSM #1. When asked any negative outcomes for a resident who abruptly stops Ativan and misses 5 consecutive doses, OSM #1 stated that a resident using Ativan long term could have withdrawal symptoms. When asked if this could lead to seizures OSM #1 stated, "It could, potentially yes. I couldn't say 100 percent." On 4/12/19 at 9:57 a.m., an interview was conducted with ASM (administrative staff member) #2, the ADON (Assistant Director of Nursing). When asked the process if her nurses were to pull an Ativan medication and it was not in the medication cart, ASM #2 stated that she would notify the Medical Doctor for a script and call pharmacy to get a code from the STAT box. ASM #2 stated that if Ativan is not in the PIXIS, she would notify the MD for alternative orders.	F 684		

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F 684	Continued From page 108 ASM #2 stated she would expect to see nursing notes regarding the reasons why the medication was unavailable and the steps taken to obtain the medication. When asked if there were any negative outcomes for a resident who abruptly stops taking Ativan and misses 5 consecutive doses, ASM #2 stated that the resident could have withdrawal symptoms. ASM #2 could not recall what had happened with Resident #22's Ativan. ASM #2 looked at Resident #22's MAR and confirmed that he had missed 5 doses of Ativan. ASM #2 stated that if the nurse was having a hard time getting in touch with the physician or medical director for a script, she should have notified administration (herself, the DON and/or administrator). On 4/12/19 at 12:46 p.m., an interview was conducted with ASM #3, the medical director and Resident #22's physician. When asked how often he was at the facility, ASM #3 stated that he was at the facility two days a week and his partner was at the facility one day a week. ASM #3 stated that on the days he and the other physician were not in the building, two nurse practitioners made rounds in the facility. ASM #3 stated that there was a medical professional present every day of the week except the weekends. When asked the process if a resident needs a script filled for a narcotic, ASM #3 stated that he and the other physicians/NPs can write a prescription while at the facility and if they are not there, the nurses can call his office. ASM #3 stated that if staff wait until the weekend, they will not be able to get a script until Monday. ASM #3 stated that nurses should ensure the resident has the medication or enough medication to last over the weekend. When asked why an on-call physician could not call in a script, ASM #3 stated that most	F 684		

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F 684	Continued From page 109 pharmacies will not take a verbal order for a narcotic. When asked the potential negative outcomes for a resident who misses 5 consecutive doses of Ativan, ASM #3 stated that some people will have increased anxiety. ASM #3 stated that the resident could also go into withdrawal, which could be more violent. ASM #3 stated that adverse effects depended on how long the resident was on Ativan. When asked if Resident #22 had been on Ativan a long time prior to December 2017, ASM #3 stated that he had. On 4/12/19 at 1:32 p.m., ASM #1, the Administrator and ASM #4, the DON were made aware of the concern for potential harm related to Resident #22's missed doses of Ativan that contributed to his seizures and lead to his hospitalization on 12/11/17. On 4/16/19 ASM #4 presented a copy of a physician note (ASM #3) dated 4/15/19 (during the survey) The following was written: "4/15/19 Review of events on about 12/11/17 til 12/15/17-pt on chronic Ativan therapy for anxiety-Comorbid conditions include liver cirrhosis, Hep. C. and recurrent hyponatremia on fluid restriction but pt (patient) is non-compliant with restriction. pt (patient) with no ativan 2-3 days since 12/8/17. Rx (script) given by myself in writing at facility 12/10. unknown why medication was not delivered 12/10. pt (patient) transferred to ER (emergency room) and subsequently hospitalized due to seizure activity. Serum sodium in ER 119. Seizure responded to IV Ativan and sodium improved with Intravenous saline solution. pt's mental status returned back to normal once seizure controlled and post-ilctal	F 684		

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F 684	Continued From page 110 state subsided. Although it is almost impossible to say with certainty what was the etiology of his seizure, the following makes it unlikely to be due to Ativan withdrawal. 1-pt exhibited no signs of withdrawal prior to seizure activity such as tremors, sweating, confusion... 2. Serum Sodium less than 120 is associated with significantly increased risk of seizure. 3- pt's mental status returned to normal as soon as seizure activity was controlled- Benzodiazapiane withdrawal will take significantly longer period to return to normal. 4-pt was discharged only on prn (as needed) ativan not on a standing dose which is not the standard practice to treat withdrawal." According to The National Institutes of Health, "Abrupt termination of Ativan treatment may be accompanied by withdrawal symptoms. Symptoms reported following discontinuation of benzodiazepines include headache, anxiety, tension, depression, insomnia, restlessness, confusion, irritability, sweating, rebound phenomena, dysphoria, dizziness, derealization, depersonalization, hyperacusis, numbness/tingling of extremities, hypersensitivity to light, noise, and physical contact/perceptual changes, involuntary movements, nausea, vomiting, diarrhea, loss of appetite, hallucinations/delirium, convulsions/seizures, tremor, abdominal cramps, myalgia, agitation, palpitations, tachycardia, panic attacks, vertigo, hyperreflexia, short-term memory loss, and hyperthermia.Convulsions/seizures may be more common in patients with pre-existing seizure disorders or who are taking other drugs that lower the convulsive threshold such as antidepressants."(3) Review of Resident #22's December 2017	F 684		

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F 684	Continued From page 111 physician order summary revealed that he was on Zoloft 25 MG.(antidepressant) daily for depression. His order documented the following: "***Do Not Give with Ativan.***" Further review of Resident #22's December 2017 MAR revealed that he was receiving Ativan 2 MG (milligrams) and Zoloft 25 MG (milligrams) every day. Zoloft was documented as being administered daily at 10:00 a.m. *Ativan (benzodiazepine) that is indicated for the management of anxiety/panic disorders or for the short-term relief of the symptoms of anxiety or anxiety associated with depressive symptoms. (1) (1) This information was obtained from the National Institutes of Health. https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=ba6ce50e-c5a9-47ca-9803-a1ed82172b0e (2) This information was obtained from The National Institutes of Health. https://aidsinfo.nih.gov/understanding-hiv-aids/glossary/2992/comprehensive-metabolic-panel (3) This information was obtained from the National Institutes of Health. https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=89057c93-8155-4040-acec-64e877bd2b4c.	F 684		
F 686 SS=D	Complaint Deficiency. Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii)	F 686		

