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	495201	A. BUILDING _____ B. WING _____	C 05/01/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SENTARA NURSING CENTER PORTSMOUTH	4201 GREENWOOD DRIVE PORTSMOUTH, VA 23701

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 04/28/19 through 05/01/19. The facility was in substantial compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities. No emergency preparedness complaints were investigated during the survey.	E 000		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 04/28/19 through 05/01/19. Significant corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. Six complaints were investigated during the survey. The census in this 124 certified bed facility was 74 at the time of the survey. The survey sample consisted of 35 current Resident reviews and 7 closed record reviews.	F 000		
F 550 SS=E	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and	F 550	1. Residents #33, #20, #2, #7 and #58 have been receiving a dignified dining experience for all meals as evidence by timely delivery of meals and serving all residents sitting at a table together during the meal period. 2. All facility residents are at risk for facility failing to provide a dignified dining experience. 3. Director of Nursing (DON), Clinical Manager, Dining Director or designee will education facility staff on standards of practice for a dignified dining experience. 4. Clinical Manager, Dining Director or designee will round 25% of residents 5 times weekly x 4 weeks, then weekly x 4 weeks to ensure residents are receiving a dignified dining experience. Variances identified will be corrected and staff re-educated as necessary. Results of audits will be reviewed for patterns and/or trends and reported to QAPI for 2 months. 5. Compliance Date: June 10, 2019	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: William [illegible]
TITLE: ADMINISTRATOR
(X6) DATE: 5/20/2019

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

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promote the rights of the resident.

§483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source.

§483.10(b) Exercise of Rights.
The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States.

§483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility.

§483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart.
This REQUIREMENT is not met as evidenced by:
Based on observation and staff interview it was determined that facility staff failed to provide a dignified dining experience for five of 42 residents in the survey sample; Resident #33, #20, #2, #7 and #58 in the activity room on unit one.

Facility staff failed to provide Resident #33 a dignified dining experience during dinner on 4/28/19; and failed to provide Residents #20, #2, #7 and #58 a dignified dining experience for lunch on 4/30/19 in the activity room on unit one.

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The findings include:

On 4/28/19 at 5:39 p.m., observation of dining in the activity room was conducted. Four residents were observed sitting in the activity room waiting for their meals.

On 4/28/19 at 5:46 p.m., three residents were served their meals. The fourth resident (Resident #33) did not have her tray at this time.

On 4/28/19 at 5:50 p.m., an aide brought in a fifth resident into the activity room for his meal.

On 4/29/18 at 5:55 p.m., Resident #33 still did not have her meal. Resident #33 appeared very agitated and stated, "I am so hungry."

On 4/28/19 at 5:59 p.m., the fifth resident was given his meal. At this time Resident #33 kept repeating, "I am so hungry. I am so hungry."

On 4/28/19 at 6:00 p.m., LPN (Licensed Practical Nurse) #3 told this writer that she had sent the nurse supervisor to get Resident #33's tray. LPN #3 stated that the resident's tray was on the second cart. When asked if Resident #33 normally ate in the activity room for dinner, LPN #3 stated that she did. When asked if her tray was always late, LPN #3 stated that the kitchen had been mixing her tray up and that sometimes it was on the first cart and sometimes it was on the second cart. When asked if she should have her meal timely with the other residents in the activity area, LPN #3 stated that she should. When asked how she would feel if she were at a restaurant and her meal was out 15 minutes later than her guests, LPN #3 stated that she would be

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impatient and upset and would expect updates on the status of her food.

On 4/28/19, Resident #33 did not receive her tray until 6:04 p.m. (18 minutes) after the first three residents received their meal.

On 4/30/19 at 12:44 p.m., this writer observed one CNA (Certified Nursing Assistant) #2, in the activity room assisting Resident #72 with her lunch. Seven residents total were observed in the activity/dining area at this time. Resident #31 and #70 were observed eating lunch and feeding themselves. These residents were almost finished with their lunch.

Resident #58 was observed sitting at a table, food untouched across from Resident #72 and the CNA. Resident #20 and #7 were also sitting in front of their food, food untouched. Resident #2 was sitting at a table with Resident #20 with no tray in front of her. CNA#2 stated that she wasn't sure if Resident #2 had ate or not. Resident #2 stated at this time that she had wanted her food.

On 4/30/19 at 12:44 p.m., an interview was conducted with CNA #2. CNA #2 stated that it was just her feeding the residents that day. CNA #2 stated that Resident #72, #58, #20, #7, and #2 all needed assistance with their meals. CNA #2 stated that feeding all five residents doesn't usually take too much time.

