STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495375	A. BUILDING _____ B. WING _____	04/18/2019

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EMPORIA MANOR LLC	200 WEAVER AVENUE EMPORIA, VA 23847

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E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 4/16/19 through 4/18/2019. Corrections are required for compliance with 42 CFR Part 483.73, requirements for Long Term Care Facilities.	E 000		
E 001 SS=F	Establishment of the Emergency Program (EP) CFR(s): 483.73 The [facility, except for Transplant Center] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility] must establish and maintain a comprehensive emergency preparedness program that meets the requirements of this section.* The emergency preparedness program must include, but not be limited to, the following elements: *[For hospitals at §482.15:] The hospital must comply with all applicable Federal, State, and local emergency preparedness requirements. The hospital must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach. *[For CAHs at §485.625:] The CAH must comply with all applicable Federal, State, and local emergency preparedness requirements. The CAH must develop and maintain a comprehensive emergency preparedness program, utilizing an all-hazards approach. This REQUIREMENT is not met as evidenced by: Based on staff interview and facility documentation review, the facility staff failed to comply with Emergency Preparedness	E 001	EMPORIA MANOR #2567 POC This plan of correction constitutes the facilities written allegation of compliance	5/29/19

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

Electronically Signed | 05/07/2019

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E 001	Continued From page 1 Regulations. The facility staff failed to have a written and documented Emergency Preparedness program. The findings include: On 4/16/2019 at 3:00 PM, as part of the annual Emergency Preparedness Survey, an interview was conducted with Employee A, Facility Administrator; Employee C, Administrator in Training; Employee D, Risk Manager; and Employee E, facility Maintenance Manager. They were asked to describe the facility's emergency preparedness program, and show evidence that the facility has an emergency program. Employee A, Facility Administrator stated that the facility did not have a formal written plan, but he was confident that, in the face of an emergency, he would be able to keep residents "safe". He stated that the facility did not have an emergency supply of food and water, but did have agreements with local vendors to supply these items in an emergency. When asked what they would do if roads were impassable, he stated that he would get water and food "somehow".	E 001	for the deficiencies cited. However, submission of this plan of correction is not an admission that deficiencies exist or that one was cited correctly. The plan of correction is submitted to meet requirements established by federal and state law. #E001 SS=F 1. The facility has a written/documented Emergency Preparedness program. 2. The facility has identified all residents as having the potential to be affected by this deficient practice. 3. Emergency Preparedness manuals have been placed on each nursing unit, all staff has been educated on the plan. Administrator and emergency preparedness team educated by Regional Administrator. The food supply has been separated and designated for the Emergency 3-day supply of food, and the required water supply is maintained at the facility. Risk Manager will provide training to new hires and will present a quarterly review of the plan to all staff. Dietary manager will include an inventory of the water and the 3-day emergency food supply in her weekly sanitation inspection. Dietician will monitor water/food supply monthly. 4. The Risk Manager/designee and the dietician will report audits findings to the QAPI committee to assure that facility remains in compliance.	

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E 004 SS=F	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 maintain an emergency preparedness plan that must be [evaluated], and updated at least annually. This REQUIREMENT is not met as evidenced by: Based on staff interview and facility documentation review, the facility staff failed to comply with Emergency Preparedness Regulations. The facility staff failed to have a written and	E 004	#E004 1. The facility has a written/documented Emergency Preparedness program that has been implemented and will be reviewed and updated annually to assure compliance.	5/29/19

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E 004	Continued From page 3 documented Emergency Preparedness program and that it was reviewed and updated annually. The findings include: On 4/16/2019 at 3:00 PM, as part of the annual Emergency Preparedness Survey, an interview was conducted with Employee A, Facility Administrator; Employee C, Administrator in Training; Employee D, Risk Manager; and Employee E, facility Maintenance Manager. They were asked to describe the facility's emergency preparedness program, and show evidence that the facility has an emergency program. Employee A, Facility Administrator stated that the facility did not have a formal written plan, but he was confident that, in the face of an emergency, he would be able to keep residents "safe".	E 004	2. The facility has identified all residents as having the potential to be affected by this deficient practice. 3. Emergency Preparedness manuals have been placed on each nursing unit, all staff has been educated on the plan. Risk Manager will provide training to new hires and will present a quarterly review of the plan to all staff at the mandatory inservice. An annual review and update will be scheduled to assure compliance. 4. The Risk Manager/designee will report education dates to new hires and all staff to the QAPI committee to assure that facility remains in compliance.	
E 006 SS=F	Plan Based on All Hazards Risk Assessment CFR(s): 483.73(a)(1)-(2) [(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:] (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach.* *[For LTC facilities at §483.73(a)(1):] (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing residents. *[For ICF/IIDs at §483.475(a)(1):] (1) Be based on and include a documented, facility-based and	E 006		5/29/19

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E 006	Continued From page 4 community-based risk assessment, utilizing an all-hazards approach, including missing clients. (2) Include strategies for addressing emergency events identified by the risk assessment. * [For Hospices at §418.113(a)(2):] (2) Include strategies for addressing emergency events identified by the risk assessment, including the management of the consequences of power failures, natural disasters, and other emergencies that would affect the hospice's ability to provide care. This REQUIREMENT is not met as evidenced by: Based on staff interview and facility documentation review, the facility staff failed to comply with Emergency Preparedness Regulations. The facility staff failed to have a written and documented Emergency Preparedness program based on a risk-assessment using an all-hazards approach specific to the geographic location of the facility. The findings include: On 4/16/2019 at 3:00 PM, as part of the annual Emergency Preparedness Survey, an interview was conducted with Employee A, Facility Administrator; Employee C, Administrator in Training; Employee D, Risk Manager; and Employee E, facility Maintenance Manager. They were asked to describe the facility's emergency preparedness program, and show evidence that the facility has an emergency program. Employee A, Facility Administrator stated that the	E 006	#E006 1. The facility has a written/documented Emergency Preparedness program that is based on a risk-assessment using an all-hazards approach specific to the geographic location of the facility and is in compliance with the plan. 2. The facility has identified all residents as having the potential to be affected by this deficient practice. 3. Emergency Preparedness manuals have been placed on each nursing unit, all staff has been educated on the plan. Risk Manager will provide training to new hires and will present a quarterly review of the plan to all staff 4. The Risk Manager/designee will report new hire and staff education dates to the QAPI committee to assure that facility remains in compliance.	

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E 006	Continued From page 5 facility did not have a formal written plan, but he was confident that, in the face of an emergency, he would be able to keep residents "safe".	E 006		
E 007 SS=C	EP Program Patient Population CFR(s): 483.73(a)(3) [(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do the following:] (3) Address patient/client population, including, but not limited to, persons at-risk; the type of services the [facility] has the ability to provide in an emergency; and continuity of operations, including delegations of authority and succession plans.** *Note: ["Persons at risk" does not apply to: ASC, hospice, PACE, HHA, CORF, CMCH, RHC, FQHC, or ESRD facilities.] This REQUIREMENT is not met as evidenced by: Based on staff interview and facility documentation review, the facility staff failed to comply with Emergency Preparedness Regulations. The facility staff failed to have a written and documented Emergency Preparedness program based on resident population that would be at risk during an emergency event. The findings include: On 4/16/2019 at 3:00 PM, as part of the annual Emergency Preparedness Survey, an interview was conducted with Employee A, Facility	E 007	#E007 1. The facility has a written/documented Emergency Preparedness program that is based on a risk-assessment using an all-hazards approach specific to the geographic location of the facility as well as the population that would be at risk during an emergency event, and is in compliance with the plan. 2. The facility has identified all residents as being at risk and having the potential to be affected by this deficient practice. 3. Emergency Preparedness manuals	5/29/19

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E 007	Continued From page 6 Administrator; Employee C, Administrator in Training; Employee D, Risk Manager; and Employee E, facility Maintenance Manager. They were asked to describe the facility's emergency preparedness program, and show evidence that the facility has an emergency program. Employee A, Facility Administrator stated that the facility did not have a formal written plan, but he was confident that, in the face of an emergency, he would be able to keep residents "safe".	E 007	have been placed on each nursing unit, all staff has been educated on the plan. Risk Manager will provide training to new hires and will present a quarterly review of the plan to all staff 4. The Risk Manager/designee will report events, action and education updates to the QAPI committee to assure that facility remains in compliance.	
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	E 009		5/29/19

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E 009	Continued From page 7 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 staff interview and facility documentation review, the facility staff failed to comply with Emergency Preparedness Regulations. The facility staff failed to have a written and documented Emergency Preparedness program that documented the facility's efforts to contact Emergency officials and, when applicable, its participation in collaborative and cooperative planning efforts. The findings include: On 4/16/2019 at 3:00 PM, as part of the annual Emergency Preparedness Survey, an interview was conducted with Employee A, Facility Administrator; Employee C, Administrator in Training; Employee D, Risk Manager; and Employee E, facility Maintenance Manager. They were asked to describe the facility's emergency preparedness program, and show evidence that the facility has an emergency program. Employee A, Facility Administrator stated that the facility did not have a formal written plan, but he was confident that, in the face of an emergency, he would be able to keep residents "safe".	E 009	#E009 1. The facility has a written/documented Emergency Preparedness program that is based on a risk-assessment using all-hazards approach specific to the geographic location of the facility and is in compliance with the plan. The facility has documented efforts to contact Emergency officials and is participating in collaborative and cooperative planning efforts when applicable. 2. The facility has identified all residents as having the potential to be affected by this deficient practice. 3. Emergency Preparedness manuals have been placed on each nursing unit, all staff has been educated on the plan. Risk Manager will provide training to new hires and will present a quarterly review of the plan to all staff 4. The Risk Manager/designee will report any meetings or collaborative and cooperative planning efforts as they occur to the QAPI committee to assure that facility remains in compliance.	
E 013 SS=C	Development of EP Policies and Procedures CFR(s): 483.73(b)	E 013		5/29/19

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E 013	Continued From page 8 (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: *[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	E 013		

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E 013	Continued From page 9 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 staff interview and facility documentation review, the facility staff failed to comply with Emergency Preparedness Regulations. The facility staff failed to have a written and documented Emergency Preparedness program and that the policies and procedures were developed based on the facility- and community-based risk assessment and communication plan, utilizing an all-hazards approach. The findings include: On 4/16/2019 at 3:00 PM, as part of the annual Emergency Preparedness Survey, an interview was conducted with Employee A, Facility Administrator; Employee C, Administrator in Training; Employee D, Risk Manager; and Employee E, facility Maintenance Manager. They were asked to describe the facility's emergency preparedness program, and show evidence that the facility has an emergency program. Employee A, Facility Administrator stated that the facility did not have a formal written plan, but he was confident that, in the face of an emergency, he would be able to keep residents "safe".	E 013	#E013 1. The facility has an Emergency Preparedness program. The facility has policies and procedures that were developed based on the facility and community based risk-assessment, and on the communication plan utilizing an all-hazards approach that is specific to the geographic location of the facility. 2. The facility has identified all residents as having the potential to be affected by this deficient practice. 3. Emergency Preparedness manuals have been placed on each nursing unit, all staff has been educated on the plan. Risk Manager will provide training to new hires and will present a quarterly review of the plan to all staff 4. The Risk Manager/designee will report on her education to new hires and all staff to the QAPI committee to assure that facility remains in compliance.	
E 015 SS=C	Subsistence Needs for Staff and Patients CFR(s): 483.73(b)(1)	E 015		5/29/19

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E 015	Continued From page 10	E 015		

[(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
(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

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E 015	Continued From page 11 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 staff interview and facility documentation review, the facility staff failed to comply with Emergency Preparedness Regulations. The facility staff failed to have a written and documented Emergency Preparedness program and that the emergency plan includes policies and procedures for the provision of subsistence needs including, but not limited to, food, water and pharmaceutical supplies for patients and staff. The findings include: On 4/16/2019 at 3:00 PM, as part of the annual Emergency Preparedness Survey, an interview was conducted with Employee A, Facility Administrator; Employee C, Administrator in Training; Employee D, Risk Manager; and Employee E, facility Maintenance Manager. They were asked to describe the facility's emergency preparedness program, and show evidence that the facility has an emergency program. Employee A, Facility Administrator stated that the facility did not have a formal written plan, but he	E 015	#E015 1. The facility has an Emergency Preparedness program. The program has policies and procedures for the provision of subsistence needs including but not limited to food, water and pharmaceutical supplies for patients and staff. 2. The facility has identified all residents as having the potential to be affected by this deficient practice. 3. Emergency Preparedness manuals have been placed on each nursing unit, all staff has been educated on the plan. Risk Manager will provide training to new hires and will present a quarterly review of the plan to all staff. Dietary manager will include an inventory of the water and the 3-day emergency food supply in her weekly inspection and the dietician will monitor the water/food supply monthly and include in her monthly report 4. The Dietary manager/designee will report her weekly audit findings and the	

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E 015	Continued From page 12 was confident that, in the face of an emergency, he would be able to keep residents "safe".	E 015	results of the dietician□s monthly audit to the QAPI committee to assure that facility remains in compliance.	
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 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	E 018		5/29/19

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	495375	A. BUILDING _____ B. WING _____	04/18/2019

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EMPORIA MANOR LLC	200 WEAVER AVENUE EMPORIA, VA 23847

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E 018	Continued From page 13 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. *[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 staff interview and facility documentation review, the facility staff failed to comply with Emergency Preparedness	E 018	#E018 1. The facility has an Emergency Preparedness program. The program has	

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E 018	Continued From page 14 Regulations. The facility staff failed to have a written and documented Emergency Preparedness program that used a tracking system to document locations of patients and staff is part of the facilities' emergency plan policies and procedures. The findings include: On 4/16/2019 at 3:00 PM, as part of the annual Emergency Preparedness Survey, an interview was conducted with Employee A, Facility Administrator; Employee C, Administrator in Training; Employee D, Risk Manager; and Employee E, facility Maintenance Manager. They were asked to describe the facility's emergency preparedness program, and show evidence that the facility has an emergency program. Employee A, Facility Administrator stated that the facility did not have a formal written plan, but he was confident that, in the face of an emergency, he would be able to keep residents "safe".	E 018	a tracking system to document locations of patients and staff as a part of the policies and procedures. This includes a current face sheet file located in the Risk Manager□s office to assure efficient, current tracking of residents/staff. 2. The facility has identified all residents as having the potential to be affected by this deficient practice. 3. Emergency Preparedness manuals have been placed on each nursing unit, all staff has been educated on the plan. Risk Manager will provide training to new hires and will present a quarterly review of the plan to all staff, and will maintain current facesheets for each resident at all times for emergency readiness. 4. The Risk Manager will review her new hire and staff education as well as her update of the face sheet file at the quarterly QAPI meeting to assure that facility remains in compliance.	
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	E 020		5/29/19

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E 020	Continued From page 15 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 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 staff interview and facility	E 020	#E020	

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E 020	Continued From page 16 documentation review, the facility staff failed to comply with Emergency Preparedness Regulations. The facility staff failed to have a written and documented Emergency Preparedness program and that the plan included policies and procedures for safe evacuation from the facility including all of the required elements. The findings include: On 4/16/2019 at 3:00 PM, as part of the annual Emergency Preparedness Survey, an interview was conducted with Employee A, Facility Administrator; Employee C, Administrator in Training; Employee D, Risk Manager; and Employee E, facility Maintenance Manager. They were asked to describe the facility's emergency preparedness program, and show evidence that the facility has an emergency program. Employee A, Facility Administrator stated that the facility did not have a formal written plan, but he was confident that, in the face of an emergency, he would be able to keep residents "safe".	E 020	1. The facility has an Emergency Preparedness program. The program includes policies and procedures for safe evacuation from the facility including all of the required elements of the process.. 2. The facility has identified all residents as having the potential to be affected by this deficient practice. 3. Emergency Preparedness manuals have been placed on each nursing unit, all staff has been educated on the plan. Risk Manager will provide training to new hires and will present a quarterly review of the plan to all staff, and will maintain current facesheets for each resident at all times for emergency readiness. 4. The Risk Manager will review her new hire and staff education as well as her update of the face sheet file at the quarterly QAPI meeting to assure that facility remains in compliance.	
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	E 022		5/29/19

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E 022	Continued From page 17 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 staff interview and facility documentation review, the facility staff failed to comply with Emergency Preparedness Regulations. The facility staff failed to have a written policy and documentation of an emergency preparedness program that will provide a means to shelter in place for patients, staff and volunteers who remain in a facility and that the policies and procedures for sheltering in place are aligned with the facility's emergency plan and risk assessment. The findings include: On 4/16/2019 at 3:00 PM, as part of the annual Emergency Preparedness Survey, an interview was conducted with Employee A, Facility Administrator; Employee C, Administrator in Training; Employee D, Risk Manager; and	E 022	#E022 1. The facility has an Emergency Preparedness program. The program includes policies and procedures for sheltering in place for patients, staff and volunteers who remain in the facility. 2. The facility has identified all residents as having the potential to be affected by this deficient practice. 3. Emergency Preparedness manuals have been placed on each nursing unit, all staff has been educated on the plan. Risk Manager will provide training to new hires and will present a quarterly review of the plan to all staff, and will maintain current facesheets for each resident at all times for emergency readiness.	

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E 022	Continued From page 18 Employee E, facility Maintenance Manager. They were asked to describe the facility's emergency preparedness program, and show evidence that the facility has an emergency program. Employee A, Facility Administrator stated that the facility did not have a formal written plan, but he was confident that, in the face of an emergency, he would be able to keep residents "safe".	E 022	4. The Risk Manager will review her new hire and staff education as well as her update of the face sheet file at the quarterly QAPI meeting to assure that facility remains in compliance.	
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. *[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	E 023		5/29/19

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E 023	Continued From page 19 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 staff interview and facility documentation review, the facility staff failed to comply with Emergency Preparedness Regulations. The facility staff failed to have a written policy and documentation of an emergency preparedness program and that the policies and procedures the facility has developed preserves patient information, protects confidentiality of patient information, and secures and maintains availability of records. The findings include: On 4/16/2019 at 3:00 PM, as part of the annual Emergency Preparedness Survey, an interview was conducted with Employee A, Facility Administrator; Employee C, Administrator in Training; Employee D, Risk Manager; and Employee E, facility Maintenance Manager. They were asked to describe the facility's emergency preparedness program, and show evidence that the facility has an emergency program. Employee A, Facility Administrator stated that the facility did not have a formal written plan, but he was confident that, in the face of an emergency, he would be able to keep residents "safe".	E 023	#E023 1. The facility has an Emergency Preparedness program. The program includes policies and procedures that preserves patient information, protects confidentiality of patient information and secures and maintains availability or records. 2. The facility has identified all residents as having the potential to be affected by this deficient practice. 3. Emergency Preparedness manuals have been placed on each nursing unit, all staff has been educated on the plan. Risk Manager will provide training to new hires and will present a quarterly review of the plan to all staff, and will maintain current facesheets for each resident at all times for emergency readiness. 4. The Risk Manager will review her new hire and staff education as well as her update of the face sheet file at the quarterly QAPI meeting to assure that facility remains in compliance.	