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F 686	Continued From page 112 §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on a complaint investigation, clinical record review, facility document review and staff interviews the facility staff failed to ensure timely physician orders for the care of multiple pressure ulcers were obtained for 1 of 44 residents in the survey sample, Resident #106. The facility staff failed to obtain physician orders for the care of multiple pressure ulcers upon admission for Resident #106 within a timely manner. The findings included: Resident #106 was admitted to the facility on 6/18/18 with diagnoses to include but not limited to Decubitus Ulcer of the sacral region, Malnutrition and Alcohol Abuse. The most recent Minimum Data Set (MDS) assessment was an Admission 5/Day with an Assessment Reference Date (ARD) of 6/25/18. The Brief Interview for Mental Status was a 15	F 686	F 686 Treatments to Prevent/Heal Pressure Ulcers was reviewed 1. Resident # 106 no longer resides in the facility. 2. Review of last 12 months of Admission wound orders Was conducted on 5/6/2019. Review of the last 12 months of Admit/Readmit Screener for complete assessment and measurements were conducted on 5/6/2019. 3. The Regional Nurse consultant/ DON will provide training to the Wound nurses, License Nurses on Wound care management to include Wound/skin assessment upon admission within 24 hours of admission – quarterly and with decline in condition Wound Evaluation Flow Sheet is accurately and thoroughly completed for all wounds. Obtaining physician orders on all wounds and skin concerns upon admission and changes.	5/31 2019

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F 686	Continued From page 113 out of a possible 15 indicating Resident #106 was cognitively intact and capable of daily decision making. Under Section "M" Skin Conditions, Resident #106 was coded to have 2 Stage II, 4 Stage III, and 2 Stage IV pressure areas present upon admission. Resident #106's Admission Physician Orders dated 6/18/18 were reviewed and there were no physician orders obtained for any pressure ulcer treatments Resident #106's Admit/Readmit Screener dated 6/19/19 was reviewed and is documented in part, as follows: Section C 10. Skin Integrity Site: 53) Sacrum Type: Pressure Stage: II* Site: 25) Right Trochanter (hip) Type: Pressure Stage: III* Site: 26) Left Trochanter (hip) Type: Pressure Stage: III* There were no measurements or description of the pressure areas documented in the assessment. Resident #106's Progress Notes were reviewed and are documented in part, as follows: 6/18/18 21:39 (9:39 PM) Admission Summary: Resident arrived via stretcher from (name) hospital, Resident admitted to room (number) under the care of doctor. Resident oriented to room and call bell system and voiced understanding. Orders previously verified with NP (Nurse Practitioner). 6/20/18 23:14 (11:14 PM) Skin/Wound Note: At	F 686 F 686	4. Admission wound care / Physician order Audit will be Performed to assure that the level and type of care meets the professional standards for License nurses 3x week, x 4 then 1x week by the DON/ADON The audits will be documented and maintained in the Administrator's office. Results of the training and audits will be presented Monthly to the QAPI committee by The Administrator and/or the DON to ensure compliance is achieved and sustained.	

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F 686	Continued From page 114 approximately 1600 (4 PM) the CNA (Certified Nursing Assistant) assigned to resident called this nurse to the room to apply new dressings on resident. Resident has been having loose stools and therefore soiled applied dressings. New dressings were applied temporarily until treatment orders were reviewed to see what the proper dressings and ointments are. Upon reviewing resident's chart, no documentation or treatment orders were put in at that time. Wound nurse did assessment on 6/19/18. Will follow up on proper care and treatments needed for resident. Resident #106's Physician Orders dated 6/20/18 were reviewed and are documented in part, as follows: 1. Calcium Alginate Apply to left hip topically every day shift for wound care, clean left hip with wound cleanse, apply Calcium Alginate and dry dressing daily and as needed. 2. Calcium Alginate Apply to right hip topically every day shift for wound care, clean right hip with wound cleanse, apply Calcium Alginate and dry dressing daily and as needed. 3. Dakins Solution Apply to sacrum topically every day shift for wound care, clean sacrum with wound cleanse, apply dakins soaked gauze and dry dressing daily and as needed. On 4/16/18 at 10:26 AM an interview was conducted with the Director of Nursing about Resident #106's admission orders. The Director of Nursing was asked if the facility failed to obtain wound care orders at the time of admission for Resident #106's sacrum, right trochanter and left trochanter pressure ulcers. The Director of	F 686		

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F 686	Continued From page 115 Nursing stated, "Yes, we did fail to obtain the orders on admission for the resident's pressure ulcer and we should have obtained them. We are responsible to make sure we have a continuity of care for the resident from the hospital." The facility policy titled "Admission/Readmission Orders" revised 9/2017 was reviewed and is documented in part, as follows: Policy Statement: Physicians shall provide appropriate admission and readmission orders. Outcomes: 1. Residents/patients will receive appropriate treatments and services upon admission. 2. Residents and patients will not suffer complications because of incomplete, inaccurate, or delayed admission orders. 3. The facility's care will be consistent with related standards and will comply with applicable laws and regulations. Procedure: 1. The attending physician will authorize admission and readmission orders based on his/her knowledge of the resident/patient and on a review by facility staff. 2. Admission and readmission orders will include: b. Orders related to interventions, including medications, treatments, and equipment. On 4/16/19 at 1:25 P.M. a pre-exit debriefing was held with the Administrator, the Director of Nursing and the Regional Director of Operations were the above information was shared. No further information was provided prior to exit.	F 686		

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F 686	Continued From page 116 This is a Complaint Deficiency. *The National Pressure Ulcer Advisory Panel (NPUAP.org) descriptions: Stage 2 Pressure Injury: Partial-thickness skin loss with exposed dermis Partial-thickness loss of skin with exposed dermis. The wound bed is viable, pink or red, moist, and may also present as an intact or ruptured serum-filled blister. Adipose (fat) is not visible and deeper tissues are not visible. Granulation tissue, slough and eschar are not present. These injuries commonly result from adverse microclimate and shear in the skin over the pelvis and shear in the heel. This stage should not be used to describe moisture associated skin damage (MASD) including incontinence associated dermatitis (IAD), intertriginous dermatitis (ITD), medical adhesive related skin injury (MARSI), or traumatic wounds (skin tears, burns, abrasions). Stage 3 Pressure Injury: Full-thickness skin loss Full-thickness loss of skin, in which adipose (fat) is visible in the ulcer and granulation tissue and epibole (rolled wound edges) are often present. Slough and/or eschar may be visible. The depth of tissue damage varies by anatomical location; areas of significant adiposity can develop deep wounds. Undermining and tunneling may occur. Fascia, muscle, tendon, ligament, cartilage and/or bone are not exposed. If slough or eschar obscures the extent of tissue loss this is an Unstageable Pressure Injury	F 686		
F 687 SS=D	Foot Care CFR(s): 483.25(b)(2)(i)(ii)	F 687		