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E 024 SS=C	Policies/Procedures-Volunteers and Staffing CFR(s): 483.73(b)(6) [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. At a minimum, the policies and procedures must address the following:] (6) [or (4), (5), or (7) as noted above] The use of volunteers in an emergency or other emergency staffing strategies, including the process and role for integration of State and Federally designated health care professionals to address surge needs during an emergency. *[For RNHCIs at §403.748(b):] Policies and procedures. (6) The use of volunteers in an emergency and other emergency staffing strategies to address surge needs during an emergency. *[For Hospice at §418.113(b):] Policies and procedures. (4) The use of hospice employees in an emergency and other emergency staffing strategies, including the process and role for integration of State and Federally designated health care professionals to address surge needs during an emergency. This REQUIREMENT is not met as evidenced by: Based on staff interview and facility documentation review, the facility staff failed to comply with Emergency Preparedness Regulations.	E 024	#E024 1. The facility has an Emergency Preparedness program. The program includes appropriate policies for the use	5/29/19

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E 024	Continued From page 21 The facility staff failed to have a written policy and documentation of an emergency preparedness program and that the policies and procedures for the use of volunteers and other staffing strategies are in the emergency plan. The findings include: On 4/16/2019 at 3:00 PM, as part of the annual Emergency Preparedness Survey, an interview was conducted with Employee A, Facility Administrator; Employee C, Administrator in Training; Employee D, Risk Manager; and Employee E, facility Maintenance Manager. They were asked to describe the facility's emergency preparedness program, and show evidence that the facility has an emergency program. Employee A, Facility Administrator stated that the facility did not have a formal written plan, but he was confident that, in the face of an emergency, he would be able to keep residents "safe".	E 024	of volunteers or other staffing strategies that may be necessary in the emergency event. 2. The facility has identified all residents as having the potential to be affected by this deficient practice. 3. Emergency Preparedness manuals have been placed on each nursing unit, all staff has been educated on the plan. Risk Manager will provide training to new hires and will present a quarterly review of the plan to all staff, and will maintain current facesheets for each resident at all times for emergency readiness. Administrator will update agreements as company/position changes occur. 4. Administrator will inform QAPI committee meeting if any new staffing strategies are added to the plan to assure that facility remains in compliance.	
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:]	E 025		5/29/19

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E 025	Continued From page 22 *[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):] 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 staff interview and facility documentation review, the facility staff failed to comply with Emergency Preparedness Regulations. The facility staff failed to have a written policy and documentation of an emergency preparedness program and that the plan has arrangements and/or any agreements the facility has with other facilities to receive patients in the event the facility	E 025	#E025 1. The facility has an Emergency Preparedness program. The program includes agreements the facility has with other facilities to receive patients in the event the facility is not able to care for them during an emergency. 2. The facility has identified all residents as having the potential to be affected by	

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E 025	Continued From page 23 is not able to care for them during an emergency. The findings include: On 4/16/2019 at 3:00 PM, as part of the annual Emergency Preparedness Survey, an interview was conducted with Employee A, Facility Administrator; Employee C, Administrator in Training; Employee D, Risk Manager; and Employee E, facility Maintenance Manager. They were asked to describe the facility's emergency preparedness program, and show evidence that the facility has an emergency program. Employee A, Facility Administrator stated that the facility did not have a formal written plan, but he was confident that, in the face of an emergency, he would be able to keep residents "safe".	E 025	this deficient practice. 3. Emergency Preparedness manuals have been placed on each nursing unit, all staff has been educated on the plan. Risk Manager will provide training to new hires and will present a quarterly review of the plan to all staff, and will maintain current facesheets for each resident at all times for emergency readiness. Administrator will update agreements as company/position changes occur. 4. Administrator will inform QAPI committee meeting of any transfer agreement changes that occur to assure that facility remains in compliance.	
E 026 SS=C	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	E 026		5/29/19

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E 026	Continued From page 24 officials. *[For RNHCIs at §403.748(b):] Policies and procedures. (8) The role of the RNHCI under a waiver declared by the Secretary, in accordance with section 1135 of Act, in the provision of care at an alternative care site identified by emergency management officials. This REQUIREMENT is not met as evidenced by: Based on staff interview and facility documentation review, the facility staff failed to comply with Emergency Preparedness Regulations. The facility staff failed to have a written policy and documentation of an emergency preparedness program and that the policies and procedures in the emergency plan describe the facility's role in providing care and treatment at alternate care sites under an 1135 waiver. The findings include: On 4/16/2019 at 3:00 PM, as part of the annual Emergency Preparedness Survey, an interview was conducted with Employee A, Facility Administrator; Employee C, Administrator in Training; Employee D, Risk Manager; and Employee E, facility Maintenance Manager. They were asked to describe the facility's emergency preparedness program, and show evidence that the facility has an emergency program. Employee A, Facility Administrator stated that the facility did not have a formal written plan, but he was confident that, in the face of an emergency, he would be able to keep residents "safe".	E 026	#E026 1. The facility has an Emergency Preparedness program. The program includes a policy for providing care and treatment at alternate care sites under a 1135 waiver. 2. The facility has identified all residents as having the potential to be affected by this deficient practice. 3. Emergency Preparedness manuals have been placed on each nursing unit, all staff has been educated on the plan. Risk Manager will provide training to new hires and will present a quarterly review of the plan to all staff. 4. Administrator will inform QAPI committee of any changes in alternate care sites under a 1135 waiver to assure that facility remains in compliance.	

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	495375	A. BUILDING _____ B. WING _____	04/18/2019

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E 029	Continued From page 25	E 029		
E 029 SS=F	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 staff interview and facility documentation review, the facility staff failed to comply with Emergency Preparedness Regulations. The facility staff failed to have a written policy and documentation of an emergency preparedness program and that the program included a written communication plan and that the communication plan has been reviewed (and updated as necessary) on an annual basis. The findings include: On 4/16/2019 at 3:00 PM, as part of the annual Emergency Preparedness Survey, an interview was conducted with Employee A, Facility Administrator; Employee C, Administrator in Training; Employee D, Risk Manager; and Employee E, facility Maintenance Manager. They were asked to describe the facility's emergency preparedness program, and show evidence that the facility has an emergency program. Employee A, Facility Administrator stated that the facility did not have a formal written plan, but he was confident that, in the face of an emergency, he would be able to keep residents "safe".	E 029	E029 1. The facility has an Emergency Preparedness program. The program includes a written communication plan that has been reviewed by the committee and scheduled for an annual review. 2. The facility has identified all residents as having the potential to be affected by this deficient practice. 3. Emergency Preparedness manuals have been placed on each nursing unit, all staff has been educated on the plan. Risk Manager will provide training to new hires and will present a quarterly review of the plan to all staff. 4. Risk Manager will inform QAPI committee of any changes in the communication should they occur between annual reviews to assure that facility remains in compliance.	5/29/19

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E 030	Continued From page 26	E 030		
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 following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians. (iv) Volunteers.	E 030		5/29/19

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E 030	Continued From page 27 *[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 staff interview and facility documentation review, the facility staff failed to comply with Emergency Preparedness Regulations. The facility staff failed to have a written policy and documentation of an emergency preparedness program and that all required facility contacts are	E 030	#E030 1. The facility has an Emergency Preparedness program. The program includes a written communication plan that includes all of the required facility contacts and has been reviewed by the committee and scheduled for an annual review.	

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E 030	Continued From page 28 included in the communication plan. The findings include: On 4/16/2019 at 3:00 PM, as part of the annual Emergency Preparedness Survey, an interview was conducted with Employee A, Facility Administrator; Employee C, Administrator in Training; Employee D, Risk Manager; and Employee E, facility Maintenance Manager. They were asked to describe the facility's emergency preparedness program, and show evidence that the facility has an emergency program. Employee A, Facility Administrator stated that the facility did not have a formal written plan, but he was confident that, in the face of an emergency, he would be able to keep residents "safe".	E 030	2. The facility has identified all residents as having the potential to be affected by this deficient practice. 3. Emergency Preparedness manuals have been placed on each nursing unit, all staff has been educated on the plan. Risk Manager will provide training to new hires and will present a quarterly review of the plan to all staff. 4. Risk Manager will inform QAPI committee of any changes in the communication should they occur between annual reviews to assure that facility remains in compliance.	
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.	E 031		5/29/19

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E 031	Continued From page 29 (iii) The Office of the State Long-Term Care Ombudsman. (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 staff interview and facility documentation review, the facility staff failed to comply with Emergency Preparedness Regulations. The facility staff failed to have a written policy and documentation of an emergency preparedness program and that all required Emergency Officials contacts are included in the communication plan. The findings include: On 4/16/2019 at 3:00 PM, as part of the annual Emergency Preparedness Survey, an interview was conducted with Employee A, Facility Administrator; Employee C, Administrator in Training; Employee D, Risk Manager; and Employee E, facility Maintenance Manager. They were asked to describe the facility's emergency preparedness program, and show evidence that the facility has an emergency program. Employee A, Facility Administrator stated that the facility did not have a formal written plan, but he was confident that, in the face of an emergency, he would be able to keep residents "safe".	E 031	#E031 1. The facility has an Emergency Preparedness program. The program includes a written communication plan that includes all of the required facility contacts as well as all of the required Emergency Officials contact information and has been reviewed by the committee and scheduled for an annual review. 2. The facility has identified all residents as having the potential to be affected by this deficient practice. 3. Emergency Preparedness manuals have been placed on each nursing unit, all staff has been educated on the plan. Risk Manager will provide training to new hires and will present a quarterly review of the plan to all staff. 4. Risk Manager will inform QAPI committee of any changes in the communication should they occur between annual reviews to assure that	

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E 031	Continued From page 30	E 031	facility remains in compliance.	
E 032 SS=C	Primary/Alternate Means for Communication CFR(s): 483.73(c)(3) [(c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least annually.] The communication plan must include all of the following: (3) Primary and alternate means for communicating with the following: (i) [Facility] staff. (ii) Federal, State, tribal, regional, and local emergency management agencies. *[For ICF/IIDs at §483.475(c):] (3) Primary and alternate means for communicating with the ICF/IID's staff, Federal, State, tribal, regional, and local emergency management agencies. This REQUIREMENT is not met as evidenced by: Based on staff interview and facility documentation review, the facility staff failed to comply with Emergency Preparedness Regulations. The facility staff failed to have a written policy and documentation of an emergency preparedness program and that the communication plan includes primary and alternate means for communicating with facility staff, Federal, State, tribal, regional and local emergency management agencies. The findings include:	E 032	#E032 1. The facility has an Emergency Preparedness program. The program includes primary and alternate means of communicating with facility staff, Federal, State, tribal regional and local emergency management agencies. 2. The facility has identified all residents as having the potential to be affected by this deficient practice. 3. Emergency Preparedness manuals have been placed on each nursing unit, all staff has been educated on the plan.	5/29/19

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E 032	Continued From page 31 On 4/16/2019 at 3:00 PM, as part of the annual Emergency Preparedness Survey, an interview was conducted with Employee A, Facility Administrator; Employee C, Administrator in Training; Employee D, Risk Manager; and Employee E, facility Maintenance Manager. They were asked to describe the facility's emergency preparedness program, and show evidence that the facility has an emergency program. Employee A, Facility Administrator stated that the facility did not have a formal written plan, but he was confident that, in the face of an emergency, he would be able to keep residents "safe".	E 032	Risk Manager will provide training to new hires and will present a quarterly review of the plan to all staff. 4. Risk Manager will inform QAPI committee of any changes in the plan should they occur between annual reviews to assure that facility remains in compliance.	
E 033 SS=C	Methods for Sharing Information CFR(s): 483.73(c)(4)-(6) [(c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least annually.] The communication plan must include all of the following: (4) A method for sharing information and medical documentation for patients under the [facility's] care, as necessary, with other health providers to maintain the continuity of care. (5) A means, in the event of an evacuation, to release patient information as permitted under 45 CFR 164.510(b)(1)(ii). [This provision is not required for HHAs under §484.102(c), CORFs under §485.68(c), and RHCs/FQHCs under §491.12(c).] (6) [(4) or (5)]A means of providing information about the general condition and location of	E 033		5/29/19

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E 033	Continued From page 32 patients under the [facility's] care as permitted under 45 CFR 164.510(b)(4). *[For RNHCIs at §403.748(c):] (4) A method for sharing information and care documentation for patients under the RNHCI's care, as necessary, with care providers to maintain the continuity of care, based on the written election statement made by the patient or his or her legal representative. *[For RHCs/FQHCs at §491.12(c):] (4) A means of providing information about the general condition and location of patients under the facility's care as permitted under 45 CFR 164.510(b)(4). This REQUIREMENT is not met as evidenced by: Based on staff interview and facility documentation review, the facility staff failed to comply with Emergency Preparedness Regulations. The facility staff failed to have a written policy and documentation of an emergency preparedness program and that the communication plan includes 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 by reviewing the communication plan and that the facility has developed policies and procedures that address the means the facility will use to release patient information to include the general condition and location of patients, by reviewing the communication plan. The findings include:	E 033	#E033 1. The facility has an Emergency Preparedness program. The program includes 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. The facility has developed policies and procedures that address the means the facility will use to release patient information to include the general condition and location of patients by reviewing the communication plan. 2. The facility has identified all residents as having the potential to be affected by this deficient practice. 3. Emergency Preparedness manuals have been placed on each nursing unit, all staff has been educated on the plan.	

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E 033	Continued From page 33 On 4/16/2019 at 3:00 PM, as part of the annual Emergency Preparedness Survey, an interview was conducted with Employee A, Facility Administrator; Employee C, Administrator in Training; Employee D, Risk Manager; and Employee E, facility Maintenance Manager. They were asked to describe the facility's emergency preparedness program, and show evidence that the facility has an emergency program. Employee A, Facility Administrator stated that the facility did not have a formal written plan, but he was confident that, in the face of an emergency, he would be able to keep residents "safe".	E 033	Risk Manager will provide training to new hires and will present a quarterly review of the plan to all staff. 4. Risk Manager will inform QAPI committee of any changes in the plan should they occur between annual reviews to assure that facility remains in compliance.	
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 Center, or designee. *[For Inpatient Hospice at §418.113:] (7) A means of providing information about the hospice's	E 034		5/29/19

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E 034	Continued From page 34 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 staff interview and facility documentation review, the facility staff failed to comply with Emergency Preparedness Regulations. The facility staff failed to have a written policy and documentation of an emergency preparedness program and that the communication plan includes a means of providing information about the facility's needs, and its ability to provide assistance, to the authority having jurisdiction, the Incident Command Center, or designee by reviewing the communication plan and that the communication plan includes a means of providing information about their occupancy. The findings include: On 4/16/2019 at 3:00 PM, as part of the annual Emergency Preparedness Survey, an interview was conducted with Employee A, Facility Administrator; Employee C, Administrator in Training; Employee D, Risk Manager; and Employee E, facility Maintenance Manager. They were asked to describe the facility's emergency preparedness program, and show evidence that the facility has an emergency program. Employee A, Facility Administrator stated that the facility did not have a formal written plan, but he was confident that, in the face of an emergency, he would be able to keep residents "safe".	E 034	#E034 1. The facility has an Emergency Preparedness program. The program includes a means of providing information about the facility□s needs and its ability to provide assistance to the authority having jurisdiction, the incident Command Center, or designee by reviewing the communication plan. This includes a means of providing information about their occupancy. 2. The facility has identified all residents as having the potential to be affected by this deficient practice. 3. Emergency Preparedness manuals have been placed on each nursing unit, all staff has been educated on the plan. Risk Manager will provide training to new hires and will present a quarterly review of the plan to all staff. 4. Risk Manager will inform QAPI committee of any changes in the plan should they occur between annual reviews to assure that facility remains in compliance.	

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E 035	Continued From page 35	E 035		
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 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 staff interview and facility documentation review, the facility staff failed to comply with Emergency Preparedness Regulations. The facility staff failed to have a written policy and documentation of an emergency preparedness program and that the communication plan includes a method for sharing information from the emergency plan, and that the facility has determined it is appropriate with residents or clients and their families or representatives by reviewing the plan. The findings include: On 4/16/2019 at 3:00 PM, as part of the annual Emergency Preparedness Survey, an interview was conducted with Employee A, Facility Administrator; Employee C, Administrator in Training; Employee D, Risk Manager; and Employee E, facility Maintenance Manager. They were asked to describe the facility's emergency	E 035	#E035 1. The facility has an Emergency Preparedness program communication plan that includes a method for sharing information from the emergency plan, and that the facility has determined it is appropriate with residents or clients and their families or represenatatives by reviewing the plan. 2. The facility has identified all residents as having the potential to be affected by this deficient practice. 3. Emergency Preparedness manuals have been placed on each nursing unit, all staff has been educated on the plan. Risk Manager will provide training to new hires and will present a quarterly review of the plan to all staff. 4. Risk Manager will inform QAPI	5/29/19

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E 035	Continued From page 36 preparedness program, and show evidence that the facility has an emergency program. Employee A, Facility Administrator stated that the facility did not have a formal written plan, but he was confident that, in the face of an emergency, he would be able to keep residents "safe".	E 035	committee of any changes in the plan should they occur between annual reviews to assure that facility remains in compliance.	
E 036 SS=F	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 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	E 036		5/29/19

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E 036	Continued From page 37 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 staff interview and facility documentation review, the facility staff failed to comply with Emergency Preparedness Regulations. The facility staff failed to have a written policy and documentation of an emergency preparedness program that the program has a written training and testing program. The findings include: On 4/16/2019 at 3:00 PM, as part of the annual Emergency Preparedness Survey, an interview was conducted with Employee A, Facility Administrator; Employee C, Administrator in Training; Employee D, Risk Manager; and Employee E, facility Maintenance Manager. They were asked to describe the facility's emergency preparedness program, and show evidence that the facility has an emergency program. Employee A, Facility Administrator stated that the facility did not have a formal written plan, but he was confident that, in the face of an emergency, he would be able to keep residents "safe".	E 036	#E036 1. The facility has an Emergency Preparedness plan has a written testing and training program. 2. The facility has identified all residents as having the potential to be affected by this deficient practice. 3. Emergency Preparedness manuals have been placed on each nursing unit, all staff has been educated on the plan. Risk Manager will provide training to new hires and will present a quarterly review of the plan to all staff. 4. Risk Manager will inform QAPI committee of any changes in the plan should they occur between annual reviews to assure that facility remains in compliance.	
E 037	EP Training Program	E 037		5/29/19

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E 037 SS=C	Continued From page 38 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. (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	E 037		

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E 037	Continued From page 39	E 037		

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 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.

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E 037	Continued From page 40 *[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 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.	E 037		

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E 037	Continued From page 41 *[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 staff interview and facility documentation review, the facility staff failed to comply with Emergency Preparedness Regulations. The facility staff failed to have a written policy and documentation of an emergency preparedness program and that the facility had initial emergency preparedness training and annual emergency preparedness training. The findings include: On 4/16/2019 at 3:00 PM, as part of the annual Emergency Preparedness Survey, an interview was conducted with Employee A, Facility Administrator; Employee C, Administrator in Training; Employee D, Risk Manager; and Employee E, facility Maintenance Manager. They were asked to describe the facility's emergency preparedness program, and show evidence that the facility has an emergency program. Employee A, Facility Administrator stated that the facility did not have a formal written plan, but he	E 037	#E037 1. The facility has an Emergency Preparedness plan that provides the signatures of attendance for the the initial emergency preparedness training as well as a calendar scheduled annual review, update and training each year. 2. The facility has identified all residents as having the potential to be affected by this deficient practice. 3. Emergency Preparedness manuals have been placed on each nursing unit, all staff has been educated on the plan. Risk Manager will provide training to new hires and will present a quarterly review of the plan to all staff. 4. Risk Manager will inform QAPI committee of any changes in the plan should they occur between annual reviews to assure that facility remains in compliance.	

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E 037	Continued From page 42 was confident that, in the face of an emergency, he would be able to keep residents "safe".	E 037		
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.	E 039		5/29/19

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E 039	Continued From page 43 (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed. *[For RNHCIs at §403.748 and OPOs at §486.360] (d)(2) Testing. The [RNHCI and OPO] must conduct exercises to test the emergency plan. The [RNHCI and OPO] must do the following: (i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group discussion led by a facilitator, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (ii) Analyze the [RNHCI's and OPO's] response to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCI's and OPO's] emergency plan, as needed. This REQUIREMENT is not met as evidenced by: Based on staff interview and facility documentation review, the facility staff failed to comply with Emergency Preparedness Regulations. The facility staff failed to have a written policy and documentation of an emergency preparedness program and that the facility had a annual tabletop and full scale exercise. The findings include: On 4/16/2019 at 3:00 PM, as part of the annual Emergency Preparedness Survey, an interview was conducted with Employee A, Facility	E 039	#E039 1. The facility has an Emergency Preparedness plan includes the annual tabletop and full scale exercise. 2. The facility has identified all residents as having the potential to be affected by this deficient practice. 3. Emergency Preparedness manuals have been placed on each nursing unit, all staff has been educated on the plan. Risk Manager will provide training to new hires and will present a quarterly review of	

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E 039	Continued From page 44 Administrator; Employee C, Administrator in Training; Employee D, Risk Manager; and Employee E, facility Maintenance Manager. They were asked to describe the facility's emergency preparedness program, and show evidence that the facility has an emergency program. Employee A, Facility Administrator stated that the facility did not have a formal written plan, but he was confident that, in the face of an emergency, he would be able to keep residents "safe".	E 039	the plan to all staff. 4. Risk Manager will inform QAPI committee of any changes in the plan should they occur between annual reviews to assure that facility remains in compliance.	
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	E 041		5/29/19

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E 041	Continued From page 45 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) 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.	E 041		

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E 041	Continued From page 46 (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. (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 staff interview and facility documentation review, the facility staff failed to comply with Emergency Preparedness Regulations. The facility staff failed to have a written policy and documentation of an emergency preparedness program and that this program: 1) has the required emergency and standby power systems to meet the requirements of the facility's emergency plan and corresponding policies and procedures;	E 041	#E041 1. The facility has an Emergency Preparedness that has: 1)the required emergency and standby power systems to meet the requirements of the facility□s emergency plan and corresponding policies and procedures 2) emergency power systems or plans in place to maintain safe operations while sheltering in place 3)maintains an onsite fuel source in accordance with NFPA 110 for their	

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E 041	Continued From page 47 2) has emergency power systems or plans in place to maintain safe operations while sheltering in place; 3) maintains an onsite fuel source in accordance with NFPA 110 for their generator; 4) has a plan for how to keep the generator operational during an emergency, unless the facility plans to evacuate. The findings include: On 4/16/2019 at 3:00 PM, as part of the annual Emergency Preparedness Survey, an interview was conducted with Employee A, Facility Administrator; Employee C, Administrator in Training; Employee D, Risk Manager; and Employee E, facility Maintenance Manager. They were asked to describe the facility's emergency preparedness program, and show evidence that the facility has an emergency program. Employee A, Facility Administrator stated that the facility did not have a formal written plan, but he was confident that, in the face of an emergency, he would be able to keep residents "safe".	E 041	generator 4)has a plan for how to keep the generator operational during an emergency, unless the facility plans to evacuate 2. The facility has identified all residents as having the potential to be affected by this deficient practice. 3. Emergency Preparedness manuals have been placed on each nursing unit, all staff has been educated on the plan. Risk Manager will provide training to new hires and will present a quarterly review of the plan to all staff. 4. Risk Manager will inform QAPI committee of any changes in the plan should they occur between annual reviews to assure that facility remains in compliance.	
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 4-15-19 through 4-18-19. Significant corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. No complaints were investigated during the survey. The census in this 120 certified bed facility was 83 at the time of the survey. The survey sample consisted of 35 Resident reviews.	F 000		

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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 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	F 582		5/29/19

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	495375	A. BUILDING _____ B. WING _____	04/18/2019

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F 582	Continued From page 49 deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility documentation review, facility staff failed to complete an Advanced Beneficiary Notice (ABN) for one (Residents # 60) of 3 sampled residents. 1. For Resident # 60, the facility staff did not complete an Advanced Beneficiary Notice (ABN) timely. The findings included: 1. For Resident # 60, the facility staff did not complete an Advanced Beneficiary Notice (ABN) timely. Resident # 60 was chosen from a list of residents discharged in the previous 6 months. On 4/17/2019 at 9:00 AM, the Business Office Manager was asked for a copy of the Advance Beneficiary Notice for Resident # 60. The Business Office Manager presented a form that she stated was the ABN.	F 582	F 582 SS=D Medicaid/Medicare coverage/Liability Notice CFR(s): 483.10 (g)(17)(18)(i)-(v) With regard to the alleged deficient practice, the facility has taken the following action: 1. Corrective actions(s) accomplished for those residents found to have been affected by the alleged deficient practice. The NOMNC for resident #60 was not sent timely. Resident came off skilled care 3/19/19. The NOMNC was sent certified mail on 3/18/19 and received 3/22/19, which did not allow time for an immediate appeal. The Business Office Manager did speak with Resident #60 POA on 3/22/19 per telephone, POA did confirm that she had received the NOMNC and did not wish to	

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F 582	Continued From page 50 The reviewed form showed Form CMS-10123 NOMNC (Notice of Medicare Non-Coverage) form was not signed by the resident or the authorized representative. The form had information documented in the "additional information" section that stated "Your record shows the services you need no longer meet Medicare guidelines to be given in a skilled nursing facility (SNF). The guidelines require that you need daily nursing or daily therapy. On March 18th, at 9:00 a.m., 10:27 a.m., 11:05 a.m., 11:37 a.m., and again at 12:47p.m._____(Responsible Party) was called numerous times and could not leave a message because due to her mail box being full. A certified letter was sent. ___(Resident # 60) will be coming off skilled care effective March 19, 2019 and March 20th, 2019 being his first (NF) day. This is the number to....call no later than noon on the day before the effective date indicated above. Effective March 20th, 2019 he would be responsible for his Medicaid patient liability." (sic) A copy of the certified letter receipt was reviewed with a date of 3/18/2019. The letter was sent to Colorado and would not have been received prior to the end of Medicare coverage for services on the next day, 3/19/2019. The date of the letter did not allow time for an immediate appeal of "no later than noon of the day before the effective date indicated above" as listed on the NOMNC form. An interview was conducted with the Business Office Manager on 04/17/19 at 02:10 PM. The Business Office Manager (Employee K) stated that she sent the certified letter because she could not contact the responsible party via the telephone. Employee K stated she normally sent	F 582	initiate an appeal. 2. Identify other residents who have the potential to be affected by the same deficient practice and what corrective action was taken. The facility has identified all residents that had changes in coverage covered by Medicare in the last (30) days, to ensure timely advanced notice. Those without appropriate advance notification were called to ensure appeal is not requested 3. Measures/systemic changes put in place to ensure this deficient practice does not reoccur: Business Office Manager has been in-serviced by the Regional Accounts Receivable Director on Form CMS-10123, NOMNC (Notice of Medicare Non-Coverage). Beneficiary Liability Notice process. Business Office Manager will attend daily (M-F) PPS (Perspective Payment System) meeting in addition to MDS coordinator, Therapy Director and Social Services director for review of services provided and any anticipated change in Medicare Coverage. Medicare tracking form has been developed that will be reviewed daily in PPS meeting, this will allow tracking of covered services, any upcoming change in Medicare coverage and will allow for timely notice of Medicare Non-coverage to resident or the authorized representative. (Form CMS-10123)	

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F 582	Continued From page 51 a certified letter "a day or two before the benefits end" as proof that the family was notified. Employee K stated she thought she was doing the ABN notifications correctly. Employee K was informed that the facility did not allow time for the resident or responsible party to appeal. During the end of day debriefing on 4/17/2019, the Director of Nursing and Administrator in training (Employee C)were informed of the findings. The facility staff did not present any further information regarding the findings.	F 582	4. Monitoring of corrective action to ensure the deficient practice does not reoccur: Accounts Payable director will audit all residents with change in Medicare covered services weekly for (3) months to assure timely notification is provided to the resident or authorized representative of Medicare Non-Coverage. (Form CMS-10123) Reports of the findings from the audits will be reported by the Accounts Payable director to the QAPI meeting for review until thresholds are met. Any trends or patterns identified will be addressed and corrective action plan revised if applicable.	
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk.	F 584		5/29/19

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F 584	Continued From page 52 (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and facility documentation review, the facility staff failed to provide a clean environment for one resident (Resident #81) in a sample size of 35 residents. The bathroom in Resident #81's room had mold on the floor, had a strong odor of mold and urine, and the hot water handle on Resident #81's room sink was loose. The findings included: Resident #81, an 80-year old male, was admitted	F 584	F 584 SS=D Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10 (i)(1)-(7) With regard to the alleged deficient practice, the facility has taken the following action: 1. Corrective actions(s) accomplished for those residents found to have been affected by the alleged deficient practice.	

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F 584	Continued From page 53 to the facility on 09/10/2013. Diagnoses included but not limited to dementia without behavioral disturbance, hypertension, and dysphasia. Resident #81's most recent Minimum Data Set with an Assessment Reference Date of 03/19/2019 was coded as a quarterly review. Cognitive skills for daily decision-making was coded as severely impaired. Toileting and personal hygiene were coded as total dependence on staff. On 04/16/2019 at approximately 9:55 AM, a survey of Resident #81's room was conducted. Upon opening the bathroom door, there was a strong odor of mold and urine detected. There was urine in the toilet (not flushed). The bathroom had linoleum flooring and no urine spillage on the floor was observed. There was a black mold stain around the base of the toilet on the linoleum and it extended out approximately 10 inches on the right front aspect of the commode. It was also observed the hot water handle for Resident #81's room sink was loose. The mounting hardware was unsecured and the hole and pipe under the handle could be seen. On 04/16/2019 at approximately 10:20 AM, an interview with an employee from the maintenance department, Employee E, was conducted. When asked about the process for identifying maintenance needs, Employee E stated he makes daily rounds. He also stated that when other staff see a problem, they will submit a work order. While standing in front of Resident #81's room, Employee E was asked what projects he currently had for this unit, he did not list any issues associated with Resident #81's room or bathroom.	F 584	On 5/1/19 Housekeeping Director provided deep cleaning to resident #81 bathroom, removing mold from the floor and removing the smell of urine and mold. Resident #81 was placed on a toileting schedule. Housekeeping department will increase surveillance/cleaning as needed of resident #81 bathroom to three times a day. Maintenance Director is receiving quotes on resident #81 bathroom floor replacement. On 4/16/19 director of maintenance tightened the hot water handle on resident #81 room sink. 2. Identify other residents who have the potential to be affected by the same deficient practice and what corrective action was taken. The facility has identified all resident rooms have the potential to be affected by non-compliant measures to provide a Safe/Clean/Comfortable/ Homelike Environment. Maintenance department conducted rounds on all resident rooms to inspect for any sinks with loose handles, completed 5/3/19. Any areas of concern were repaired upon identification. Housekeeping Director conducted rounds on all resident rooms/bathrooms for any visual signs of mold/offensive odors. Any	

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F 584	Continued From page 54 On 04/16/2019 at approximately 11:10 AM, this surveyor and Employee E entered Resident #81's room. When asked about the loose hot water handle, Employee E wiggled the handle and stated it is difficult to maintain because "they are rough with it." Upon opening Resident #81's bathroom door, there was a strong odor of mold and urine. When asked about the odors in Resident #81's bathroom, Employee E agreed that "it smells in here." Employee E stated that staff is "supposed to mop this floor every day." When asked if he was aware of the mold on the floor, he stated, "Yes." He also stated, "This is a problem because [Resident #81] urinates on the floor." When asked if there were plans for improvement, Employee E stated, "I will be replacing the floor" and added, "But he {Resident #81] will continue to urinate on it (the floor)." When asked what has been done so far in making repairs, Employee E stated he was looking at pricing. A copy of work orders and documentation associated with Resident #81's bathroom and sink repairs was requested. On 04/16/2019 at approximately 5:30 PM, Employee E verified there were no work orders or documentation associated with the loose sink handle or the mold on the bathroom floor in Resident #81's room. On 04/17/2019 at approximately 4:45 PM, the DON was notified of findings and offered no further information or documentation.	F 584	areas of concern addressed with deep cleaning. Rounds were completed on 5/3/19. 3. Measures/systemic changes put in place to ensure this deficient practice does not reoccur: Measures to provide a safe/clean/comfortable/homelike environment have been added to the daily guardian angel round visit tool; specifically Does room have any offensive odors? Are there any signs of mold? Any loose handles on sinks? Guardian angel round results will be reviewed during morning Interdisciplinary team meeting. Areas of concern will be assigned by the Nursing Home Administrator with timely follow-up for resolution. A staff in-service was completed regarding completion of maintenance work orders. 4. Monitoring of corrective action to ensure the deficient practice does not reoccur: Guardian Angel Round tools will be reviewed/audited by Risk Manager daily. Reports of the findings from the audits will be reported by the Risk Manager to the QAPI meeting for review until thresholds are met. Any trends or patterns identified will be addressed and corrective action revised if applicable.	
F 623	Notice Requirements Before Transfer/Discharge	F 623		5/29/19

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F 623 SS=D	Continued From page 55 CFR(s): 483.15(c)(3)-(6)(8)	F 623		

§483.15(c)(3) Notice before transfer.
Before a facility transfers or discharges a resident, the facility must-
(i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman.
(ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and
(iii) Include in the notice the items described in paragraph (c)(5) of this section.

§483.15(c)(4) Timing of the notice.
(i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the 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,

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F 623	Continued From page 56	F 623		

under paragraph (c)(1)(i)(A) of this section; or
(E) A resident has not resided in the facility for 30 days.

§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:
(i) The reason for transfer or discharge;
(ii) The effective date of transfer or discharge;
(iii) The location to which the resident is transferred or discharged;
(iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;
(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;
(vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and 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.