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F 687	Continued From page 117 §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: Based on a complaint investigation, facility record review, staff interviews, resident interviews and facility document review the facility staff failed ensure 2 of 44 residents in the survey sample received their diabetic shoes in a timely manner, Resident #17 and Resident #24. 1. The facility staff failed to ensure a pair of diabetic shoes was provided to Resident #24 in a timely manner. 2. The facility staff failed to provide Resident #17 with physician ordered diabetic shoes. The findings included: 1. Resident #24 was a 76 year old admitted to the facility on 1/11/18 with diagnoses to include but not limited to Type 2 Diabetes Mellitus and Peripheral Vascular Disease. The most recent Minimum Data Set was an Annual assessment with an Assessment Reference Date of 1/21/19. The Brief Interview for Mental Status was a 12 out of a possible 15	F 687	F 687 Foot care 1. Resident # 24 Received her diabetic shoes on 1/19/2019. The Medical Director was notified of the date of receipt. Resident # 17 diabetic Physician orders dated and stamped Was re-submitted to the Ortho-clinic due to resident having Amputated toes to the right foot. On 5/9/2018 and appointment has been set by the Orthotics And prosthetics clinic for specialty diabetic shoes due to amputated Toes. 2. Beginning on 5/3/2019 a Review of Diabetic resident Physician Orders, Podiatry and wound orders were reviewed for any foot care orders, to include diabetic shoes was conducted by the Regional Nurse consultant. Review of Physician orders to include podiatrists and wound care will be reviewed 5x week in clinical start-up by the DON/ADON.	5/31 2019

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F 687	Continued From page 118 indicating Resident #24 was cognitively intact and capable of daily decision making. Resident #24's Telephone Physician Order dated 3/7/18 was reviewed and is documented in part, as follows: 3/7/18; Diabetic Shoes (Name) Shoes with phone number listed. On 4/15/19 at 10:15 A.M. an interview was conducted with Resident #24 about her diabetic shoes. Resident #24 pointed to a pair of shoes near the wall at the head of her bed and stated, "There they are, it took forever but I finally got then. It took a long time to get them but I like them." On 4/15/19 at 2:00 P.M. an interview was conducted with the Pediorthist who was the company owner that was called to size and order Resident #24's diabetic shoes. The Pediorthist stated, "We went out on 3/21/18 to size her (Resident #24) and do an evaluation. Also on 3/21/18 we faxed over the documents we needed to be completed by the residents physician. We re-faxed the same documents on 4/25/18, 7/18/18, and again on 12/19/18. We finally received the completed and signed documents from the physician on 1/4/19. The diabetic shoes were delivered to the resident on 1/19/19. Once we have obtained all the necessary documentation from the physician it is only a 2 week turn around time for the shoes to arrive for the resident. The hold-up for her (Resident #24's) shoes was not us it was the physician." Documents provided from the Pediorthist for Resident #24's diabetic shoes were reviewed and	F 687	3. The Regional Nurse consultant/DON will provide training to License nurses and social services on Timely review of physician Orders for ordering Diabetic shoes, appropriate paperwork to completed to include the physician orders to the provider and to follow-up on progress of the delivery of the shoes to ensure timely delivery. Inservice/training began on 5/3/2019. 4. Assistive device and equipment audit to include diabetic shoes Timely ordering and receiving of the shoes will be conducted by DON/ADON 1x week x 4 then 1x month x 3 then Quarterly. The audits will be documented and maintained in the Administrator's office. Results of the training and audits will be presented Monthly to the QAPI committee by The Administrator and/or the DON to ensure compliance is achieved and sustained.	

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	495330	A. BUILDING _____ B. WING _____	C 04/16/2019

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F 687	Continued From page 119 revealed the Attending Physician's signature on 1/3/19. The facility policy titled "Assistive Devices and Equipment" revised 7/2017 was reviewed and is documented in part, as follows: Policy Statement: Our facility provides, maintains, trains and supervises the use of assistive devices and equipment for residents. 1. Devices and equipment that assist with resident mobility, safety and independence are provided for residents. These include, but are not limited to: a. Wheelchairs; b. Walkers; and c. Canes. 7. Requests or the need for special equipment should be referred to the Social Services Department. On 4/16/19 at 1:25 P.M. a pre-exit debriefing was held with the Administrator, the Director of Nursing and the Regional Director of Operations were the above information was shared. The Director of Nursing was asked when would she have expected Resident #24 to have received her diabetic shoes and if ten and a half months was a reasonable amount of time to have to wait for them. The Director of Nursing stated, "She should have received them as soon as the provider could get them shipped to the facility and yes she should have had them much sooner. We should have followed-up and had better communication with the physician and the shoe provider." The Regional Director of Operations stated, "This is dually noted and we know that this	F 687		

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F 687	Continued From page 120 is something we need to work on." Prior to exit no further information was shared. This is a Complaint Deficiency. 2. Resident #17 was admitted to the facility on 1/15/18 with diagnoses of hypertension, cardiovascular disease, epilepsy, anxiety, diabetes, and dementia. The facility staff failed to provide Resident #17 with physician ordered diabetic shoes. An Annual MDS dated 1/22/19 assessed this resident as having no hearing, or speech difficulty. Resident #17 was assessed as needing glasses. In the area of Cognitive Patterns this resident was assessed as having a BIMS score of 15 which indicated no cognitive impairment. A Care Plan revised 2/4/19 indicated: Focus: The resident has an ADL self-care deficit due to seizures. Goal: The resident will maintain current level of function within the scope of the disease process. Approaches: Monitor/document/report PRN any changes, potential for improvement, reasons, for self-care deficit, expected course, declines in function. The resident is at risk for falls due to seizures, anxiety, diabetes, cardiovascular disease, pain, Goal-resident will not sustain serious injury through the review; Approaches/Tasks-Ensure that the resident is wearing appropriate footwear when ambulating. A Physician order dated 2/28/19 indicated: "Resident #17 was ordered to have diabetic shoes." During an interview on 4/15/19 at 2:15 P.M. with the Social Worker, she stated, "She	F 687		

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F 687	Continued From page 121 was not aware Resident #17 had a order for diabetic shoes." During an interview with the Unit South Nurse Manager, she stated, she did not know the reason for the hold up for Resident #17 not having diabetic shoes. The facility staff failed to provide Resident #17 with physician ordered diabetic shoes.	F 687		
F 697 SS=D	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on record review, staff interview and a complaint investigation, the facility staff failed to adequately assess and obtain pain medication for one resident (Resident #57) in the survey sample of 44 residents. The findings included: Resident #57 was re-admitted to the facility on 1/28/19 with diagnoses which included a history of sepsis due to Escherichia coli (E.Coli) esophagitis, muscle weakness, dysphagia, abnormalities of gait, hypertension, COPD, depression, diabetes, cardiovascular disease, hyperlipidemia, and contracture of left hand. The facility staff failed to provide routine pain medications to Resident #57. A Re-entry Minimum Data Set (MDS) dated	F 697	F 697 Pain Management 1. Resident #57 narcotic count was completed on 4/12/2019 for availability, reorder needs and adequate supply. 2. All residents have the potential to be affected 3. On 5/3/2019 License nurse training began on Medication Availability by the Regional Nurse consultant/DON.	5/31 2019