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F 623	Continued From page 57 §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review, and facility documentation review, the facility staff failed for one resident (Resident #72), in the survey sample of 35 residents, to notify the Ombudsman of a hospital transfer. The facility staff failed to notify the Ombudsman that Resident #72 had been transferred to the hospital. The Findings included: Resident #72 was a 79 year old who was admitted to the facility on 3/16/17. Resident #72's diagnoses included Type 2 Diabetes Mellitus, Congestive Heart Failure, Rheumatoid Arthritis and Hemiplegia. The Minimum Data Set, which was a Quarterly Assessment with an Assessment Reference Date	F 623	F 623 SS=D Notice Requirements Before Transfer/Discharge CFR(s): 483.15 (c)(3)-(6)(8) With regard to the alleged deficient practice, the facility has taken the following action: 1. Corrective actions(s) accomplished for those residents found to have been affected by the alleged deficient practice. Social Services Director notified state ombudsman 5/1/2019 of facility initiated transfer of resident #72 on 4/4/2019. 2. Identify other residents who have the potential to be affected by the same	

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F 623	Continued From page 58 of 3/22/19 was reviewed. It coded Resident #72 as having a Brief Interview of Mental Status Score of 15, indicating that there was no cognitive impairment. On 4/17/19 a review was conducted of Resident #72's clinical record. The Nurse's note read, "4/5/19. 11:25 (AM). Resident was sent to ER (Emergency Room) on previous day for evaluation of rash spreading on left upper leg. Resident returned AMA (Against Medical Advice) from hospital. Rash has spread from left leg to posterior left upper arm. Resident has no c/o (complaints of) pain, discomfort, and is A-febrile." On 4/17/19 at 1:30 PM, an interview was conducted with the Director of Nursing (DON-Employee B) The DON stated that the Ombudsman had not been notified. The DON was unable to explain why the Ombudsman had not been notified of the transfer. No further information was received.	F 623	deficient practice and what corrective action was taken. The facility has identified all facility initiated resident transfers/discharges as having the potential to be affected by this deficient practice. Social Services director reviewed all facility-initiated transfers/discharges for the past (90) days to assure ombudsman notification of the transfer/discharge. Ombudsman was notified of any omissions that were identified during review. 3. Measures/systemic changes put in place to ensure this deficient practice does not reoccur: Social Services Director has been in-serviced per the regional quality assurance nurse regarding ombudsman notification of any facility initiated resident transfer/discharge; Transfer/Discharge Notice Policy. Training was completed on 5/1/19. Social Services Director now has a Transfer/Discharge Notice log that will be reviewed daily against the electronic tracking of discharges. All facility initiated resident transfers/discharges will be listed on the log and it will be sent to the ombudsman daily. (M-F). 4. Monitoring of corrective action to	

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F 623	Continued From page 59	F 623	ensure the deficient practice does not reoccur: Risk Manager will audit all facility- initiated transfer/discharges x (90) days to assure ombudsman notification occurred. Reports of the findings from the audits will be reported by the Risk Manager to the QAPI meeting for review until thresholds are met. Any trends or patterns identified will be addressed and corrective action plan revised if applicable.	
F 644 SS=D	Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2) §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility documentation	F 644	F 644	5/29/19

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F 644	Continued From page 60 and clinical record review the facility failed to ensure that a Level II PASARR (Pre Admission Screening And Resident Review) was performed prior to admission for 1 Resident (# 45) in a survey sample of 35 Residents. For Resident #45, the facility staff failed to obtain a PASARR prior to admission. The findings included; Resident #45 an 84 year old man admitted to the facility on 6/15/10 with diagnosis of but not limited to unspecified psychosis not due to a substance or known physiological condition, altered mental status, Major depressive disorder, Psychotic and behavioral factors associated with disorder classified elsewhere, Parkinsonism, and Osteoarthritis. On 4/17/19 during clinical record review it was noted that Resident #45 had a PASARR Level One that stated: 1. Does the individual meet nursing facility criteria? YES 2. Does the individual have a current serious mental illness (MD)? YES a. Is this major mental disorder diagnosable under DSM IV (e.g. Schizophrenia, mood, paranoid panic or other serious anxiety disorder somatoform disorder, personality disorder, other psychotic disorder that may lead to chronic disability? YES b. Has this disorder resulted in functional limitations in major life activities within the past	F 644	SS=D Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2) With regard to the alleged deficient practice, the facility has taken the following action: 1) Resident #45 Preadmission Screening and Resident Review (PASARR) for Level II evaluation requested on 4/24/19. 2) All residents currently admitted are at risk. An audit of current residents was completed for Level II PASARR. No additional residents were identified. 3) Education provided to the social service director and administrator of PASARR training for Virginia Providers of requirement of Level II screen prior to admission and policy for PASARR screening process to be completed prior to admission for acceptance to facility. New PASARR request form was developed to notify discharging facility of PASARR copy of Level II evaluation for admission to facility. New hires for social services will be trained on the preadmission screening process for Virginia PASRR for providers. The social service director or license nurse will review new admits during the standard clinical meeting for completion and address identified services in the plan of care. The Admission director or License nurse will complete a weekly audit of residents of new admits for PASARR no less than 3 months.	

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F 644	Continued From page 61 3-6 months? YES c. Does the treatment history indicate that the individual has experienced psychiatric treatment more intensive than outpatient care more than once in the past two years or the individual has experienced within the last two years a significant disruption to the normal living situation due to the mental illness? Yes On 4/17/19 at 2:45 PM, during an interview with the DON she stated that Resident #45 didn't need a Level II because he has dementia. Upon closer look into resident diagnosis list, Resident #45 was not diagnosed with Dementia until a year after admission to the facility. At the time of admission the Resident had primary diagnosis of mental illness along with Parkinsonism. On 4/18/19 at 12:15 PM during the end of day meeting the Administrator was made aware of the issues and no further information was provided.	F 644	4) Social Service Director will present the findings of the audit to the Quality Assurance Performance Improvement committee monthly for their review and recommendation if deemed necessary. The findings will be reported to the committee until the committee is satisfied sustainable compliance has been achieved.	
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following -	F 656		5/29/19

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F 656	Continued From page 62 (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observations, resident interviews, staff interviews, clinical record review, and facility documentation, the facility staff failed to develop comprehensive, resident-centered care plan for 2 residents (Resident #14, Resident #81) in a sample size of 35 residents. 1. For Resident #14, the facility staff failed to	F 656	F 656 SS=D Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) With regard to the alleged deficient practice, the facility has taken the following action:	

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F 656	Continued From page 63 develop and implement an Activities program. 2. For Resident #81, the facility staff failed to develop a plan of care for a skin wound on his left upper forearm. The findings included: 1. For Resident #14, the facility staff failed to develop and implement an Activities program. Resident #14, a 62-year old male, was admitted to the facility on 10/09/2018. Diagnoses included but not limited to unspecified dementia without behavioral disturbance and gastroesophageal reflux disease. Resident #14's most recent Minimum Data Set with an Assessment Reference Date of 01/15/2019 was coded as a quarterly review. The Brief Interview for Mental Status was coded as 7 out of a possible 15 indicative of severe cognitive impairment. Toileting, dressing, and personal hygiene were coded as total dependence on staff. On 04/16/2019 at approximately 8:40 AM, Resident #14 was observed sleeping in his bed with the head of the bed elevated approximately 45 degrees. Resident #14 was wearing a white, short-sleeved t-shirt and covered with a blanket from the waist down. On 04/16/2019 at approximately 3:15 PM, Resident #14 was observed sleeping in his bed with the head of the bed elevated approximately 45 degrees. Resident #14 was wearing a white, short-sleeved t-shirt and covered with a blanket from the waist down.	F 656	1) ¿ Resident #14□s activity care plan was developed by the activity director of individualize patient-centered activities of his preferences and choices that are important to him. ¿ Resident # 81 care plan was developed of the skin impairment. 2) All residents who are dependent on staff for ADL□s and activities of interest have the potential to be affected by the practice and care plans will be developed or reviewed/updated following the minimum data set (MDS) calendar. Completed skin audit on all current residents, care plans updated for skin impairment identified. 3) Education provided by certified resident care coordinator to the activity director of development of person-centered care plan includes measurable objectives and timeframes for all residents to be completed using the activity assessment form that includes preferences, past hobbies and choices of former lifestyle will be utilize to complete a person-centered plan of care. Participation will be recorded and on participation record and reviewed per the activity director per the MDS calendar. Education provided to the interdisciplinary team of developing plan of care per the resident assessment instrument (RAI) guidelines and during the clinical review of change in condition of residents. Will complete a weekly audit of care plan development per MDS calendar no less than 3 months by the MDS coordinator or License Nurse.	

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F 656	Continued From page 64 On 04/16/2019, Resident #14's care plan was reviewed. A problem onset dated 10/19/2018 documented, "Potential for feeling of sadness and despair associated with current medical conditions." An intervention for this problem dated 01/16/2019 documented, "Resident is up in the w/c (wheelchair) daily, likes to sit in the dayroom watching TV." There was not a specific focus or measurable goals for Activities. On 04/17/2019 at approximately 9:00 AM, Resident #14 was observed sleeping in his bed with the head of the bed elevated approximately 60 degrees. Resident #14 was wearing a white, short-sleeved t-shirt and covered with a blanket from the waist down. On 04/17/2019 at 10:10 AM, an interview with Employee I was conducted. When asked what activities Resident #14 enjoys, Employee I stated [Resident #14] likes to watch westerns on TV. Employee I also stated that Resident #14 will attend group activities such as Bingo and church. When asked how frequently Resident #14 attends group activities, Employee I stated, "I don't know, maybe 4 to 5 times a week." When asked for a copy of activity attendance for Resident #14, Employee I stated she does not document resident attendance. When asked how she tracks activity attendance, she stated, "I don't know; I just know the residents." When asked if she would expect to see activities addressed on the care plan, she stated, "Yes." Employee I looked for activities on Resident #14's care plan and stated, "Activities aren't on the care plan but they should be." On 04/17/2019 at 12:35 PM, Employee I provided	F 656	4) The MDS Coordinator will present the findings of the audit to the Quality Assurance Performance Improvement committee monthly for their review and recommendation if deemed necessary. The findings will be reported to the committee until the committee is satisfied sustainable compliance has been achieved.	

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F 656	Continued From page 65	F 656		

a copy of an Activities care plan and stated, "This was developed today." The problem onset dated 04/17/2019 documented, "[Resident #14] participates in activities of his choice." The goal associated with this problem documented, "[Resident #14] will participate in at least 3-4 activities a week of his choice." Interventions listed documented, " [Resident #14] likes to watch Westerns on TV; [Resident #14] likes to play games like bingo, horse race, etc but needs assistance; [Resident #14]likes to go outside when the weather is nice; [Resident #14] enjoys visits with his family; [Resident #14] likes to listen to music; [Resident #14] needs assistance getting to and from activities."

On 04/17/2019 at approximately 4:45 PM, the DON was notified of findings and offered no further information or documentation.

2. For Resident #81, the facility staff failed to develop a plan of care for a skin wound on his left upper forearm.

Resident #81, an 80-year old male, was admitted to the facility on 09/10/2013. Diagnoses included but not limited to dementia without behavioral disturbance, hypertension, and dysphasia.

Resident #81's most recent Minimum Data Set with an Assessment Reference Date of 03/19/2019 was coded as a quarterly review. Cognitive skills for daily decision-making was coded as severely impaired. Toileting and personal hygiene were coded as total dependence on staff.

On 04/16/2019 at 9:55 AM, Resident #81 was

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observed laying in his bed sleeping with the head of the bed elevated approximately 45 degrees. Resident #81 had a scab on his left upper forearm approximately the size of a quarter. The edges around the scab were reddened.

On 04/16/2019 at approximately 5:10 PM, an interview with Resident #81's nurse, LPN A, was conducted. When asked about the skin wound on Resident #81's left forearm, LPN A stated she was not aware of a skin wound on his left forearm. This surveyor and LPN A approached Resident #81 to examine Resident #81's left forearm. LPN A was asked to describe the skin wound and stated it was "scabbed", "no drainage", "red around the edges", "not new." At that time, RN A came over and looked at the wound and stated she would look in the chart to find out more about it. After looking through the chart, RN A stated there was no documentation in the chart about it. When asked what the process is when a skin wound is discovered, RN A stated it would be assessed, the MD (doctor) would be notified, the supervisor would be notified, an incident report would be written, the wound care nurse would be notified, and an order for antibiotic ointment would be written.

On 04/16/2019, the clinical record was reviewed. There were no physician's orders for treatments of left forearm skin wound. There were no nurse's notes addressing the skin wound. The skin assessments for March 2019 and April 2019 did not address the skin wound to left forearm. The care plan did not address the skin wound to left forearm.

On 04/17/2019 at approximately 4:45 PM, the DON was notified of findings and offered no

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F 656	Continued From page 67 further information or documentation	F 656		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility documentation review and clinical record review the facility staff failed to review and revise the careplan for three residents (Resident #22, Resident #43, and Resident #81) in a survey sample of 35 residents.	F 657	F 657 SS=D Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii)	5/29/19

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F 657	Continued From page 68 1. For Resident #22, the facility staff failed to review and revise the careplan to include the physician ordered, pureed diet with nectar thick liquids. 2. For Resident #43, the facility staff failed to review and revise the careplan to include the physician ordered palm guards. 3 For Resident #81, the facility staff failed to revise the care plan on the status of an anti-anxiety medication. The findings included: 1. For Resident #22, the facility staff failed to review and revise the careplan to include the physician ordered, pureed diet with nectar thick liquids. Resident #22, was originally admitted to the facility on 6/28/12, with a most recent readmission on 2/15/18. Diagnoses for Resident #22 included but were not limited to: unspecified psychosis, unspecified intellectual disabilities, difficulty in walking, type 2 diabetes, gastro-esophageal reflux disease, hypertension, anxiety, and unspecified convulsions. Resident #22's most recent MDS (minimum data set) (an assessment tool) with an ARD (assessment reference date) of 1/23/19, was coded as a significant change assessment. Resident #22 was coded as having a BIMS (brief interview for mental status) score of 6, which indicated severe cognitive impairment. Resident #22 was coded as being total care, dependent upon one staff member for assistance with	F 657	With regard to the alleged deficient practice, the facility has taken the following action: 1) " Resident #22 nutritional care plan was reviewed and updated to include the physician ordered of pureed diet with nectar thick liquids. " Resident #43 care plan updated to reflect the current order related to the palm guard. " Resident #81 care plan was updated with the current antianxiety classification of medication. 2) All residents are at risk for the same practice. Current residents with altered diet audited to include the current physician order, identified residents care plan will be updated to reflect the current physician order. Current residents with adaptive devices will be audited for care plan intervention, residents identified will have care plan updated with current physician order. Current residents on psychotropic medications care plans reviewed for current physician orders, no other residents identified. 3) Education provided to the interdisciplinary team by certified resident care coordinator of responsibility of development of the plan of care within 7 days of a comprehensive assessment and after each assessment, including both comprehensive and quarterly with resident centered care approaches. Changes to resident□s treatment plan will be reviewed during the clinical meeting and care plans updated by the IDT to reflect	

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F 657	Continued From page 69 transfers, dressing, eating, personal hygiene and bathing. Review of Resident #22's careplan with a handwritten update, dated 2/13/19 read: "mech. soft ground meat diet, thin liquids." Review of Resident #22's physician order sheet for the month of April 2019, read: "PUREE DIET, NECTAR THICK LIQUIDS", date signed by physician on 4/3/19. Review of Resident #22's speech therapy recertification and updated plan of treatment for certification period of: 3/28/19-4/26/19 revealed the following: Current status 3/28/19 "patient continues to improve toward goal attainment as noted by progress to date; diet modification from mechanical soft/ground meats and thin liquids to puree and nectar thick liquids with following results: increased oral transit, poor mastication with decreased coordination of lingual and mandibular muscular strength and endurance; slow bolus formation, control and propulsion with delayed swallow initiation time ~3-15 seconds with delayed laryngeal elevation and increased signs and symptoms of penetration, mostly at end of meal due ?? to fatigue; patient does like to talk and eat with poor attention to task and need to re-direct back to task; not at maximum potential for skilled speech therapy at this time; will continue current goal." An interview was conducted with CNA C on 4/17/19 at 9:16am. CNA C stated that Resident #22 "is on thickened liquids." Review of the facility policy titled "Using the Care Plan" with a revision date of August 2006 read,	F 657	the changes. MDS staff member or license nurse will audit weekly timely care plan revision of plan care per the Rai guidelines no less than 3 months. 4) The MDS Coordinator will present the audit findings to the Quality Assurance Performance Improvement committee monthly for their review and recommendation if deemed necessary. The findings will be reported to the committee until the committee is satisfied sustainable compliance has been achieved.	

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"The care plan shall be used in developing the resident's daily care routines and will be available to staff personnel who have responsibility for providing care or services to the resident."

The facility Administrator, DON and ADON were made aware of staff's failure to review and revise the careplan for Resident #22 on 4/17/19 during an end of day meeting.

No further information was provided.

2. For Resident #43, the facility staff failed to review and revise the careplan to include the physician ordered palm guards.

Resident #43, was originally admitted to the facility on 9/22/08, with a most recent readmission on 4/24/09. Diagnoses for Resident #43 included but were not limited to: age related osteoporosis, glaucoma, dementia, pick's disease and unspecified kidney failure.

Resident #43's most recent MDS (minimum data set) (an assessment tool) with an ARD (assessment reference date) of 2/22/19 was coded as a quarterly assessment. Resident #43 was coded as having severe cognitive impairment based on a staff assessment, a BIMS (brief interview for mental status) was not able to be conducted. Resident #43 was coded as being total care, dependent upon one staff member, for assistance with dressing, eating, personal hygiene and bathing.

Review of Resident #43's careplan revealed no updates or revisions to include the order for palm guards to both hands.

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Review of the physician's orders revealed an order written 3/20/19 that read, "patient to wear bilateral palm guards q (every) d (day) except skin checks q shift and hygiene. Doff (remove) q h.s. (bed time). Patient to wear as tolerated,. Monitor for s/sx (signs and symptoms) skin breakdown." Review of Physician Orders for the month of April 2019, it read; "bilateral palm guards 8 + hours."

Review of the facility policy titled "Using the Care Plan" with a revision date of August 2006 read, "The care plan shall be used in developing the resident's daily care routines and will be available to staff personnel who have responsibility for providing care or services to the resident."

The facility Administrator, DON, and ADON were made aware of the findings on 4/18/19 of facility staff's failure to review and revise the careplan for Resident #43 to include the physician ordered palm guards. .

No further information was provided.

3. For Resident #81, the facility staff failed to revise the care plan on the status of an anti-anxiety medication.

Resident #81, an 80-year old male, was admitted to the facility on 09/10/2013. Diagnoses included but not limited to dementia without behavioral disturbance, hypertension, anxiety, and dysphasia.

Resident #81's most recent Minimum Data Set

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F 657	Continued From page 72 with an Assessment Reference Date of 03/19/2019 was coded as a quarterly review. Cognitive skills for daily decision-making was coded as severely impaired. Toileting and personal hygiene were coded as total dependence on staff. On 04/16/2019, the care plan was reviewed. A problem onset dated 03/13/2019 documented, "[Resident #81] receives Ativan for anxiety prn (as needed). He is at risk for side effects from antianxiety medication use. Risk for falls. Targeted behavior anxiousness." The goal associated with this problem documented, "[Resident #81] will have no injury related to medication usage/side effects through next review." An intervention dated 04/08/2019 documented, "Meds are given as ordered." The active physician's orders were reviewed. An entry dated 03/25/2019 documented, "Alprazolam (Xanax, an anti-anxiety medication) 0.25 mg tablet po (by mouth) QD (every day). Ativan was not listed on active orders. An order for Ativan prn (as needed) was discontinued on 03/01/2018. On 04/17/2019 at 2:10 PM, the DON was asked about the care plan entry for prn Ativan. The DON stated, "No one is on Ativan prn." When asked if she would expect the care plan to be revised when there is a change in medications, she stated, "Yes." On 04/17/2019 at approximately 4:45 PM, the DON was notified of findings and offered no further information or documentation.	F 657		
F 679 SS=D	Activities Meet Interest/Needs Each Resident CFR(s): 483.24(c)(1)	F 679		5/29/19

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F 679	Continued From page 73 §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, clinical record review, and facility documentation, the facility staff failed to plan and implement Activities for one resident (Resident #14) out of a sample size of 35 residents. The findings included: Resident #14, a 62-year old male, was admitted to the facility on 10/09/2018. Diagnoses included but not limited to unspecified dementia without behavioral disturbance and gastroesophageal reflux disease. Resident #14's most recent Minimum Data Set with an Assessment Reference Date of 01/15/2019 was coded as a quarterly review. The Brief Interview for Mental Status was coded as 7 out of a possible 15 indicative of severe cognitive impairment. Toileting, dressing, and personal hygiene were coded as total dependence on staff. On 04/16/2019 at approximately 8:40 AM, Resident #14 was observed sleeping in his bed with the head of the bed elevated approximately	F 679	F 679 SS=D Activities Meet Interest/Needs Each Resident CFR(s): 483.24 (c)(1) With regard to the alleged deficient practice, the facility has taken the following action: 1. Corrective actions(s) accomplished for those residents found to have been affected by the alleged deficient practice. Activities assessment was completed on resident #14 per the Activities Director. The individualized care plan was updated to address resident #14 choice of activities, personal preferences and areas of interest to him. The Certified Nursing Assistant Kardex was also updated to include resident #14 activity preferences. 2. Identify other residents who have the	

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F 679	Continued From page 74 45 degrees. Resident #14 was wearing a white, short-sleeved t-shirt and covered with a blanket from the waist down. On 04/16/2019 at approximately 3:15 PM, Resident #14 was observed sleeping in his bed with the head of the bed elevated approximately 45 degrees. Resident #14 was wearing a white, short-sleeved t-shirt and covered with a blanket from the waist down. On 04/16/2019, Resident #14's care plan was reviewed. A problem onset dated 10/19/2018 documented, "Potential for feeling of sadness and despair associated with current medical conditions." An intervention for this problem dated 01/16/2019 documented, "Resident is up in the w/c (wheelchair) daily, likes to sit in the dayroom watching TV." There was not a specific focus or measurable goals for Activities. On 04/17/2019 at approximately 9:00 AM, Resident #14 was observed sleeping in his bed with the head of the bed elevated approximately 60 degrees. Resident #14 was wearing a white, short-sleeved t-shirt and covered with a blanket from the waist down. On 04/17/2019 at 10:10 AM, an interview with Employee I was conducted. When asked what activities Resident #14 enjoys, Employee I stated [Resident #14] likes to watch westerns on TV. Employee I also stated that Resident #14 will attend group activities such as Bingo and church. When asked how frequently Resident #14 attends group activities, Employee I stated, "I don't know, maybe 4 to 5 times a week." When asked for a copy of activity attendance for Resident #14, Employee I stated she does not	F 679	potential to be affected by the same deficient practice and what corrective action was taken. All residents who are dependent on staff for ADL□s and activities of interest have the potential to be affected by the practice and new activity assessments will be completed following the MDS calendar&with updates to care plan and Kardex to reflect individual activity choices and areas of interest. 3. Measures/systemic changes put in place to ensure this deficient practice does not reoccur: Activity tracking log for each individual resident implemented. An audit completed by the activities director and social services director for all residents with dementia or inability to make needs known, and interviews with family/responsible parties to be completed using the activity assessment form that includes preferences, past hobbies and choices of former lifestyles. Individualized care plans and Kardex will be updated to included resident preferences. New admission assessments will be completed per policy to obtain individualized resident preferences as it relates to personal choice activities, with care plan and Kardex update. New admission records will be brought to daily clinical review meeting for compliance with activity assessment completion, activity care plan update and Kardex will be reviewed.	

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F 679	Continued From page 75 document resident attendance. When asked how she tracks activity attendance, she stated, "I don't know; I just know the residents." When asked if she would expect to see activities addressed on the care plan, she stated, "Yes." Employee I looked for activities on Resident #14's care plan and stated, "Activities aren't on the care plan but they should be." On 04/17/2019 at 12:35 PM, Employee I provided a copy of an Activities care plan and stated, "This was developed today." The problem onset dated 04/17/2019 documented, "[Resident #14] participates in activities of his choice." The goal associated with this problem documented, "[Resident #14] will participate in at least 3-4 activities a week of his choice." Interventions listed documented, " [Resident #14] likes to watch Westerns on TV; [Resident #14] likes to play games like bingo, horse race, etc but needs assistance; [Resident #14]likes to go outside when the weather is nice; [Resident #14] enjoys visits with his family; [Resident #14] likes to listen to music; [Resident #14] needs assistance getting to and from activities." The policy entitled, Participation in Activities" was provided by the facility staff. Section 1 documented, "Residents are encouraged to attend and participate in activities of their choice." There was no evidence an individualized plan for activities was scheduled or implemented for Resident #14. On 04/17/2019 at approximately 4:45 PM, the DON was notified of findings and offered no further information or documentation.	F 679	4. Monitoring of corrective action to ensure the deficient practice does not reoccur: Risk Manager will audit (10) charts a week x (90) days to assure activities assessment is current, care plan/kardex reflects individualized activity choice. Audit (10) residents a week x (90) days for individualized activity participation completion. Reports of the findings from the audits will be reported by the Risk Manager to the QAPI meeting for review until thresholds are met. Any trends or patterns identified will be addressed and corrective action plan revised if applicable.	

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F 684	Continued From page 76	F 684		
F 684 SS=E	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, facility documentation review, and clinical record review the facility staff failed to provide quality of care for three Residents (Resident #53, Resident #81, and Resident #41) in a survey sample of 35 Residents. 1. For Resident #53, the facility staff failed to assess the resident to determine the cause of her distress (i.e. crying), and seek appropriate treatment. The resident was documented as crying for 9 of 16 days. 2. For Resident #81, the facility staff failed to identify, assess, treat and monitor a skin wound on his left upper forearm. 3a. For Resident #41, the facility staff failed to document the administration of multiple medications during April, 2019. 3b. For Resident #41, the facility staff failed to administer five doses of physician-ordered insulin in April, 2019.	F 684	F 684 SS=E Quality of Care CFR(s): 483.25 With regard to this alleged deficient practice, the facility has taken the following actions: 1. Corrective action(s) accomplished for those residents to have been affected by the alleged deficient practice includes: A. Resident #53 was assessed by her Physician and psychiatric nurse, to determine the cause of her distress. B. Resident #53 received a new order for Tylenol with Codeine 10ml via g-tube every 6 hours for pain. C. Resident #53 was seen by a dentist on 5-6-19 D. Resident #81 had a skin assessment completed to ensure there were no further unidentified skin issues and was referred	5/29/19

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F 684	Continued From page 77 The findings included: 1. For Resident #53, the facility staff failed to assess the resident to determine the cause of her distress (i.e. crying), and seek appropriate treatment. The resident was documented as crying for 9 of 16 days. Resident # 53 had an original admission to this facility on 10/1/15, with a recent readmission on 1/28/19. Resident #53's diagnoses included but were not limited to: Parkinson's, dysphagia, hyperglycemia, hypokalemia, vascular dementia, GERD, and C4 Cervical Spinal Cord Injury. Resident #53's most recent MDS (minimum data set) (an assessment tool) with an ARD (assessment reference date) of 3/6/19, was coded as a quarterly assessment. Resident #53 was coded as being severely cognitively impaired. For activities of daily living (ADL's) to include transfers, dressing, eating, personal hygiene, toileting and bathing, Resident #53 was totally dependent on one staff member for care. Review of Resident #53's CNA (Certified Nursing Assistant) ADL Flow Sheet for April 2019 revealed that from April 1-16, 2019, Resident #53 was recorded as having crying on 9 of the days. Further review revealed that this crying is of new onset and has recently worsened. Review of the CNA ADL Flow Sheet for Jan-March, 2019 reveal only four total days in the three month period with crying as compared to the 9 days from April 1-16. On 4/17/19, an interview was conducted with LPN C. LPN C stated that the resident "was started on	F 684	to the wound physician for wound on Left elbow. Treatment orders were obtained. E. The physician and resident representative for resident #41 were made aware of the medication omissions to include the omitted insulin administration. 2. How will the facility identify other residents who have the potential to be affected by the same alleged deficient practice includes: The facility has identified all residents as having the potential to be affected by this alleged deficient practice. A. DON/Designee and nurse management will complete 100% assessments by 5/19/19 for all residents to identify any verbal or non-verbal signs or symptoms of distress. Appropriate interventions were implemented for any identified issues. B. DON/Designee and nurse management 100% Skin assessments was completed on 5/1/19 for all residents to ensure there were no unidentified skin issues. C. 100% audit was completed on 5/7/19 for all resident medication administration records for the past 30 days to include those residents who receive insulin, to identify omissions. Resident representatives and Physicians were	

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F 684	Continued From page 78 scheduled Tylenol and it has helped. I think it is behavioral because it is worse when her family visits." On 4/17/19 the DON was asked to provide any and all psychiatric and/or psychology notes where services had been provided. She returned and stated, "we don't have any." Review of Resident #53's nursing notes and physician progress notes from Jan. 1, 2019 through April 16, 2019, revealed that no discussion had been made to address or determine the cause of Resident #53's crying and distress. Review of Resident #53's careplan revealed that the facility identified the resident to be "at risk moaning due to generalized pain" and they were monitoring for symptoms such as "moaning and grimacing." There was no mention of crying as a symptom of pain, emotional or psychological distress noted in the careplan. During an end of day meeting on 4/17/19 at 4:39pm, the DON, ADON and AIT were present and made aware of the facility staff's failure to assess, determine the cause and attempt to treat Resident #53's symptoms of distress (i.e. crying). The DON agreed that crying is an indication of distress and they are unaware if her crying is pain, psychological, or something else, there is nothing to show what Resident #53's crying is from. On the morning of 4/18/19 the DON returned and provided a copy of Resident #53's careplan where it is noted she is at risk for moaning due to generalized pain. She also brought copies of	F 684	made aware on any findings. 3. Measures/systematic changes put in place to ensure this alleged deficient practice does not recur include: A. Licensed staff were in-serviced by the DON/designee on assessing for verbal and non-verbal signs and symptoms of distress to determine the cause, and notification of the physician for interventions. B. Staff who perform guardian angel rounds were in-serviced by DON/Designee on verbal and non-verbal indicators of distress to report to the charge nurse when making rounds. Guardian Angel rounds were updated to include indicators of verbal and non-verbal indicators of distress. C. Licensed staff were in serviced by DON/Designee on the identification, assessment and treatment of skin issues. D. Licensed staff were in-serviced by DON/designee on appropriate documentation of medications to include insulin administration and (MAR) medication administration record accuracy. 4. Monitoring of the corrective action to ensure this alleged deficient practice does not recur included: A. DON/Designee and nurse management will audit guardian angel rounds for indicators of distress, and	

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F 684	Continued From page 79 Resident #53's Medication Administration Record (MAR) indicating that staff are assessing for signs of pain every shift. However, she failed to provide any documentation that the facility staff had assessed to determine the cause of distress/crying, notified the physician and any services were being provided to relieve the Resident's distress. On 4/18/19 the Administrator, DON and ADON were made aware of the facility staff's failure to assess Resident #53 to determine the cause of her distress and failure to seek treatment for her distress. No further information was provided. 2. For Resident #81, the facility staff failed to identify, assess, treat, and monitor a skin wound on his left upper forearm. Resident #81, an 80-year old male, was admitted to the facility on 09/10/2013. Diagnoses included but not limited to dementia without behavioral disturbance, hypertension, and dysphasia. Resident #81's most recent Minimum Data Set with an Assessment Reference Date of 03/19/2019 was coded as a quarterly review. Cognitive skills for daily decision-making was coded as severely impaired. Toileting and personal hygiene were coded as total dependence on staff. On 04/16/2019 at 9:55 AM, Resident #81 was observed laying in his bed sleeping with the head of the bed elevated approximately 45 degrees. Resident #81 had a scab on his left upper	F 684	round with charge nurse 3 days per week x 4 weeks then weekly to ensure compliance. B. DON/Designee and nurse managers will audit weekly Skin Assessments 5 days per week X 4 weeks then weekly to ensure all skin issues have been identified and have appropriate treatments and interventions in place. C. DON/Designee and nurse management team will audit 100% of the Medication Administration records for 5 days per week X 4 weeks then weekly. Omissions will be reported to the resident representatives and Physicians. D. The findings of the audits will be reported to the Nursing Home Administrator immediately when the policy is not adhered to. E. Reports of the findings from the audits, will be reported for 3 months by the Director of Nursing to the Quality Assurance committee consisting of the Director of Nursing, Medical Director, NHA, MDS coordinator, Pharmacy Consultant, Social Service Director and Dietary Manager on a monthly basis. Any trends or patterns identified will be addressed and revisions to the plan of action will be implemented.	

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forearm approximately the size of a quarter. The edges around the scab were reddened.

On 04/16/2019 at approximately 5:10 PM, an interview with Resident #81's nurse, LPN A, was conducted. When asked about the skin wound on Resident #81's left forearm, LPN A stated she was not aware of a skin wound on his left forearm. This surveyor and LPN A approached Resident #81 to examine Resident #81's left forearm. LPN A was asked to describe the skin wound and stated it was "scabbed", "no drainage", "red around the edges", "not new." At that time, RN A came over and looked at the wound and stated she would look in the chart to find out more about it. After looking through the chart, RN A stated there was no documentation in the chart about it. When asked what the process is when a skin wound is discovered, RN A stated it would be assessed, the MD (doctor) would be notified, the supervisor would be notified, an incident report would be written, the wound care nurse would be notified, and an order for antibiotic ointment would be written. A copy of wound care protocol was requested.

On 04/16/2019, the clinical record was reviewed. There were no physician's orders for treatments of left forearm skin wound. There were no nurse's notes addressing the skin wound. The skin assessments for March 2019 and April 2019 did not address the skin wound to left forearm. The care plan did not address the skin wound to left forearm.

The facility provided a copy of their wound care protocols. It contained protocols for pressure wounds, ulcers, and skin tears. Under the "Skin Tear Protocol" section 3 entitled, "Cleanse wound

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with skin cleanser", part (b) documented, "If partial tissue loss and edges cannot be approximated, apply Vaseline gauze or silicone; change every 3-7 days and prn (as needed)." Part (c) documented, "If complete tissue loss, apply collagen or hydrocel dressing and cover dressing; change every 3-7 days and prn."

On 04/17/2019 at approximately 9:00 AM, the DON verified the facility resource for professional standards was Mosby's.

Elsevier's (Mosby's) Concepts for Nursing Practice, Second Edition, page 256, stated "The ANA Standards of Professional Practice are to be used as evidence of the standard of care that registered nurses provide their patients." The ANA's (American Nurses Association) Standards of Professional Nursing Practice, Third Edition, page 8, under the section entitled, "Tenets Characteristic of Nursing Practice" in Part 3, it stated, "Nurses use theoretical and evidence-based knowledge of human experiences and responses to collaborate with healthcare consumers to assess, diagnose, identify outcomes, plan, implement, and evaluate care that has been individualized to achieve the best outcomes."

On 04/17/2019 at approximately 4:45 PM, the DON was notified of findings and offered no further information or documentation

3a. For Resident #41, the facility staff failed to document the administration of multiple medications during April, 2019.

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Resident #41 was a 66 year old who was admitted to the facility on 11/23/18. Resident #41's diagnoses included Type 2 Diabetes Mellitus, Morbid Obesity, and Chronic Pain.

The Minimum Data Set, which was a Quarterly Assessment with an Assessment Reference Date of 2/11/19 was reviewed. It coded Resident #41 as having a Brief Interview of Mental Status Score of 15, indicating no impairment in cognition.

On 4/16/19 at 2:19 P.M. an observation was conducted of Resident #41. She was sitting in her wheelchair near the nurse's station. Resident #41 was dressed appropriately, and initiated conversations easily with other residents and staff.

On 4/6/19 a review was conducted of Resident #41's clinical record. The Medication Administration Record for April, 2019 was reviewed. There was no documentation of administration for the following medications, for which there was a signed physician order dated 4/1/19:

1. Protonix 40 mg PO (by mouth) daily- Epigastric distress - 4/8/19 and 4/14/19 at 6:30 A.M.
2. Lasix 40 MG 1 PO twice daily - 4/6/19 at 9:00 P.M.
3. Neurontin 800 Mg 1 tab by mouth three times a day - 4/6/18 at 4:00 P.M. and 4/14/19 at 12:00 A.M.

Resident #41's Care Plan read, " Problem onset: 8/20/18. (Resident #41) is at risk for uncontrolled generalized pain. Provide pain meds as ordered."

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F 684	Continued From page 83	F 684		

On 4/17/19 a review of facility documentation was conducted, revealing a Charting and Documentation policy revised July, 2017. It read, "The following information is to be documented in the resident medical record: b. Medications administered."

On 9/17/19 at 9:15 A.M. an interview was conducted with the Director of Nursing (DON Employee B). When asked about the importance of Resident #41 receiving her medications, the DON stated, "Regarding Neurontin, she has Neuropathy. It can cause weakness and numbness in lower extremities. She has localized edema. Without Lasix, it can cause her to have some swelling in her leg. She has Reflux. A missed dose of Protonix can cause her to have reflux."

On 9/17/19 at approximately 11:30 A.M. the facility Administrator (Employee A) was informed of the findings. No further information was received.

3b. For Resident #41, the facility staff failed to administer five doses of physician-ordered insulin in April, 2019.

Resident #41 was a 66 year old who was admitted to the facility on 11/23/18. Resident #41's diagnoses included Type 2 Diabetes Mellitus, Morbid Obesity, and Chronic Pain.

The Minimum Data Set, which was a Quarterly Assessment with an Assessment Reference Date of 2/11/19 was reviewed. It coded Resident #41 as having a Brief Interview of Mental Status Score of 15, indicating no impairment in

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F 684	Continued From page 84	F 684		

cognition.

On 4/16/19 at 2:19 P.M. an observation was conducted of Resident #41. She was sitting in her wheelchair near the nurse's station. Resident #41 was dressed appropriately, and initiated conversations easily with other residents and staff.

On 4/6/19 a review was conducted of Resident #41's clinical record. The Medication Administration Record for April was reviewed. No physician-ordered blood sugars were obtained on the following dates/times: 4/5/19 at 5:00 P.M., 4/6/19 at 4:30 P.M. and 9:00 P.M., 4/8/19 and 4/14/19 at 6:30 A.M. In addition, insulin had not been administered on those dates and times. The nurse's notes for April, 2019 were reviewed. There was no documentation of blood sugars or medication administration of insulin on those dates and times.