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F 697	Continued From page 122 2/25/19 assessed this resident as having no difficulties in the area of hearing, speech, vision or understanding and the ability to be understood. In the area of Cognitive Patterns this resident was assessed for a brief Interview for mental Status (BIMS) and scored a (13). This resident was assessed in the area of Activities of Daily Living (ADL'S) as requiring supervision and one person set-up in the area of bed mobility, transfers, and locomotion on unit. This resident was assessed as requiring extensive assistance with one person set-up in the area of dressing and personal hygiene. In the area of Pain Management this resident was assessed as having pain within the last 5 days. This resident was assessed as having frequent pain. This resident was assessed as having pain which made it difficult to sleep at night. In the area of Pain Intensity this resident rated pain in the last 5 days as a (10) on a scale from 0 to 10. A Care Plan dated 8/6/18 indicated: Focus- The resident has c/o pain r/t history hip fracture. History of CVA, tooth fx r/t falls, UTI. Goal- The resident will verbalize adequate relief of pain or ability to cope with incompletely relieved pain through the review date. Approaches/Tasks - Administer analgesia as per orders. Anticipate the resident's need for pain relief and respond immediately to any complaint of pain. Evaluate the effectiveness of pain interventions. Review for compliance, alleviation of symptoms, dosing schedules and resident satisfaction with results, impact on functional ability and impact on cognition. Monitor/document for probable cause of each pain episode. Remove/limit causes where possible. A Re-admission Summary dated 7/10/18 at 33:00	F 697	4. Medication Availability/Narcotic Audit will be conducted by the DON/ADON/UM 2x week x 4 then 1 x week. The audits will be documented and maintained in the Administrator's office. Results of the training and audits will be presented Monthly to the QAPI committee by The Administrator and/or the DON to ensure compliance is achieved and sustained.	

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F 697	Continued From page 123 (12:33 A.M.) indicated: "Resident arrived via WC, accompanied by two unknown individuals and admitted to Rm. (number). Grocery bag w/bottles of medications left at nurses station. members of administration evaluated resident and determined, due to his poor condition and presentation, he was to be sent back out to ER for further evaluation. Transport arrived at approximately 18:35. Resident refused to go to hospital. Transport expressed that since resident is A & O X 3, he has the right to refuse." A Medication Order Summary dated 7/10/18 Indicated: "The following medications: Norco Tablet 5-325 MG (Hydrocodene Acetaminophen) give 1 tablet by mouth every 4 hours as needed for PAIN. Percocet Tablet 10-325 MG (Oxycodone-Acetaminophen) give 1 tablet by mouth every 4 hours as needed for Pain max daily amount 12 tabs. Percocet Tablet 10-325 MG (Oxycodone-Acetaminophen) give 2 tablets by mouth every 4 hours as needed for Pain Max daily amount 12 tabs. A Medication Manifesto signed and dated 7/11/18 indicated: the following medications were received for Resident #57. Quantity- 30- Baclofen tab 20 mg 60- Benztropine tab 0.5 mg 30 -Citalopram tab 20 mg 40 -Cephalexin cap 500 mg 30 -Glipizide tab 5 mg 30 -Atorvastatin tab 40 mg 30 -Lisinopril tab 2.5 mg	F 697		

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F 697	Continued From page 124 60- Metformin tab 500 mg 30 -Clopidogrel tab 75 mg 30 -Finasteride tab 5 mg Resident #57's pain medications were not available. An Admission summary dated 1/28/19 at 22:36 (10:36 P.M.) indicated: "Resident arrived at 1743, on stretcher, able to make wants and needs known. No complaints of pain, Resident has a Foley 16 French. Foley is draining clear yellow urine. No dentures or hearing aides seen. clear lungs sound. weak left side of body. Dressing on the right upper on where PICC line was in place. Dry and intact, no bruises or marks on the body. No open areas. Resident has redness on the scrotum and on the sacrum area. Call bell within reach will continue to monitor." A Orders-Administration Note dated 1/28/19 at 22:23 (10:23 P.M.) indicated: " Pharmacy called about the residents medication and stated that the insurance paid for his medication for the month and he would not be able to send all his meds. Stated that they would send some of his medication and then when the month started over they would send all the medication." A review of the Medication Administration Record (MAR) dated January 2019 indicated: Pain level every shift for Pain start date 7/10/18. A review of the MAR from January 28 through January 31 indicated Resident #57 was not assessed for pain nor did he receive pain medications during this time period. During an interview on 4/16/19 at 11:15 A.M. with the Assistant Director of Nursing (ADON) she was asked if Resident #57 should have received	F 697		

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F 697	Continued From page 125 his medications and she stated, Yes. When asked were the pain medications given to Resident #57 she stated, "No." When asked if the facility had stat meds for use, the ADON stated, "Yes." When asked why staff did not provide this resident pain meds from the stat box she stated, "she did not know." The facility staff failed to provide pain medications.	F 697		
F 727 SS=E	RN 8 Hrs/7 days/Wk, Full Time DON CFR(s): 483.35(b)(1)-(3) §483.35(b) Registered nurse §483.35(b)(1) Except when waived under paragraph (e) or (f) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. §483.35(b)(2) Except when waived under paragraph (e) or (f) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. §483.35(b)(3) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. This REQUIREMENT is not met as evidenced by: Based on staff interviews and facility documentation review, the facility staff failed to staff a Registered Nurse (RN) for at least 8 hours a day, 7 days a week and failed to ensure the Director of Nursing (DON) worked as a supervisor/charge nurse only when the facility had a census of 60 or less. The findings included:	F 727	F727 RN hours/ 7 days/Wk., Full Time DON 1. The RN schedule for weekend coverage was reviewed for the month of April 2019 to ensure RN coverage for 8 hours Was scheduled. The staffing coordinator received immediate re-training on the process to ensure 8 hours of RN coverage was scheduled.	5/31 2019

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F 727	Continued From page 126 A review of the as work schedules from October 2018 through April 14, 2019, were reviewed which resulted in further review of the RN weekend coverage. The review concluded there was no RN coverage for at least 8 consecutive hours and the DON worked as a supervisor/charge nurse when the facility had a census of more than 60 residents on the following days: 1. Sunday, October 7, 2018, the scheduled RN called out, there was a RN in the facility but she was on orientation. She worked 5.5 hours (9:45 a.m.-3.15 p.m.). 2. Saturday, October 20, 2018, the Director of Nursing (DON) worked as the supervisor/charge nurse. She worked 5.5 hours (10:45 a.m.-4:15 p.m.) with a facility census of 108. 3. Sunday, October 21, 2018, the Director of Nursing (DON) worked as the supervisor/charge nurse. She worked 7.25 hours (8:15 a.m.-3:30 p.m.) with a facility census of 108. 4. Sunday, January 06, 2019, the RN only worked 7.5 hours (7:02 a.m. - 3:07 p.m.). 5. Saturday, January 19, 2019, the RN only worked 7.75 hours (6:59 a.m. - 3-15 p.m.). 6. Sunday, March 17, 2019, the RN only worked 7.75 hours (6.57 a.m. - 3:22 p.m.). 7. Saturday, March 23, 2019, the RN only worked 4.75 hours (7:02 a.m. - 11:40 a.m.). 8. Saturday, March 23, 2019, the Director of Nursing (DON) worked as the supervisor/charge	F 727	2. RN supervisors scheduled to provide RN coverage for the month of April was immediately notified on 4/14/2019 of the requirements of 8 hours. 7 days a week review of RN staffing hours will be conducted by the staffing coordinator and Administrator. This began on 4/16/2019 3. On 4/15/2019 License Registered Nurses who are active/current employees received training on Staffing requirements for RN coverage by the Regional Director of Clinical operation. On 5/2/2019 The DON received training conducted by the Regional Director of Clinical Operation on when the Director of Nursing may serve as a charge nurse and the average daily occupancy requirements.	

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F 727	Continued From page 127 nurse. The DON did a split shift with another nurse on 03/23/19 (a.m.-3:30 p.m. shift). The DON worked from (11:14 a.m.-4:24 p.m.) with a facility census of 103. 9. Saturday, April 06, 2019, the Director of Nursing (DON) worked as the supervisor/charge nurse. She worked 9.5 hours (7:28 a.m. - 5:08 p.m.) with a facility census of 106. 10. Saturday, April 13, 2019, the RN only worked 7.75 hours (7:00 a.m.-3:15 p.m.). A phone interview was conducted with the Staffing Coordinator on 04/12/19 at approximately 10:15 a.m. She said she does not work on weekend so if someone calls out, the nursing staff will call the nurse on call to provide the necessary RN coverage. The Staffing Coordinator stated, "The nurses know they should be working 8 hours when they are providing RN coverage on the weekends." A briefing was conducted via phone with the Administrator and Interim Director of Nursing (IDON) on 04/12/19 at approximately 4:55 p.m. No other information was provided. A phone interview was conducted with the IDON on 04/15/19 at approximately 11:45 a.m. The IDON stated, "The DON can only work as a charge nurse or supervisor when the facility has a census of 60 or less." She also said the RN providing weekend coverage must work at least 8 consecutive hours.	F 727	4. Registered Nurse staff hours audit will be conducted by the DON/ Administrator 1x week The audits will be documented and maintained in the Administrator's office. Results of the training and audits will be presented Monthly to the QAPI committee by The Administrator and/or the DON to ensure compliance is achieved and sustained.	
F 755	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3)	F 755		

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F 755	Continued From page 128 §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 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 record review, staff interview and a complaint investigation, the facility staff failed to have available pain medication to one resident (Resident #57) in the survey sample of 44 residents.	F 755	F 755 Pharmacy Srvcs/ Procedures, /Pharmacist/ Records 1. Resident #57 narcotic count was completed on 4/12/2019 for availability, reorder needs and adequate supply. Resident # 57 medication administration record was reviewed for the month of April. Resident #57 MD was notified of the omission of resident pain medication on 7/11/2018 and 1/28/2019 2. All residents have the potential to be affected. 3. On 5/3/2019 License nurse training began on Medication Availability and MD notification by the Regional Nurse consultant/DON.	5/31/19

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F 755	Continued From page 129 The findings included: Resident #57 was re-admitted to the facility on 1/28/19 with diagnoses which included a history of sepsis due to Escherichia coli (E.Coli) esophagitis, muscle weakness, dysphagia, abnormalities of gait, hypertension, COPD, depression, diabetes, cardiovascular disease, hyperlipidemia, and contractures of left hand. The facility staff failed to have routine pain medications available to Resident #57. A Re-entry Minimum Data Set (MDS) dated 2/25/19 assessed this resident as having no difficulties in the area of hearing, speech, vision or understanding and the ability to be understood. In the area of Cognitive Patterns this resident was assessed for a brief Interview for mental Status (BIMS) and scored a (13). This resident was assessed in the area of Activities of Daily Living (ADL'S) as requiring supervision and one person set-up in the area of bed mobility, transfers, and locomotion on unit. This resident was assessed as requiring extensive assistance with one person set-up in the area of dressing and personal hygiene. In the area of Pain Management this resident was assessed as having pain within the last 5 days. This resident was assessed as having frequent pain. This resident was assessed as having pain which made it difficult to sleep at night. In the area of Pain Intensity this resident rated pain in the last 5 days as a (10) on a scale from 0 to 10. A Care Plan dated 8/6/18 indicated: Focus- The resident has c/o pain r/t history hip fracture. History of CVA, tooth fx r/t falls, UTI. Goal- The resident will verbalize adequate relief of pain or ability to cope with incompletely relieved pain	F 755	4. Medication Availability/Narcotic Audit will be conducted by the DON/ADON/UM 2x week x 4 then 1 x week. The audits will be documented and maintained in the Administrator's office. Results of the training and audits will be presented Monthly to the QAPI committee by The Administrator and/or the DON to ensure compliance is achieved and sustained.	

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GREENBRIER REGIONAL MEDICAL CENTER	1017 GEORGE WASHINGTON HIGHWAY NORTH CHESAPEAKE, VA 23323

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F 755	Continued From page 130 through the review date. Approaches/Tasks - Administer analgesia as per orders. Anticipate the resident's need for pain relief and respond immediately to any complaint of pain. Evaluate the effectiveness of pain interventions. Review for compliance, alleviation of symptoms, dosing schedules and resident satisfaction with results, impact on functional ability and impact on cognition. Monitor /document for probable cause of each pain episode. Remove/limit causes where possible. A Re-admission Summary dated 7/10/18 at 33:00 (12:33 A.M.) indicated: "Resident arrived via WC, accompanied by two unknown individuals and admitted to Rm. (number). Grocery bag w/bottles of medications left at nurses station. members of administration evaluated resident and determined, due to his poor condition and presentation, he was to be sent back out to ER for further evaluation. Transport arrived at approximately 18:35. Resident refused to go to hospital. Transport expressed that since resident is A & O X 3, he has the right to refuse." A Medication Order Summary dated 7/10/18 Indicated: "The following medications: Norco Tablet 5-325 MG (Hydrocodene Acetaminophen) give 1 tablet by mouth every 4 hours as needed for PAIN. Percocet Tablet 10-325 MG (Oxycodone-Acetaminophen) give 1 tablet by mouth every 4 hours as needed for Pain max daily amount 12 tabs. Percocet Tablet 10-325 MG (Oxycodone-Acetaminophen) give 2 tablets by mouth every 4 hours as needed for Pain Max	F 755		

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F 755	Continued From page 131 daily amount 12 tabs. A Medication Manifesto signed and dated 7/11/18 indicated: the following medications were received for Resident #57. Quantity- 30- Baclofen tab 20 mg 60- Benztropine tab 0.5 mg 30 -Citalopram tab 20 mg 40 -Cephalexin cap 500 mg 30 -Glipizide tab 5 mg 30 -Atorvastatin tab 40 mg 30 -Lisinopril tab 2.5 mg 60- Metformin tab 500 mg 30 -Clopidogrel tab 75 mg 30 -Finasteride tab 5 mg Resident #57's pain medications were not available. An Admission summary dated 1/28/19 at 22:36 (10:36 P.M.) indicated: "Resident arrived at 1743, on stretcher, able to make wants and needs known. No complaints of pain, Resident has a Foley 16 French. Foley is draining clear yellow urine. No dentures or hearing aides seen. clear lungs sound. weak left side of body. Dressing on the right upper on where PICC line was in place. Dry and intact, no bruises or marks on the body. No open areas. Resident has redness on the scrotum and on the sacrum area. Call bell within reach will continue to monitor." A Orders-Administration Note dated 1/28/19 at 22:23 (10:23 P.M.) indicated: " Pharmacy called about the residents medication and stated that the insurance paid for his medication for the month and he would not be able to send all his meds. Stated that they would send some of his medication and then when the month started over	F 755		