Resident #41's clinical record contained a Hemoglobin A1c lab test that was conducted on 1/21/19. It read: "Out of Range 7.0 High. For someone with known diabetes, a value of less that 7 indicates that their diabetes is well controlled and a value of greater than or equal to 7% indicates suboptimal control."

Resident #41's signed physician order read, "Novolog 100 Unit/ML vial for blood sugars before meals and at bedtime per 150-200=2 units, 201-250= 4 units, 251-300= 6 units, 301-350=8 units, 351-400=10 units, 401 and above 12 units and notify MD."

According to Resident #41's Medication Administration Record for April, 2019, she usually

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F 684	Continued From page 85 required between 2 and 10 units of insulin. A review was conducted of facility documentation, revealing a Diabetes Clinical Protocol dated 9/2017. It read, "The Physician will order desired parameters for monitoring and reporting information related to blood sugar management. The staff will incorporate such parameters into the Medication Administration Record and care plan. Resident #41's Care Plan read, "Problem onset: 8/20/18. (Resident #41) likes plenty of snacks such as honey buns and sodas. She is at risk for elevated blood sugars. Monitor blood sugars per MD orders and record." On 9/17/19 at 9:15 A.M. an interview was conducted with the Director of Nursing (DON Employee B). When asked about the importance of diabetic management for Resident #41, the DON stated, "Because it needs to be documented, that's how the doctor is going to know if any changes are needed. They can be hypoglycemic." Regarding Novolog, the DON stated, "it's insulin, without checking the blood sugars they are not able to manage the diabetes." On 9/17/19 at approximately 11:30 A.M. the facility Administrator (Employee A) was informed of the findings. No further information was received.	F 684		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a	F 686		5/29/19

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F 686	Continued From page 86 resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and clinical record review the facility staff failed to provide services to prevent the development of pressure ulcers for one resident (Resident #22) in a survey sample of 35 Residents. For Resident #22, the facility staff failed to provide prevalon boot to left foot, as ordered by the physician, to prevent the development of a pressure ulcer. The findings included: Resident #22, was originally admitted to the facility on 6/28/12, with a most recent readmission on 2/15/18. Diagnoses for Resident #22 included but were not limited to: unspecified psychosis, unspecified intellectual disabilities, difficulty in walking, type 2 diabetes, gastro-esophageal reflux disease, hypertension, anxiety, and unspecified convulsions. Resident #22's most recent MDS (minimum data set) (an assessment tool) with an ARD (assessment reference date) of 1/23/19, was	F 686	F 686 SS=D Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) With regard to this alleged deficient practice, the facility has taken the following actions: 1. Corrective action(s) accomplished for those residents to have been affected by the alleged deficient practice includes: A. Resident #22 order for prevalon boot to the left foot to be worn at all times was discontinued on 4/27/19. 2. How will the facility identify other residents who have the potential to be affected by the same alleged deficient practice includes: The facility has identified all residents as having the potential to be affected by this alleged deficient practice. A. 100% audit was conducted to ensure	

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F 686	Continued From page 87 coded as a significant change assessment. Resident #22 was coded as having a BIMS (brief interview for mental status) score of 6, which indicated severe cognitive impairment. Resident #22 was coded as being total care, dependent upon one staff member for assistance with transfers, dressing, eating, personal hygiene and bathing. During observation of Resident #22 on 04/16/19 at 10:05 AM, Resident #22 was observed in the dayroom with a tennis shoe on his right foot and his left foot with only a sock on. Resident #22 was observed on 04/16/19 at 11:32 AM in the dining room being fed by staff. Resident #22 had a tennis shoe on his right foot, and a sock on the left foot. On 4/17/19, staff were getting Resident #22 out of bed. Once out of bed, in the wheel chair, Resident #22 was observed with a prevalon boot to the left foot. An interview was conducted with CNA C, when asked about the boot on the left foot, CNA C stated; "(Resident #22) wears that to prevent wounds." Review of Physician Orders for the month of April 2019, it read; "prevalon boot to left foot at all times. Remove every shift for skin checks and hygiene and reapply." Resident #22 had a history of skin integrity issues to his left foot as indicated by review of Resident #22's careplan. The careplan had an onset date of 1/30/19, and read, "[Resident #22's name] is at risk for impaired skin integrity r/t (related to) aging process." There is a handwritten entry dated 2/28/19 that read; "left heel DTI (deep tissue injury) hyperpigmented area" which was crossed out and initialed as being resolved but not dated as to when this issue resolved.	F 686	observation matched order and wearing schedule for all residents with orders for assistive devices. B. 100% audit of the treatment records of residents that wear assistive devices was conducted to ensure orders were written to allow nurses to sign off verifying placement of the devices every shift. 3.Measures/systematic changes put in place to ensure this alleged deficient practice does not recur include: A. Licensed staff were in-serviced by DON/designee on the principles of skin integrity, identification, prevention and treatment of pressure ulcers to include the use of assistive devices. B. The Resident Kardex and care plans were updated for all residents that wear assistive devices to include placement and wearing schedule. C. Licensed staff were in serviced to observe for the placement of assistive devices during resident rounds and to sign them off on the treatment administration record every shift. 4. Monitoring of the corrective action to ensure this alleged deficient practice does not recur included: A. DON/Designee and nurse managers will audit 10 residents per week X 4 weeks then monthly to ensure assisted devices are in place as ordered.	

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F 686	Continued From page 88 The facility Administrator, DON, and ADON were made aware of the findings on 4/18/19 of facility staff's failure to provide services as ordered by a physician to prevent the development of pressure ulcers for Resident #22. No further information was provided.	F 686	B. The findings of the audits will be reported to the Nursing Home Administrator immediately when the policy is not adhered to. C. Reports of the findings from the audits, will be reported for 3 months by the Director of Nursing to the Quality Assurance committee consisting of the Director of Nursing, Medical Director, NHA, MDS coordinator, Pharmacy Consultant, Social Service Director and Dietary Manager on a monthly basis. Any trends or patterns identified will be addressed and revisions to the plan of action will be implemented.	
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced	F 688		5/29/19

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F 688	Continued From page 89 by: Based on observation and clinical record review the facility staff failed to provide services to prevent the decline in ROM (range of motion) for one resident (Resident #43) in a survey sample of 35 Residents. For Resident #43, the facility staff failed to provide palm guards, as ordered by the physician, to prevent the decline in ROM. The findings included: Resident #43, was originally admitted to the facility on 9/22/08, with a most recent readmission on 4/24/09. Diagnoses for Resident #43 included but were not limited to: age related osteoporosis, glaucoma, dementia, pick's disease and unspecified kidney failure. Resident #43's most recent MDS (minimum data set) (an assessment tool) with an ARD (assessment reference date) of 2/22/19 was coded as a quarterly assessment. Resident #43 was coded as having severe cognitive impairment based on a staff assessment, a BIMS (brief interview for mental status) was not able to be conducted. Resident #43 was coded as being total care, dependent upon one staff member, for assistance with dressing, eating, personal hygiene and bathing. During observation of Resident #43 on 04/16/19 at 10:04 AM, in the dayroom, Resident #43 was sitting in a geri-chair with no palm guards on. Resident #43 was observed on 04/16/19 at 11:34 AM during the lunch meal without palm guards on. Observation on 04/16/19 at 02:13 PM, Resident #43 was observed without palm guards	F 688	F 688 SS=D Increase/Prevent Decrease ROM/Mobility CFR(s): 483.25(c)(1)-(3) With regard to this alleged deficient practice, the facility has taken the following actions: 1. Corrective action(s) accomplished for those residents to have been affected by the alleged deficient practice includes: A. A skin assessment was completed on resident #43 to ensure she did not have any skin issues related to her palm guards not being in place as ordered. The palm guards were applied as ordered on 4/16/19. The palm guard order was clarified to include device and wearing schedule on Treatment Administration Schedule to allow nurse to observe and sign off that device is in place as ordered. 2. How will the facility identify other residents who have the potential to be affected by the same alleged deficient practice includes: The facility has identified all residents with adaptive equipment, as having the potential to be affected by this alleged deficient practice. A.100% audit of residents with adaptive equipment was conducted to ensure observation matched order and wearing schedule for all residents with orders for assistive devices.	

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F 688	Continued From page 90 on. Review of the physician's orders revealed an order written 3/20/19 that read, "patient to wear bilateral palm guards q (every) d (day) except skin checks q shift and hygiene. Doff (remove) q h.s. (bed time). Patient to wear as tolerated,. Monitor for s/sx (signs and symptoms) skin breakdown." Review of Physician Orders for the month of April 2019, it read; "bilateral palm guards 8 + hours." The facility Administrator, DON, and ADON were made aware of the findings on 4/18/19 of facility staff's failure to provide services as ordered by a physician to prevent a decline in ROM for Resident #43. No further information was provided.	F 688	B. 100% audit of the treatment records of residents that wear assistive devices was conducted to ensure orders were written to allow nurses to sign off verifying placement of the devices every shift. 3.Measures/systematic changes put in place to ensure this alleged deficient practice does not recur include: A. Licensed staff were in-serviced by DON/designee to ensure residents with limited mobility/ROM receive appropriate services, assistance and equipment that include the use of assistive devices. B. The Resident Care Plan and Kardex was updated for all resident that wear assistive devices to include placement and wearing schedule. C. Licensed staff were in serviced to observe for the placement of assistive device during resident rounds and to sign them off on the treatment administration record every shift. 4. Monitoring of the corrective action to ensure this alleged deficient practice does not recur included: A. DON/Designee and nurse managers will audit 10 residents per week X 4 weeks then monthly to ensure assisted devices are in place as ordered. B. The findings of the audits will be reported to the Nursing Home Administrator immediately when the policy	

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F 688	Continued From page 91	F 688	is not adhered to. C. Reports of the findings from the audits will be reported for 3 months by the Director of Nursing to the Quality Assurance committee consisting of the Director of Nursing, Medical Director, NHA, MDS coordinator, Pharmacy Consultant, Social Service Director and Dietary Manager on a monthly basis. Any trends or patterns identified will be addressed and revisions to the plan of action will be implemented.	
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and facility documentation review, the facility staff failed to ensure the environment was free of accident hazards on one of three nursing units. The facility staff failed to lock and secure a housekeeping cart on the 200 hall, which included chemicals and a sharp object. The findings included: During facility rounds on 4/17/19 at 9:23am a	F 689	F 689 SS=D Free of Accident Hazards/Supervision/Devices CFR(s): 483.25 (d)(1)(2) With regard to the alleged deficient practice, the facility has taken the following action: 1. Corrective actions(s) accomplished for those residents found to have been	5/29/19

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F 689	Continued From page 92 housekeeping cart was observed, unattended outside of room 206. Residents, visitors, and staff were observed in the hallway that could access the contents of the housekeeping cart. The cabinet door, where chemicals and sharp objects were stored, was observed to be ajar. When opened, the following contents were observed: 1. Enzym D- a cleaning chemical 2. a roll of trash bags 3. a pair of scissors with a sharp, pointed end 4. a toilet bowl brush 5. a scrapper (rectangle shaped metal (approximately 3" long, 2" wide), with a plastic handle) 6. hand sanitizer On 4/17/19 at 9:25am an interview was conducted with a housekeeper, other staff C, who came out of room 206. Staff member C stated, "it should be locked." She then moved items around in the cabinet and found two keys that she then used to attempt to lock the cart, but was not able to lock/secure the cabinet. On 4/17/19 at 1:53pm, an interview was conducted with other employee D, the housekeeping supervisor. When asked what the expectation was about securing hazardous chemicals and items when the cart is unattended, Employee D stated, "it should be locked, they are to have the opening turned around toward the wall, they shouldn't have anything where a resident can get a hold of it." Review of maintenance request forms from 1/1/19 through 4/17/19 revealed no work order for the housekeeping cart, to notify maintenance that the cart was not able to be locked.	F 689	affected by the alleged deficient practice. On 4/17/19 Maintenance director replaced the lock on the cabinet door of the identified housekeeping cart, noted outside of room 206. One key was given to the housekeeper in charge of the cart and the other to the housekeeping supervisor. 2. Identify other residents who have the potential to be affected by the same deficient practice and what corrective action was taken. Facility has a total of (3) housekeeping carts □ all had the cabinet door lock replaced on 4/17/19. 3. Measures/systemic changes put in place to ensure this deficient practice does not reoccur: Regional nurse completed training with Housekeeping director on Storage Areas, Environmental Services policy. Housekeeping director then completed training with housekeeping department on Storage Policy. Additional training completed with housekeeping department on measures to take if cabinet lock does not secure. 4. Monitoring of corrective action to ensure the deficient practice does not reoccur:	

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F 689	Continued From page 93 Review of facility policy titled, "Storage Areas, Environmental Services" stated the following, "cleaning supplies shall be stored as instructed on the label of such products." Review of the product label for Enzym D read: "WARNING causes serious eye damage. Harmful if swallowed. May cause an allergic skin reaction. May cause respiratory irritation . Do not handle until all safety precautions have been read and understood Avoid breathing dust, fume gas, mist, vapors or spray. Wear protective gloves/protective clothing/eye protection/face protection." Review of the Safety Data Sheet for Enzym D product, read as follows: "GHS (Globally Harmonized System) Classification: Respiratory sensitization. Hazard Statement(s): May cause allergy or asthma symptoms or breathing difficulties if inhaled. may cause genetic defects. May cause cancer. Storage: Store locked up. Conditions for safe storage: store in an area that is: cool, dry" The facility Director of Nursing, Assistant Director of Nursing and Administrator in Training were informed of the failure of staff to secure and lock the housekeeping cart on 4/17/19 at 4:39pm. The Administrator was not able to be present. The facility Administrator, DON, and ADON were again made aware of the findings on 4/18/19 and advised that the locks had been repaired by maintenance. No further information was provided.	F 689	Risk Manager will perform safety rounds (3) times per week x (60) days on random units/random halls to assess compliance with housekeeping cabinet door securing. Reports of the findings from the audits will be reported by the Risk Manager to the monthly QAPI meeting for review until thresholds are met. Any trends or patterns identified will be addressed and corrective action plan revised if applicable. 5. completion date 5/29/19	

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F 757	Continued From page 94	F 757		
F 757 SS=D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review and facility documentation, and hospital discharge record review the facility staff failed to ensure Residents free from unnecessary medications for 1 Resident (#77) in a survey sample of 35 Residents. For Resident #77 the facility staff failed to hold or discontinue Colace 100 (Milligrams) mg twice daily [given for constipation] when the Resident had loose stools since readmission from the hospital.	F 757	F757 SS=D Drug Regime is Free from Unnecessary Drugs CFR (s): 486.45 (d) (1) -(6) With regard to the alleged deficient practice, the facility has taken the following actions: 1.Corrective action(s) accomplished for this resident found to have been affected by the alleged practice includes:	5/29/19

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	495375	A. BUILDING _____ B. WING _____	04/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMPORIA MANOR LLC	200 WEAVER AVENUE EMPORIA, VA 23847

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F 757	Continued From page 95 The findings included; Resident #77 an 87 year old woman was admitted to the facility on 11/30/18 with diagnoses of but not limited to left and right above knee amputation, Hemiplegia following cerebral infarction (stroke), Contracture multiple sites, Pressure ulcer (unstageable), Diabetes type 2, and chronic Atrial fibrillation and history of pacemaker. Resident #77's most recent (Minimum Data Set) MDS coded as a PPS 60 Day Scheduled Assessment, codes Resident as having a (Brief Interview of Mental Status) BIMS Score of 0. A score of 0 indicates the Resident has severe cognitive impairment. The MDS also scores the Resident as requiring total physical assistance of 2 people with all aspects of care. The Resident was sent to the hospital and admitted from 1/18/19 until 1/30/19 during this hospitalization the Resident was treated for Dehydration, Sepsis (from an infection to her sacral pressure ulcer) as well as Aspiration Pneumonia, she also had a Feeding Tube placement and had gained up to 84 lbs. The Resident returned to facility and resumed previous orders of Colace 100 mg twice a day. NOTE: Colace is given for constipation. On 4/18/19 at 10:00 AM during an interview with the DON about Resident weight loss, the DON stated that the tube feeding was causing diarrhea and that contributed to her weight loss. When asked why the Resident was ordered Colace (stool softener) 100 mg twice a day if she was	F 757	A. Resident #77 order for Colace was discontinued on 3/22/19 2.How will the facility identify others as having the potential to be affected by this alleged deficient practice. The facility has identified all residents receiving stool softeners as having the potential to be affected by this alleged deficient practice. A. A 100% audit of all physician orders were completed for residents who receive stool softeners to add the parameter to hold administration for loose stools. Measures/systematic changes put in place to ensure this alleged deficient practice does not recur includes: A. Licensed nurses were in-serviced by DON/Designee on the assessment of adverse consequences of stool softeners which indicate the dose should be held or discontinued in accordance with manufacturer guidelines. B. Licensed staff were in serviced by DON/Designee to add any resident that experiences loose stools to the 24-hour report. All new MD orders will be reviewed daily in the morning mtg. including new orders for stool softeners 4. Monitoring of corrective action to ensure this alleged deficient practice will not recur includes:	

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F 757	Continued From page 96 having loose stools. DON stated well we got it discontinued 3/22/19. When asked if Resident #77 is doing better since the Colace was discontinued she answered yes. According to the manufacturer of Colace: Stop using Colace and call your doctor at once if you have: Pounding heartbeats or fluttering in your chest; a light-headed feeling, like you might pass out; rectal bleeding or Irritation; numbness or a rash around your rectum; Vomiting, diarrhea or stomach cramps; or continued constipation, or no bowel movement. On 4/18/19 at 12:15pm, the DON and Administrator were made aware of the issues with the unnecessary medication and no further information was provided.	F 757	A. All new MD orders will be reviewed daily in the morning mtg. including new orders for stool softeners B. DON/Designee and nurse management team will review for the presence of stool softeners without parameters for holding with loose stools C. Reports of the findings from the audits, will be reported for 3 months by the Director of Nursing to the Quality Assurance committee consisting of the Director of Nursing, Medical Director, NHA, MDS coordinator, Pharmacy Consultant, Social Service Director and Dietary Manager on a monthly basis. Any trends or patterns identified will be addressed and corrective action plan revised if applicable.	
F 790 SS=D	Routine/Emergency Dental Srvcs in SNFs CFR(s): 483.55(a)(1)-(5) §483.55 Dental services. The facility must assist residents in obtaining routine and 24-hour emergency dental care. §483.55(a) Skilled Nursing Facilities A facility- §483.55(a)(1) Must provide or obtain from an outside resource, in accordance with with §483.70(g) of this part, routine and emergency dental services to meet the needs of each resident; §483.55(a)(2) May charge a Medicare resident an	F 790		5/29/19

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F 790	Continued From page 97 additional amount for routine and emergency dental services; §483.55(a)(3) Must have a policy identifying those circumstances when the loss or damage of dentures is the facility's responsibility and may not charge a resident for the loss or damage of dentures determined in accordance with facility policy to be the facility's responsibility; §483.55(a)(4) Must if necessary or if requested, assist the resident; (i) In making appointments; and (ii) By arranging for transportation to and from the dental services location; and §483.55(a)(5) Must promptly, within 3 days, refer residents with lost or damaged dentures for dental services. If a referral does not occur within 3 days, the facility must provide documentation of what they did to ensure the resident could still eat and drink adequately while awaiting dental services and the extenuating circumstances that led to the delay. This REQUIREMENT is not met as evidenced by: Based on resident representative interview, staff interview, facility documentation review, and clinical record review, the facility staff failed to provide dental services for one resident (Resident #53) in a survey sample of 35 residents. The facility staff failed to provide routine dental services for Resident #53. The findings included: Resident # 53 had an original admission on 10/1/15, with a recent readmission on 1/28/19.	F 790	F 790 SS=D Routine/Emergency Dental Srvcs in SNF□s CFR(s): 483.55 (a)(1)-(5) With regard to the alleged deficient practice, the facility has taken the following action: 1. Corrective actions(s) accomplished for those residents found to have been affected by the alleged deficient practice.	