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F 755	Continued From page 132 they would send all the medication." During an interview on 4/16/19 at 11:15 A.M. with the Assistant Director of Nursing (ADON) she was asked if Resident #57 should have received his medications and she stated, Yes. When asked were the pain medications given to Resident #57 she stated, "No." A facility Policy on Pharmacy and Therapeutics Oversight: Policy Statement - Physicians shall help the facility monitor its use of medications and biologicals as well as the quality of its pharmacy services. Procedure: B.- Safe procurement, storage, distribution, use and disposal of drugs and biologicals. The facility staff failed to ensure pharmaceutical services were provided to acquire medications	F 755		
F 770 SS=E	Laboratory Services CFR(s): 483.50(a)(1)(i) §483.50(a) Laboratory Services. §483.50(a)(1) The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. (i) If the facility provides its own laboratory services, the services must meet the applicable requirements for laboratories specified in part 493 of this chapter. This REQUIREMENT is not met as evidenced by: Based on clinical record review, staff interviews, and review of the facility's policy the facility staff failed to meet the needs of the residents by	F 770		

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F 770	Continued From page 133 collecting specimens and obtain laboratory services for 1 of 44 residents (Resident #51), in the survey sample. The facility staff failed to obtain Resident #51's monthly complete blood count ordered 6/4/18, and the facility staff failed to obtain a complete metabolic panel, thyroid stimulating hormone, hemoglobin A1C levels, magnesium, uric acid, and a lipid profile ordered every April, August and December beginning 6/4/18. The findings included: Resident #51 was originally admitted to the facility 6/29/15 and the resident has never been discharged from the facility. The current diagnoses include; stroke with hemiparesis, renal insufficiency and anemia. The quarterly Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 2/15/19 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 13 out of a possible 15. This indicates Resident #51's cognitive abilities for daily decision making were intact. In section "G" (Physical functioning) the resident was coded as requiring supervision after set-up with off unit locomotion, dressing and eating, limited assistance of one with toileting and personal hygiene, extensive assistance of one with person with bed mobility, transfers, and bathing. A review of the April 2019, physician order summary revealed orders dated 6/4/18, for a monthly complete blood count, and complete metabolic panel, thyroid stimulating hormone, hemoglobin A1C levels, magnesium, uric acid,	F 770	F 770 Laboratory Services 1. Resident # 51 MD was notified on April 11, 2018 by the ADON of omitted labs in August 2018, September 2018, October 2018, December 2018, and March 2019 Lab orders scheduled for April 2019 were clarified by the Nurse Practitioner on 4/11/2019 and scheduled to be drawn in the Month of April 2019. 2. 100% Audits of Labs began on 4/12/2019. MD will be notified of any omissions and needs for clarifications by the DON/ADON. 3. On 5/3/2019 License nurse training began on Lab Processing/Tracking of labs. 4. Lab tracking audit will be conducted by the Unit manager/ADON 1x week x 4 weeks then 1x month. The audits will be documented and maintained in the Administrator's office Results of the training and audits will be presented Monthly to the QAPI committee by The Administrator and/or	5/31 2019

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F 770	Continued From page 134 and lipid profile ordered every April, August and December. Review of the laboratory reports revealed monthly complete blood counts were obtained 7/2018, 8/2018, 11/2018, 1/2019, 2/2019 and 4/2019, therefore monthly labs for 9/18, 10/18, 12/18 and 3/19 were not obtained. The complete metabolic panel, thyroid stimulating hormone, hemoglobin A1C levels, magnesium, uric acid, and lipid profile levels were not obtained August 2018, December 2018 or scheduled for April 2019. An interview was conducted with the Assistant Director of Nursing 4/11/19, at approximately 4:45 p.m. The Assistant Director of Nursing stated she audited the resident's clinical record and presented a list of all labs the resident had obtained since 6/4/18. The audit revealed as above, many labs were not obtained. She also stated the orders were active but some of them should have been discontinued therefore; the physician had given new orders reducing the number of labs ordered. The above findings were shared with the Administrator, Director of Nursing and the Corporate Consultant on 4/16/19 at approximately 1:40 p.m. The Director of Nursing stated the orders had been reviewed and new orders were obtained. The facility's policy titled "Lab and Diagnostic Test Results-Clinical Protocol" dated 9/2012 read; the physician will identify and order diagnostic and lab testing based on diagnostic and monitoring needs. The staff will process test requisitions. and arrange for test. The laboratory, diagnostic radiology provider, or other testing source will report test results to the facility.	F 770	the DON to ensure compliance is achieved and sustained.	

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F 810 SS=D	Assistive Devices - Eating Equipment/Utensils CFR(s): 483.60(g) §483.60(g) Assistive devices The facility must provide special eating equipment and utensils for residents who need them and appropriate assistance to ensure that the resident can use the assistive devices when consuming meals and snacks. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interviews, clinical record review, and review of the facility's policy, the facility staff failed to provide an assistive eating device to a resident who needed it to improve their ability to eat independently for 1 of 44 residents (Resident #11), in the survey sample. The facility staff failed to provide Resident #11 with the ordered Rocker knife during the midday meal on 4/11/19 and 4/12/19. The findings included: Resident #11 was originally admitted to the facility 3/12/15 and readmitted 4/12/17 after an acute care hospital stay. The current diagnoses included intellectual disability, right hemiparesis and cerebral palsy. The quarterly Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 1/14/19, coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 15 out of a possible 15. This indicated Resident #11's cognitive abilities for daily decision making are intact. In section "G" (Physical functioning) the resident was coded as requiring supervision of one person with eating,	F 810	F 810 Assistive Devices- Eating Equipment/Utensils 1. Resident # 1 Rocker Knife was placed on the meal tray card and observed in use during meals on 4/14/2019. 2. 100% audit of Resident with assistive eating devices were conducted on 4/18/2019 by the Regional Director of Clinical Operation. 3. On 4/18/2019 Training was provided to the Dietary manage by the Regional Director of Clinical operation on Tray accuracy to include Assistive meal devices and availability of the equipment at the time of meal service.	5/31 2019

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F 810	Continued From page 136 extensive assistance of one person with bed mobility, transfers, locomotion, dressing, and personal hygiene and total care with toileting, and bathing. On the 1/14/19, MDS assessment in section "P0100" (Physical Restraints), Resident #11 was coded as utilizing a limb restraint daily. Review of the April 2019, physician order summary revealed the following order dated 5/21/18: Regular diet, regular texture, Lactose intolerance. Serve 2 boiled eggs, no gravy, and Rocker knife with scoop plate related to hemiplegia affecting the right dominant side. Dysphagia, oropharyngeal phase, and other mega colon. Review of the nutrition care plan dated 7/31/18, didn't include the assistive eating devices; a Rocker knife or scoop plate. On 4/11/19 at 12:30 p.m., the resident was observed in the dining room during lunch. The resident presented with right upper extremity hemiparesis, his meal was served in a scoop plate but the Rocker knife wasn't present. The resident had a grilled cheese sandwich which required cutting but experienced difficulty because he didn't have the most appropriate assistive device. An interview was conducted with the Dietary Manager on 4/11/19 at 12:50 p.m., the Dietary Manager stated Resident #11 utilized a specialty knife at each meal and apparently it didn't come back to the kitchen from the breakfast meal but she would follow-up on it. Upon return the Dietary Manager stated she had retrieved the Rocker knife and she would consult with the Rehabilitation Department to obtain a second	F 810	4. Meal Service audit to include availability and use of adaptive equipment will be conducted 3x day x 4 weeks then weekly during random meals service times by the Dietary Manager/ DON/UM. Results of all reviews and audits will be incorporated into the Center's QAPI process to ensure compliance is achieved and sustained.	

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F 810	Continued From page 137 Rocker knife for events such as had occurred. On 4/12/19 at approximately 12:15 p.m., Resident #11 was again observed in the dining room during the lunch meal, his meal consisted of a piece of crusted fish served in a scoop plate. The Rocker knife needed to cut the fish wasn't present but a regular butter knife was included in his eating utensils. An interview was conducted with the Dietary Manager 4/12/19 at approximately 12:45 p.m. The Dietary Manager stated Resident #11's Rocker knife was cleaned after breakfast and package for use at the midday meal. The Dietary Manager spoke with the staff on duty in the dining room. She stated the staff reported the utensils all come from the kitchen package the same therefore; they are unable to determine if it is a resident specific item or general utensils. The Dietary Manager stated Resident #11's Rocker knife was located; they had been given to another resident by mistake. The Dietary Manager further stated she needed a system to identify resident specific assistive devices from the general population utensils. The above findings were shared with the Administrator, Director of Nursing and the Corporate Consultant on 4/16/19 at approximately 1:40 p.m. The facility staff provided no additional information. The facility's policy titled "Assistance with Meals" dated 7/2017 read under the heading "Residents who may benefit from assistive devices read at #1., adaptive devices (special eating equipment and utensils) will be provided for residents who need or request them, These may include	F 810		

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F 810	Continued From page 138 devices such as silverware with enlarged/padded handles, plate guards and/or specialized cups.	F 810		
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: §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;	F 880	F 880 Infection Prevention and Control 1. On 4-12-2019 Resident #79 wound was assessed for signs and symptoms of infection. Wound care was provided using clean technique and observed by the Regional Nurse Consultant. The Wound MD was notified on 4-13-2019 by the Regional Nurse Consultant. Weekly wound assessment and evaluation conducted for any signs of infection by the Wound MD. On 4-12-2019 the Treatment Cart supplies were removed. The Treatment Cart was wiped out thoroughly using a germicidal cleaner. The container of 4x4 were removed and replaced with new supplies. The Dankins solution container was thoroughly cleaned and replaced into the clean treatment cart. Clean scissors x3 pair were placed into the Treatment Cart. On 4-13-2019 LPN #2 received 1:1 retraining on Infection Control during wound care conducted by the Regional Nurse Consultant. In	

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F 880	Continued From page 139 (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 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 observation, staff interview, facility document review, and clinical record review, it was determined that facility staff failed to maintain infection control practices during wound care observation for one of 44 residents in the survey sample, Resident #79.	F 880	the laundry area on 4-10-2019 plastic bags containing the residents clothing and the towels that were leaning against the wall were removed by the Housekeeping Supervisor and the Administrator. These items were washed and dried using proper infection control technique. On 4-11-2019 Bins for cleaning clothing were provided and resident clothing were placed in the bins by the Housekeeping Supervisor. 2. All residents have the potential to be affected. 3. Infection Control Prevention training will be done with Licensed Nurses and was began on 5-3-2019 by the Regional Nurse Consultant / DON. On 5-5-2019 Infection Control training was conducted by the Director of	

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F 880	Continued From page 140 For Resident #79, facility staff failed to maintain infection control practices during wound care observation of his right heel pressure ulcer (1). (1) A pressure ulcer is an inflammation or sore on the skin over a bony prominence (e.g., shoulder blade, elbow, hip, buttocks, or heel), resulting from prolonged pressure on the area, usually from being confined to bed. Most frequently seen in elderly and immobilized persons, decubitus ulcers may be prevented by frequently change of position, early ambulation, cleanliness, and use of skin lubricants and a water or air mattress. Also called bedsores. Pressure sores. Barron ' s Dictionary of Medical Terms for the Non Medical Reader 2006; Mikel A. Rothenberg, M.D. and Charles F. Chapman. Page 155. The findings include: Resident #79 was admitted to the facility on 12/11/18 with diagnoses that included but were not limited to Pressure Ulcer of the right heel, stage 4 (2), type two diabetes mellitus, multiple sclerosis (3) and high blood pressure. Resident #79's most recent MDS (minimum data set) assessment was a quarterly assessment with an ARD (assessment reference date) of 3/18/19. Resident #79 was coded as being cognitively intact in the ability to make daily decisions scoring 13 out of 15 on the BIMS (Brief Interview for Mental Status) exam. Review of Resident #79's April 2019 Physician Order Sheet revealed the following order: "Dakins Solution Apply to right heel topically every day shift for wound care cleanse area with dakins, pat dry, and skin prep periwound area, apply dakins moisten gauze to wound bed. cover (sic) with dry	F 880	Housekeeping on Infection Control Prevention in Laundry Care. 4. Infection Control Prevention laundry audits will be conducted 3x week x4 weeks then 1x week by the Administrator or Designee. Infection Control Clean Dressing Change audit will be conducted 3x week x4 weeks then 1x week x4 weeks then monthly x3 months by the DON/ADON. The audits will be documented and maintained in the Administrator's office. Results of the training and audits will be presented Monthly to the QAPI committee by the Administrator and/ or DON 5. Completion Date 5/31/2019	