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F 790	Continued From page 98 Resident #53's diagnoses included but were not limited to: Parkinson's, dysphagia, hyperglycemia, hypokalemia, vascular dementia, GERD, and C4 Cervical Spinal Cord Injury. Resident #53's most recent MDS (minimum data set) (an assessment tool) with an ARD (assessment reference date) of 3/6/19, was coded as a quarterly assessment. Resident #53 was coded as being severely cognitively impaired. For activities of daily living (ADL's) to include transfers, dressing, eating, personal hygiene, toileting and bathing, Resident #53 was totally dependent on one staff member for care. On 4/16/19 at 02:41 PM, during a resident representative interview, the resident representative stated, "she has decayed teeth, we have talked to them about it but they seem to pay it no mind. They have not sent her to a dentist and I think this may be causing some of her problems." On 4/17/19, an interview was conducted with LPN C. LPN C stated that she was not aware of any dental problems or the dental status of Resident #53. LPN C attempted to observe the dental status of Resident #53, but Resident #53 was not cooperative and would not open her mouth. On 4/16/19 and on 4/17/19 copies of dental visits and evaluations for Resident #53 since admission in 2015, was requested. The Director of Nursing (DON) stated, "we have none." Review of the policy titled, Dental Services with a revision date of December 2016, was reviewed and it read, "routine and emergency dental services are available to meet the resident's oral	F 790	Resident #53 pain medication regimen was modified on 4/24/18 for increase in frequency/dosage with positive results. Resident # 53 was seen by a dentist on 5-6-19 2. Identify other residents who have the potential to be affected by the same deficient practice and what corrective action was taken. Director of Nursing/Assistant Director of Nursing/Unit Manager completed pain assessments on all residents who presented with verbal/non-verbal signs or symptoms of pain or distress. Assessments to be completed by 5/19/19. Appropriate interventions will be implemented for any identified issues. 3. Measures/systemic changes put in place to ensure this deficient practice does not reoccur: Licensed staff in-serviced by the Director of Nursing/Associate Director of Nursing/Risk Manager on assessing of verbal and non-verbal signs and symptoms of distress to determine underlying cause and notification of the physician for interventions. Nurse management team will review (24) hour reports in daily clinical meeting for any alerts of resident with verbal or non-verbal signs of symptoms of distress and action taken. New resident behaviors will be discussed at the weekly standard of care meeting and daily morning	

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F 790	Continued From page 99 health services in accordance with the resident's assessment and plan of care. Routine and 24-hour emergency dental services are provided to our residents through: a. A contract agreement with a licensed dentist that comes to the facility monthly; b. referral to the resident's personal dentist; c. referral to community dentists; or d. referral to other health care organizations that provide dental services." "All dental services provided are recorded in the resident's medical record." Review of the facility policy titled "Dental Consultant" with a revision date of April 2007 was reviewed. It read: "A consultant dentist is retained by our facility and is responsible for: a. Providing consultation to physicians and providing other service relative to dental matters; b. providing a dental assessment of each resident within ninety (90) day of admission; c. performing or supervising an annual dental reevaluation for each resident; d. providing staff in-service education; e. assuring that emergency dental services are available; and f. providing necessary information concerning residents to appropriate staff, care planning conferences, and/or committees." The DON, ADON, and Administrator in Training (AIT) were made aware of the staff's failure to provide dental services for Resident #53 on 4/17/19 at 4:39pm. The Administrator was not able to be present. No further information was provided.	F 790	meeting as noted. 4. Monitoring of corrective action to ensure the deficient practice does not reoccur: Director of Nursing/Associate Director of Nursing will audit (10) charts a week x (90) days to assure completion of ordered resident pain assessments, any verbal or non-verbal signs/symptoms of distress was addressed timely and follow-up for effectiveness is documented. Reports of the findings from the audits will be reported by the Director of Nursing to the QAPI meeting for review until thresholds are met. Any trends or patterns identified will be addressed and corrective action plan revised if applicable. 5. completion date 5/29/19	
F 808	Therapeutic Diet Prescribed by Physician	F 808		5/29/19

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F 808 SS=D	Continued From page 100 CFR(s): 483.60(e)(1)(2) §483.60(e) Therapeutic Diets §483.60(e)(1) Therapeutic diets must be prescribed by the attending physician. §483.60(e)(2) The attending physician may delegate to a registered or licensed dietitian the task of prescribing a resident's diet, including a therapeutic diet, to the extent allowed by State law. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility documentation review, and clinical record review the facility staff failed to provide a therapeutic diet, as ordered by the physician, for one resident (Resident #22) in a survey sample of 35 Residents. For Resident #22, the facility staff failed to nectar thick liquids as ordered by the physician. The findings included: Resident #22, was originally admitted to the facility on 6/28/12, with a most recent readmission on 2/15/18. Diagnoses for Resident #22 included but were not limited to: unspecified psychosis, unspecified intellectual disabilities, difficulty in walking, type 2 diabetes, gastro-esophageal reflux disease, hypertension, anxiety, and unspecified convulsions. Resident #22's most recent MDS (minimum data set) (an assessment tool) with an ARD (assessment reference date) of 1/23/19, was coded as a significant change assessment. Resident #22 was coded as having a BIMS (brief	F 808	F808 SS=D Therapeutic Diet Prescribed by Physician CFR(s): 483.60(e)(1)(2) With regard to the alleged deficient practice, the facility has taken the following actions: 1. Corrective action(s) accomplished for this resident found to have been affected by the alleged practice includes: A. The water pitcher was removed from resident #22 bedside. B. The resident representative and physician were made aware of the resident having thin liquids at his bedside on 4/16/19 and 4/17/19. 2. How will the facility identify others as having the potential to be affected by this alleged deficient practice: The facility has identified all residents with	

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F 808	Continued From page 101 interview for mental status) score of 6, which indicated severe cognitive impairment. Resident #22 was coded as being total care, dependent upon one staff member for assistance with transfers, dressing, eating, personal hygiene and bathing. On 4/16/19 at 8:16am during facility observation, Resident #22 was observed to be in bed with his breakfast tray at the side of the bed, the breakfast tray contained 4 oz containers of nectar thick liquids. Also, at the bedside was a water pitcher which contained ice water, which was observed to be at a thin consistency. On 4/17/19 at 9:16am, Resident #22 was observed to be in bed and on his over bed table was a 4 oz plastic cup which contained a thin substance that appeared to be juice. Review of Resident #22's physician order sheet for the month of April 2019 read: "NECTAR THICK LIQUIDS". Review of Resident #22's speech therapy recertification and updated plan of treatment for certification period of: 3/28/19-4/26/19 revealed the following: Current status 3/28/19 "patient continues to improve toward goal attainment as noted by progress to date; diet modification from mechanical soft/ground meats and thin liquids to puree and nectar thick liquids with following results: increased oral transit, poor mastication with decreased coordination of lingual and mandibular muscular strength and endurance; slow bolus formation, control and propulsion with delayed swallow initiation time ~3-15 seconds with delayed laryngeal elevation and increased signs and symptoms of penetration, mostly at end	F 808	thickened liquids as having the potential to be affected by this alleged deficient practice. A. 100% audit was completed by the DON/Designee of all residents that have orders for thickened liquids to ensure they did not have thin liquids or water pitchers at the bedside. 3. Measures/systematic changes put in place to ensure this alleged deficient practice does not recur includes: A. Staff were in-serviced by DON/Designee on therapeutic diets to include thickened liquids, the disuse of water pitchers and how to identify residents that receive thickened liquids. B. A system was developed to incorporate pictures of humming birds and honey bees in resident rooms to identify to staff the residents that receive thickened liquids. C. A list of residents that receive thickened liquids was placed at each nurses station, the general store, in the activities department and given to each staff member that performs Guardian Angel rounds. 4. Monitoring of corrective action to ensure this alleged deficient practice will not recur includes: A. DON/Designee will complete rounds daily x 4 weeks then weekly on varying shifts to ensure residents have thickened	

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F 808	Continued From page 102 of meal due ?? to fatigue; patient does like to talk and eat with poor attention to task and need to re-direct back to task; not at maximum potential for skilled speech therapy at this time; will continue current goal." An interview was conducted with CNA C on 4/17/19 at 9:16am. CNA C was asked about the cup of thin liquid on the over bed table and when asked what it was, CNA C said "it looks like juice, the ladies that brought juices around to the rooms left it." When CNA C was asked if there was a problem with Resident #22 having this juice, CNA C stated "no..... well, actually he is on thickened liquids." When asked if the juice in the cup was thickened, CNA C stated "no, it's regular juice." She then poured it out into the sink. On 4/17/19 an interview was conducted with the Director of Nursing (DON). The DON stated, "we don't have water pitchers in the room if they are on thickened liquids. Dietary sends extra liquids on their meal trays." Review of the facility policy titled "Therapeutic Diets" with a revision date of November 2015 read as follows: "Therapeutic diets shall be prescribed by the Attending Physician. Mechanically altered diets as well as diets modified for medical or nutritional needs, will be considered therapeutic diets. Snacks will be compatible with the therapeutic diet." The facility Administrator, DON and ADON were made aware of staff's failure to provide a therapeutic diet for Resident #22 as ordered by the physician on 4/17/19 during an end of day meeting.	F 808	liquids at the bedside as ordered by the Physician. . B. The findings of the audits will be reported to the Nursing Home Administrator immediately when the policy is not adhered to. C. Reports of the findings from the audits, will be reported for 3 months by the Director of Nursing to the Quality Assurance committee consisting of the Director of Nursing, Medical Director, NHA, MDS coordinator, Pharmacy Consultant, Social Service Director and Dietary Manager on a monthly basis. Any trends or patterns identified will be addressed and corrective action plan revised if applicable.	

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F 808	Continued From page 103 No further information was provided.	F 808		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and facility documentation review, the facility staff failed to store, prepare, and serve food in accordance with professional standards for food service safety. 1. Facility staff failed to provide a sanitizing solution with appropriate concentration levels to ensure adequate sanitization during manual dishwashing. 2. Facility staff failed to properly label and date food items stored in the walk-in freezer.	F 812	F 812 SS=E Food Procurement, Store/Prepare/Serve Sanitary CFR(s): 483.60 (i)(1)(2) With regard to the alleged deficient practice, the facility has taken the following action: 1. Corrective actions(s) accomplished for those residents found to have been affected by the alleged deficient practice.	5/29/19

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F 812	Continued From page 104 3. Facility staff failed to follow appropriate hygiene/sanitary procedures by not wearing a hairnet in the kitchen. The Findings included: 1. Facility staff failed to provide a sanitizing solution with appropriate concentration levels to ensure adequate sanitization during manual dishwashing. On 04/16/2019 at approximately 08:00 AM, a tour of the kitchen took place and a three part sink was observed with the right compartment approximately 2/3 full with clear water which the Dietary Assistant (Other Employee A) described as "the sanitizing solution". She stated that the solution was prepared using chlorine bleach just a few minutes earlier in preparation for breakfast clean-up. The sanitizing solution was tested with a testing strip by Other Employee A and resulted at 10 ppm (parts per million, a unit of measure indicating the concentration of a solution). When asked about these results she stated, "it should be at least 50, there must not be enough bleach in there". The Dietary Manager (Employee H) arrived and when asked what her expectations were regarding the concentration of the sanitizing solution she stated, "between 50-100ppm". She performed another test with a test strip which resulted at 10ppm. She had no further comment. At approximately 11:20 AM, during another inspection of the kitchen, the sanitizer was tested by Employee H and resulted at 50ppm. On 04/17/2019, a copy of the facility policy regarding sanitization was requested and provided by the DON (Director of Nursing, Employee B). The facility policy entitled	F 812	1. Dietary Assistant Manager drained the manual dishwashing sink when identified on 4/16/19, sink was then refilled, and sanitizing solution concentration was verified to ensure adequate sanitization during manual dishwashing. 2. Dietary Manager removed all food items that were identified on 4/16/19. All food items that were not dated/labeled were removed and discarded. 3. Dietary Manager reviewed the Employee Hygiene and Sanitary Practices with the Maintenance Assistant. A hair/beard net was provided to the maintenance assistance. 2. Identify other residents who have the potential to be affected by the same deficient practice and what corrective action was taken. No known residents were affected by the practice 3. Measures/system changes put in place to ensure this deficient practice does not reoccur: 1. Registered Dietician provided training to the Dietary Manager on the Sanitization policy on 5/1/19. The dietary manager completed training with dietary staff on the Sanitization Policy. Dietary Manager has implemented a sanitizing solution log that will record the sanitizing solution concentration test results. This will be completed at a minimum of (3) times per day and any time the sink is refilled. Any test results	

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F 812	Continued From page 105 "Sanitization", (undated), had a "Policy Statement" that read "The food service area shall be maintained in a clean and sanitary manner". A subheading, "Policy Interpretation and Implementation", line item #4 read, "Sanitizing of environmental surfaces must be performed with one of the following solutions: (a.) 50-100 ppm chlorine solution...". Line item #9 read, "Manual washing and sanitizing will employ a three-step process for washing, rinsing, and sanitizing: (a.) Scrape food particles and wash using hot water and detergent; (b.) Rinse with hot water to remove soap residue; and (c.) Sanitize with hot water or chemical sanitizing solution. Chemical sanitizing solutions may consist of: (1.) Chlorine 50ppm for 10 seconds;...". On 04/17/2019, during the end of the day debriefing, the Facility Administrator-in-Training (Employee C) and the DON (Director of Nursing, Employee B) were informed of the findings. No further information was received. 2. Facility staff failed to properly label and date food items stored in the walk-in freezer. On 04/16/2019 at approximately 08:50 AM during a tour of the kitchen with the Dietary Manager (Employee H), unlabeled and undated food items were observed in the walk-in freezer. The food items included: a tray covered with clear cellophane wrap containing 5 individual servings of pie--each piece on a dessert plate without label or date, 1 opened bag of garlic bread without label or date, 2 packages of luncheon meat without label or date, and 2 packages of ground beef without label or date. The Dietary Manager (Employee H) stated, "the pie was served	F 812	that are out of sanitizing parameter, adjustments will be made and retested before manual dishwashing will be initiated. 2. Registered Dietician provided training to the Dietary Manager on 5/1/19 regarding Food Receiving and Storage Policy. The Dietary Manager will complete training with the dietary staff on Food Receiving and Storage Policy. AM/PM cook will complete a walk-through of food storage areas at end of their shift to assure foods are properly stored/labeled/dated. The results of their walk-thru will be noted on a tracking log. Any foods not stored according to policy will be discarded. 3. Registered Dietician provided training to the Dietary Manager on 5/1/19 regarding Preventing Foodborne Illness-Employee Hygiene and Sanitary Practices policy. Dietary Manager will provide training to all dietary/maintenance employees regarding same policy. STOP sign has been placed on all (3) dietary entrances that is a visual prompt for anyone entering area must don a hair/beard covering net before entering dietary kitchen area. 4. Monitoring of corrective action to ensure the deficient practice does not reoccur: Risk Manager will complete a dietary walk thru (1) x per week x□s (90) days to assure all food stored in refrigerator/freezer has been properly labeled/dated. During this time Risk Manager will view dietary employees for	

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F 812	Continued From page 106 yesterday and the garlic bread was from last Saturday dinner. I think the lunch meat is beef bologna because that is usually what we order. The ground beef came out of a box similar to the case that it is sitting next to over there". When asked what her expectations would be regarding labeling and dating, she replied, "it should be done". On 04/17/2019, a copy of the facility policy regarding food storage was requested and provided by the DON (Director of Nursing, Employee B). The facility policy entitled "Food Receiving and Storage", (undated), had a "Policy Statement" that read, "Foods shall be received and stored in a manner that complies with safe food handling practices". A subheading, "Policy Interpretation and Implementation", line item #7 read, "All foods stored in the refrigerator or freezer will be covered, labeled, and dated ("use by" date)". On 04/17/2019, during the end of the day debriefing, the Facility Administrator-in-Training (Employee C) and the DON (Director of Nursing, Employee B) were informed of the findings. No further information was received. 3. Facility staff failed to follow appropriate hygiene/sanitary procedures by not wearing a hairnet in the kitchen. On 04/16/2019 at approximately 09:05 AM during a tour of the kitchen with the Dietary Manager (Employee H), the Maintenance Assistant (Other Employee B) was observed by the stove and food prep area without a beard net and hairnet. This observation was pointed out to the Dietary	F 812	proper wear of hair/beard cover nets. Registered Dietician will audit manual sink sanitization chemical concentration (1) x month x (3) months. Reports of the findings from the audits will be reported by the Risk Manager/Registered Dietician to the QAPI meeting for review until thresholds are met. Any trends or patterns identified will be addressed and corrective action plan revised if applicable. 5. completion date 5/29/19	

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F 812	Continued From page 107 Manager (Employee H) who stated, "Yes, I would expect him to put a hairnet on to cover his beard and hair". Dietary Manager (Employee H) offered no immediate correction to the Maintenance Assistant (Other Employee B). On 04/17/2019, a copy of the facility policy regarding the use of hairnets and beard nets was requested and provided by the DON (Director of Nursing, Employee B). The facility policy entitled "Preventing Foodborne Illness--Employee Hygiene and Sanitary Practices", dated October 2008, subheading "Policy Interpretation and Implementation", line item #12 read, "Hair nets or caps and/or beard restraints must be worn to keep hair from contacting exposed food, clean equipment, utensils, and linens". On 04/17/2019, during the end of the day debriefing, the Facility Administrator-in-Training (Employee C) and the DON (Director of Nursing, Employee B) were informed of the findings. No further information was received.	F 812		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted	F 842		5/29/19

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F 842	Continued From page 108	F 842		

professional standards and practices, the facility must maintain medical records on each resident that are-
(i) Complete;
(ii) Accurately documented;
(iii) Readily accessible; and
(iv) Systematically organized

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

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

§483.70(i)(4) Medical records must be retained for-
(i) The period of time required by State law; or
(ii) Five years from the date of discharge when there is no requirement in State law; or
(iii) For a minor, 3 years after a resident reaches legal age under State law.