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F 880	Continued From page 141 dressing and wrap kerlix loosely." On 4/10/19 at 1:29 p.m., wound care observation with LPN (Licensed Practical Nurse) #2 was conducted. LPN #2 stated that the wound care nurse was not available that day and that she had to do wound care. LPN #2 was first observed to grab gauze from a stock package with her bare hands and then place the gauze onto a piece of paper on top of the treatment cart. The gauze was not wrapped in individual wrapping. LPN #2 was then observed running plain water over paper towels and then used these towels to wipe off Resident #79's bedside table. LPN #2 stated, "You gotta little bit of lunch here." LPN #2 donned gloves and then put dry paper towels on top of Resident #79's bedside table. LPN #2 then put supplies (house stock bottle of normal saline, house stock bottle of Dakins, and package of Kerlix on top Resident #79's bedside table. LPN #2 then took her scissors from her scrub pocket and placed them onto the table with the supplies. LPN #2 did not sanitize her scissors at this time. LPN #2 donned a new pair of gloves and removed the old dressing. This dressing was dated 4/9/18. LPN #2 then removed her gloves and washed her hands. LPN #2 donned new gloves and cleaned Resident #79's wound with normal saline and gauze pads that she had touched with her bare hands prior. Next, LPN #2 applied skin prep to the outside of the wound. LPN #2 then applied dakins to a gauze pad that she had touched with her bare hands, and placed it over the wound bed. LPN #2 then covered the gauze pad with a mepilex border. LPN #2 then wrapped Resident #79's heel in Kerlix and cut the kerlix using the unsanitized scissors. LPN #2 put the rest of the unused kerlix back in the package and placed it into her scrub pocket. The wrapper	F 880		

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	495330	A. BUILDING _____ B. WING _____	C 04/16/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREENBRIER REGIONAL MEDICAL CENTER	1017 GEORGE WASHINGTON HIGHWAY NORTH CHESAPEAKE, VA 23323

(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 880	Continued From page 142 was open in her scrub pocket. LPN #2 then washed her hands. LPN #2 then placed the house stock saline, Dakins solution and kerlix back into the treatment cart. LPN #2 did not sanitize the house stock bottles of saline and Dakins prior to putting them back into the treatment cart. LPN #2 was not observed to sanitize her scissors after wound care. On 4/11/19 at 2:55 a.m., an interview was conducted with LPN #2. When asked how to maintain infection control during wound care, LPN #2 stated that she would wash hands and wear gloves during wound care. When asked how she cleaned Resident #79's bedside table, LPN #2 stated that she used hand sanitizer from the wall on paper towels to clean his bedside table. When told LPN #2 the above observations, LPN #2 stated that she had wiped his table down again with water because some food debris was stuck on the table from lunch. When asked how she is to gather supplies, LPN #2 stated that she didn't have to wear gloves when removing gauze pads from the house stock because had washed her hands after doing her last wound (on a different resident). LPN #2 did confirm that all gauze pads were used directly on Resident #79's wound. When asked if the piece of paper that she placed all the gauze pads on top of was clean, LPN #2 stated that it was not okay to put gauze pads on a piece of paper because of infection control. When asked if the normal saline and Dakins solution used to clean Resident #79's wound was a house stock that could be used on all residents, LPN #2 confirmed that it was. When asked if it was okay to take the house stock bottles into the residents' rooms, LPN #2 stated that nurses could take house stock bottles into resident's rooms. LPN #2 stated that house stock bottles did not have to be	F 880		

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F 880	Continued From page 143 disinfected prior to placing them back into the treatment cart. LPN #2 stated only if the bottles were contaminated. When asked if it was okay to store her scissors in her scrub pocket and not sanitize them prior to use on a resident, LPN #2 stated that she usually wipes (cleans) her scissors before doing a dressing. When asked if her scrub top was clean, LPN #2 stated, "I would think it was clean." When asked what else was in her scrub top pocket with the scissors on 4/10/19, LPN #2 stated her pens. If asked if her pens were clean, LPN #2 stated, "I guess not completely clean." On 4/12/19 at 1:32 p.m., ASM (administrative staff member) #1, the administrator and ASM #4, the DON (Director of Nursing) were made aware of the above concerns. Facility policy titled, "Wound Care," documented in part, the following: "Wipe reusable supplies with alcohol wipes as indicated. (i.e. outsides of containers that were touched by unclean hands, scissor blades, etc.). Return reusable supplies to resident's drawer in treatment cart." This policy did not address the other above concerns. No further information was presented by facility staff prior to exit. (2) Stage IV: Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed. Often include undermining and tunneling. Further description: The depth of a stage IV pressure ulcer varies by anatomical location. The bridge of the nose, ear, occiput and malleolus do not have subcutaneous tissue and these ulcers can be shallow. Stage IV ulcers can	F 880		

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F 880	Continued From page 144 extend into muscle and/or supporting structures (e.g., fascia, tendon or joint capsule) making osteomyelitis possible. Exposed bone/tendon is visible or directly palpable. This information was obtained from the National Pressure Ulcer Advisory Panel website at http://www.npuap.org/pr2.htm. (3) Multiple sclerosis (MS) is a nervous system disease that affects your brain and spinal cord. It damages the myelin sheath, the material that surrounds and protects your nerve cells. This damage slows down or blocks messages between your brain and your body, leading to the symptoms of MS. This information was obtained from The National Institutes of Health. https://medlineplus.gov/multiplesclerosis.html. Based on observations, staff interviews, facility documentation review, the facility failed to ensure a sanitary environment to prevent the development and transmission of disease and infection. The facility staff failed to store the resident's clothing and failed to store resident towels in a manner to prevent the potential spread of infection. The findings included: On 04/10/19 at approximately 2:25 p.m., an observation was made of the laundry room with Laundry Assistant #1. Located in the clean area of the laundry room the following was observed: 1. Two large trash bags with the resident's socks were sitting on the floor under the folding table; the bags were open to air.	F 880		

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F 880	Continued From page 145 2. Two large trash bags with the resident's clothing were sitting on the floor next to the dryers; the bags were open to air. 3. A large stack of towels was sitting on top of a large trash bag of resident's clothing leaning up against the wall. An interview was conducted with Laundry Assistant # 1 on 04/10/19 at approximately 2:37 p.m., who stated, "I guess the resident's clothing should not be on the floor but we have a small amount of space." On the same day at approximately 4:45 p.m., another observation was made of the laundry room but with Laundry Assistant #2. The two bags of socks were observed in two hampers but the bags of clothing and towels remains unchanged. The surveyor asked, "Should the residents clothing be sitting on the floor even if they are in trash bags or the towels leaning up against the wall." She replied, "I have no idea, the residents clothing have always been placed in trash bags sitting on the floor since I started here." On 04/10/19 at approximately 4:50 p.m., an observation was made with the District Manager of Housekeeping of the laundry room. The surveyor asked, "Do you put the resident clean personal belonging (clothing) on the floor in trash bags." He stated, "Absolutely not, the residents clothing should be in a bin and covered at all times." He observed the clothing on the floor in trash bags and the towels leaning up against the wall. He stated, "The clothes and towels have to be washed again because they are now soiled." He said this could cause a major infection control problem because the germs can also fall from the ceiling and settle on the floor where the resident's	F 880		

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F 880	Continued From page 146 clothing are being stored. The resident clothes need to be off the floor and kept off the floor at all times. A briefing was conducted on 04/11/19 at approximately 4:55 p.m., with the Administrator and Interim Director of Nursing (IDON). The facility did not present any further information about the findings.	F 880		