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F 842	Continued From page 109 §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to maintain an accurate medical record for 2 residents (Resident #22 and Resident #43) in a survey sample of 35 Residents. 1. For Resident #22 the facility staff failed to conduct a quarterly review of Resident #22, to determine that placement in a secure unit continued to be appropriate for the resident. 2. For Resident #43 the facility staff failed to conduct a quarterly review of Resident #43 to determine that placement in a secure unit continued to be appropriate for the resident. The findings included: 1. For Resident #22 the facility staff failed to conduct a quarterly review to determine that continued placement in a secure unit was appropriate.	F 842	F 842 SS=D Resident Records-Identifiable Information CFR(s): 483.20 (f)(5), 483.70 (i)(1) -(5) With regard to the alleged deficient practice, the facility has taken the following action: 1. Corrective actions(s) accomplished for those residents found to have been affected by the alleged deficient practice. A. The quarterly secure unit assessment was completed for resident #22. B. The quarterly secure unit assessment was completed for resident #43 2. Identify other residents who have the potential to be affected by the same deficient practice and what corrective action was taken.	

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F 842	Continued From page 110 Resident #22, was originally admitted to the facility on 6/28/12, with a most recent readmission on 2/15/18. Diagnoses for Resident #22 included but were not limited to: unspecified psychosis, unspecified intellectual disabilities, difficulty in walking, type 2 diabetes, gastro-esophageal reflux disease, hypertension, anxiety, and unspecified convulsions. Resident #22's most recent MDS (minimum data set) (an assessment tool) with an ARD (assessment reference date) of 1/23/19, was coded as a significant change assessment. Resident #22 was coded as having a BIMS (brief interview for mental status) score of 6, which indicated severe cognitive impairment. Resident #22 was coded as being total care, dependent upon one staff member for assistance with transfers, dressing, eating, personal hygiene and bathing. Review of Resident #22's clinical chart revealed a document entitled, "Secured Unit Quarterly Assessment" it read, "date placed on secured unit: 7/26/18" Date of review: "1/10/19". On 4/17/19 at 8:55am the Director of Nursing (DON) was asked about a policy for the Secured Unit Quarterly Assessment form and the DON replied, "we don't have a policy, we just implemented this form because we felt we had to have something." When asked, when Resident #22 should have been reassessed to determine if continued placement in the secured unit was appropriate, the DON stated, "it should have been done the 10th." The facility Administrator, DON, and ADON were made aware of the findings that Resident #22's	F 842	The facility has identified all residents on the secured unit, as having the potential to be affected by this deficient practice. A. 100% audit of quarterly secured unit assessments were completed for all residents on the secured unit to determine if they remained appropriate for continued placement. 3. Measures/systemic changes put in place to ensure this deficient practice does not reoccur: A. Licensed staff has been in-serviced by the DON/Designee on the appropriate documentation for residents on the secured unit to determine if placement continues to be appropriate. B. A schedule for the secured unit assessments have been established that coincides with the resident□s quarterly reviews. C. DON/Designee will audit the quarterly skilled unit assessments 5 days a week x 4 weeks then monthly to ensure compliance. D. New admissions to the secured unit will have an assessment completed upon placement on the unit. 4. Monitoring of corrective action to ensure the deficient practice does not reoccur:	

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F 842	Continued From page 111 medical record was incomplete on 4/18/19 during end of day review. No further information was provided. 2. For Resident #43 the facility staff failed to conduct a quarterly review of Resident #43 to determine that placement in a secure unit continued to be appropriate for the resident. Resident #43, was originally admitted to the facility on 9/22/08, with a most recent readmission on 4/24/09. Diagnoses for Resident #43 included but were not limited to: age related osteoporosis, glaucoma, dementia, pick's disease and unspecified kidney failure. Resident #43's most recent MDS (minimum data set) (an assessment tool) with an ARD (assessment reference date) of 2/22/19 was coded as a quarterly assessment. Resident #43 was coded as having severe cognitive impairment based on a staff assessment, a BIMS (brief interview for mental status) was not able to be conducted. Resident #43 was coded as being total care, dependent upon one staff member, for assistance with dressing, eating, personal hygiene and bathing. Review of Resident #43's clinical chart revealed a document entitled, "Secured Unit Quarterly Assessment" it read, "date placed on secured unit: 1/15/19" Date of review: "1/15/19". On 4/17/19 at 8:55am the Director of Nursing (DON) was asked about a policy for the Secured Unit Quarterly Assessment form and the DON replied, "we don't have a policy, we just	F 842	Reports of the findings from the audits will be reported by the Director of Nursing to the QAPI meeting for review until thresholds are met. Any trends or patterns identified will be addressed and corrective action plan revised if applicable.	

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F 842	Continued From page 112 implemented this form because we felt we had to have something." When asked, when Resident #43 should have been reassessed to determine if continued placement in the secured unit was appropriate, the DON stated, "it should have been done the 15th." The facility Administrator, DON, and ADON were made aware of the findings that Resident #43's medical record was incomplete on 4/18/19 during end of day review. No further information was provided.	F 842		
F 868 SS=D	QAA Committee CFR(s): 483.75(g)(1)(i)-(iii)(2)(i) §483.75(g) Quality assessment and assurance. §483.75(g)(1) A facility must maintain a quality assessment and assurance committee consisting at a minimum of: (i) The director of nursing services; (ii) The Medical Director or his/her designee; (iii) At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; §483.75(g)(2) The quality assessment and assurance committee must: (i) Meet at least quarterly and as needed to identifying issues with respect to which quality assessment and assurance activities are necessary. This REQUIREMENT is not met as evidenced by: Based on staff interview, and facility documentation review, the facility staff failed to maintain a Quality Assessment and Assurance	F 868	F 868 SS=D QAA committee	5/29/19

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F 868	Continued From page 113 (QAA) Committee consisting of the minimum members in two of four quarters from April 2018-March 2019. 1. For the April 24, 2018 Quarterly QAA meeting, the administrator was not in attendance and the Administrator and Director of Nursing did not attend the January 28, 2019 Quarterly QAA meeting. The findings included: 1. For the April 24, 2018 Quarterly QAA meeting, the administrator was not in attendance and the Administrator and Director of Nursing did not attend the January 28, 2019 Quarterly QAA meeting. On 4/19/2019 at 11:10 AM, an interview was conducted with the Director of Nursing and Risk Manager who both stated the facility held quarterly meetings as scheduled as well as monthly meetings to discuss quality assurance. The Director of Nursing stated she and the administrator attended the QAA meetings each quarter as scheduled. On 4/18/19 at 11:15 AM, a review of the facility's Quality Assessment and Assurance (QAA) committee was conducted with the Director of Nursing (DON) and the Risk Management Nurse (Employee D). Employee D stated that the facility's QAA committee "Meets on a monthly basis and the Medical Director, Administrator and Director of Nursing are present at the quarterly meetings." When asked who was on the QAA committee, the Director of Nursing included the Administrator, Director of Nursing, Medical Director, social worker, dietary, activities director,	F 868	CFR(s): 483.75 (g)(1)(i)-(iii)(2)(i) With regard to the alleged deficient practice, the facility has taken the following action: 1. Corrective actions(s) accomplished for those residents found to have been affected by the alleged deficient practice. Training completed by the Regional Quality Assurance Nurse with the facility Nursing Home Administrator and Director of Nursing regarding the federal requirement for QAA committee attendance policy on 5/2/2019. 2. Identify other residents who have the potential to be affected by the same deficient practice and what corrective action was taken. Attendance at QAA committee meetings will be required monthly for all team members in order to better identify problematic areas and root cause analysis of areas needing improvement. This includes the Nursing Home Administrator and Director of Nursing. 3. Measures/systemic changes put in place to ensure this deficient practice does not reoccur: Risk Manager will prepare Quality Assurance & Process Improvement Meeting form that will address meeting agenda and date/time of next QAA meeting. This form will be distributed to	

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F 868	Continued From page 114 therapy and other staff members depending on what topics were being discussed. The QAA sign in sheets and Committee reports were presented and reviewed with the Director of Nursing and Employee D. The review revealed the administrator did not attend the April 24, 2018 Quarterly QAA meeting. Further review revealed the Administrator and Director of Nursing did not attend the January 28, 2019 Quarterly QAA meeting. The Director of Nursing stated she was sure she attended the meetings. A thorough review of the Committee reports on both dates revealed the Director of Nursing and/or Administrator were not in attendance as noted on the sign in sheets. During the end of day debriefing on 4/18/2019, the Director of Nursing and Administrator in training (Employee C) were informed of the findings. The facility staff did not present any further information regarding the findings.	F 868	Interdisciplinary Team (including Nursing Home Administrator and Director of Nursing) (2) weeks before the next scheduled QAA meeting as notification of the meeting date. Any conflicts in schedule will be addressed. The Risk Manager also compiled a list of all scheduled QAA meetings for the 2019 year and copy was provided to each member of QAA committee to allow them to mark the dates on their calendars. Risk Manager will provide verbal reminder to the QAA committee during morning meeting the day before the scheduled QAA meeting. 4. Monitoring of corrective action to ensure the deficient practice does not reoccur: Risk Manager will audit QAA committee attendance sign-in sheets (1) x per month x□s (6) mos. to verify Nursing Home Administrator and Director of Nursing attendance at monthly meetings. Reports of the findings from the audits will be reported by the Risk Manager to the QAPI meeting for review until thresholds are met. Any trends or patterns identified will be addressed and corrective action plan revised if applicable. 5. completion date 5/29/19	
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f)	F 880		5/29/19

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F 880	Continued From page 115 §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; (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,	F 880		

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F 880	Continued From page 116 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, resident interview, facility documentation review, and clinical record review, the facility staff failed to ensure infection prevention for 1 Resident (Resident #36) in a survey sample of 35 Residents. For Resident #36, the facility staff failed to ensure a partially full urinal was not present by his plate of food during meal services. The findings included;	F 880	F880 SS=D Infection Control & Prevention CFR(s): 483.80 (a)(1)(2)(4)(e)(f) With regard to the alleged deficient practice, the facility has taken the following actions: 1. Corrective action(s) accomplished for this resident found to have been affected by the alleged practice includes:	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 117 Resident # 36 a 75 year old man admitted to the facility on 3/8/17 with diagnosis of but not limited to Congestive Heart Failure, Hypertension, Renal Failure, and Schizophrenia. Resident #75's last (Minimum Data Set) MDS (screening tool) coded Resident as having a (Brief Interview of Mental Status) BIMS score of 15 indicating no cognitive impairment. The Resident is also coded as being incontinent and using a urinal at bedside. On 4/16/19 at 8:00 AM during initial tour, Resident #36 was sitting on the side of bed with bed table in front of him eating breakfast. Directly to the right of his plate was a urinal half filled with urine. On 4/16/19 at 12:00 PM, the Resident was noted sitting on the side of the bed eating lunch and once again the urinal was beside his plate. CNA C was asked to come and look at Resident in room and asked her what looked wrong. CNA stated the urinal shouldn't be on the table while he is eating and it needs to be emptied. On 4/17/19 3:00 PM, in an interview with the DON she was asked about the urinal on the bedside table. The DON stated that it where he likes to keep it. When asked what the importance of not having the urinal on the bedside table and she stated it's an infection risk. She stated that it should be care planned. Review of care plan did not mention Resident #36 wanting to keep the urinal on the bedside table. On 4/17/19 at 2:45 PM in an interview with the Resident he stated that he keeps the urinal on the	F 880	A. Resident #65 was interviewed by DON on 4/25/19 to detail his urinal preferences for urinal placement. B. The care plan for resident #65 was updated to include that he preferred his urinal on his bedside table within in reach C. The resident was educated on the infection control risk by leaving urinal on table when eating meals 2. How will the facility identify others as having the potential to be affected by this alleged deficient practice: The facility has identified all other residents with infection control risks with meals. A. 100% audit was completed by the DON/Designee of all residents that use urinals or other equipment to ensure preferences were care planned, and infection prevention principles were adhered to. 3. Measures/systematic changes put in place to ensure this alleged deficient practice does not recur includes: A. Staff were in-serviced by DON/Designee on the facilities infection prevention and control program. B. The infection control nurse educated the residents at the Facility Resident	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495375	A. BUILDING _____ B. WING _____	04/18/2019

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F 880	Continued From page 118 bedside table so they will see it and empty it. During end of day meeting on 4/18/19 at 12:15 PM the Administrator and DON were made aware of the issues and no further information was provided.	F 880	council meeting on infection control standards and transmission of organisms. 4. Monitoring of corrective action to ensure this alleged deficient practice will not recur includes: A. DON/Designee and nurse managers will complete rounds 5x weekly x 4 weeks then 1 x monthly x 3 months on varying shifts to ensure compliance with the infection prevention and control program. B. The findings of the audits will be reported to the Nursing Home Administrator immediately when the policy is not adhered to. C. Reports of the findings from the audits, along with any disciplinary action, if applicable, will be reported for 3 months by the Director of Nursing to the Quality Assurance committee consisting of the Director of Nursing, Medical Director, NHA, MDS coordinator, Pharmacy Consultant, Social Service Director and Dietary Manager on a monthly basis. Any trends or patterns identified will be addressed and corrective action plan revised if applicable.	
F 908 SS=D	Essential Equipment, Safe Operating Condition CFR(s): 483.90(d)(2) §483.90(d)(2) Maintain all mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT is not met as evidenced by: Based on observation, resident representative	F 908	F 908	5/29/19

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F 908	Continued From page 119 interview, and staff interview the facility staff failed to maintain equipment in safe operating condition for one resident (Resident #53) in a survey sample of 35 residents. The facility staff failed to maintain the bed and room in safe repair for Resident #53. The findings included: Resident # 53 had an original admission on 10/1/15, with a recent readmission on 1/28/19. Resident #53's diagnoses included but were not limited to: Parkinson's, dysphagia, hyperglycemia, hypokalemia, vascular dementia, GERD, and C4 Cervical Spinal Cord Injury. Resident #53's most recent MDS (minimum data set) (an assessment tool) with an ARD (assessment reference date) of 3/6/19, was coded as a quarterly assessment. Resident #53 was coded as being severely cognitively impaired. For activities of daily living (ADL's) to include transfers, dressing, eating, personal hygiene, toileting and bathing, Resident #53 was totally dependent on one staff member for care. On 4/16/19 at 02:41 PM, during a resident representative interview, the head board of Resident #53's bed was observed to be broken and leaning against the wall. The resident representative then pointed to the call bell electrical box which was not secured to the wall. The resident representative then stated "the light in the bathroom has been out for over a month." On 4/17/19 at 9:18am Employee E, the maintenance director, was taken to the room and shown the head board of the bed. The	F 908	SS=D Essential Equipment, Safe Operating Condition CFR(s): 483.90 (d)(2) With regard to the alleged deficient practice, the facility has taken the following action: 1. Corrective actions(s) accomplished for those residents found to have been affected by the alleged deficient practice. On 4/17/19 Maintenance Director repaired the headboard on Resident #53 bed and reattached to the bed, secured the call bell electrical box to the wall and replaced the bulb in the bathroom light fixture. 2. Identify other residents who have the potential to be affected by the same deficient practice and what corrective action was taken. Maintenance Director completed safety inspection of all resident rooms-focus areas of electrical outlets/switches and plates in good condition. Lighting fixtures/bulbs in good condition. Resident furniture and equipment in good condition. All areas of concern repaired. 3. Measures/systemic changes put in place to ensure this deficient practice does not reoccur: Guardian Angel Round Tool will be completed by members of Interdisciplinary Team M-F. Electrical outlets, switches	

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F 908	Continued From page 120 maintenance director stated, "this has not been reported, I see what is wrong, when they moved the bed they knocked it off." When asked about the call bell electrical box, the maintenance director stated "I don't know what is going on with them, they have broke the thing here." When Employee E was asked about the bathroom light, he stated "she just called me about this, I was headed to get a bulb when you stopped me." The facility Administrator, DON, and ADON were made aware of the findings on 4/18/19 of facility staff's failure to provide Resident #53's bed and room in safe repair. No further information was provided.	F 908	and plates added to daily guardian angel round tool. Lighting fixtures/bulbs added to guardian angel round tool. Resident furniture/equipment in good condition added to guardian angel round tool. Guardian Angel Tools will be reviewed in morning meeting any areas of safety concern are addressed and assigned as indicated, with follow-up per the nursing home administrator. Maintenance Director will complete monthly Safety inspection form which includes inspection of resident rooms for safety concerns. Results will be reported to the safety committee monthly, areas of concern to be addressed with follow-up. 4. Monitoring of corrective action to ensure the deficient practice does not reoccur: Maintenance Director to complete monthly safety inspection of resident rooms. Reports of the findings from the inspections will be reported by the Maintenance Director to the QAPI meeting for review until thresholds are met. Any trends or patterns identified will be addressed and corrective action plan revised if applicable. 5. completion date 5/29/19	