On 4/30/19 at 1 p.m., Resident #7 was observed being fed by a second CNA while CNA #2 was assisting Resident #2 with her meal.

On 4/30/19 at 1:10 p.m., a third CNA came to assist Resident #58 with her meal. Resident #58

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F 550	Continued From page 4 refused at this time. On 4/30/19 at 1:20 p.m., CNA #2 started to assist Resident #20 with her meal. On 4/30/19 at 2:18 p.m., further interview was conducted with CNA #2. When asked why there was only one CNA to five residents who needed assistance with meals, CNA #2 stated that most days there are not as many "feeders." CNA #2 stated, "Today we (staff) were kind of busy feeding other residents in their rooms." When asked if waiting 15 to 36 minutes to eat while their tray was sitting in front of them was a long time to wait for assistance, CNA #2 stated that it was a long time. When asked how she would feel if she were to wait that long to eat while people around her were eating, CNA #2 stated, "I would feel some type of way." When asked if waiting that long to eat while watching other residents eat was a dignity issue, CNA #2 stated, "I would say it was wrong." CNA #2 stated that eventually she had help from the other CNAs and that lunch time was not normally like that. On 5/1/19 at 2:20 p.m., ASM (administrative staff member) #1, the interim administrator and ASM #2, the interim DON (Director of Nursing) were made aware of the above concerns. A policy could not be provided regarding a dignified dining experience.	F 550		
F 573 SS=D	Right to Access/Purchase Copies of Records CFR(s): 483.10(g)(2)(i)(ii)(3) §483.10(g)(2) The resident has the right to access personal and medical records pertaining to him or herself.	F 573		

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F 573	Continued From page 5 (i) The facility must provide the resident with access to personal and medical records pertaining to him or herself, upon an oral or written request, in the form and format requested by the individual, if it is readily producible in such form and format (including in an electronic form or format when such records are maintained electronically), or, if not, in a readable hard copy form or such other form and format as agreed to by the facility and the individual, within 24 hours (excluding weekends and holidays); and (ii) The facility must allow the resident to obtain a copy of the records or any portions thereof (including in an electronic form or format when such records are maintained electronically) upon request and 2 working days advance notice to the facility. The facility may impose a reasonable, cost-based fee on the provision of copies, provided that the fee includes only the cost of: (A) Labor for copying the records requested by the individual, whether in paper or electronic form; (B) Supplies for creating the paper copy or electronic media if the individual requests that the electronic copy be provided on portable media; and (C)Postage, when the individual has requested the copy be mailed. §483.10(g)(3) With the exception of information described in paragraphs (g)(2) and (g)(11) of this section, the facility must ensure that information is provided to each resident in a form and manner the resident can access and understand, including in an alternative format or in a language that the resident can understand. Summaries that translate information described in paragraph (g)(2) of this section may be made available to the patient at their request and expense in	F 573	1. Resident #330 was provided a copy of the requested medical records on 12/18/19. 2. All residents, patients or resident representatives are at risk for delays in receiving medical records within required regulation timeframe(s). 3. Administrator or designee will educate staff on regulation related to medical records release. 4. Medical Record Clerk or designee will audit 100% of medical record request(s) for 4 weeks, then 50% of medical record request(s) x 4 weeks to ensure medical records are released according to regulation. Variances identified will be corrected and results of audits will be reviewed for patterns and/or trends. Findings will be reported to QAPI x 2 months. 5. Compliance Date: June 10, 2019	

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accordance with applicable law.
This REQUIREMENT is not met as evidenced by:
Based on clinical record review, staff interviews and facility documentation, the facility staff failed to provide a copy of medical record after a written request was made for 1 of 42 residents (Resident #330) in the survey sample.

The facility staff failed to provide Resident #330 a copy of his medical record after a written consent was signed.

The findings included:

Resident #330 was admitted to the facility on 11/05/18. Diagnoses for Resident #330 included but were not limited to Malignant Neoplasm of Prostate. Resident #330's Minimum Data Set (an assessment protocol) with an Assessment Reference Date (ARD) of 01/02/19 coded Resident #330 Brief Interview for Mental Status (BIMS) score a 15 of a possible 15 indicating no cognitive impairment.

In addition, the MDS coded Resident #330 as requiring total dependence of one with bed mobility, hygiene and bathing, extensive assistance of one with toilet use and dressing for Activities of Daily Living care. Resident was also coded for occasional incontinence of bowel and bladder and intermittent catheterization.

An interview was conducted with the Clinical Record Clerk on 05/01/19 at approximately 2:45 p.m. She said on 12/18/18, Resident #330's son called asking why was there a delay retrieving Resident #330's medical record. The son said that his dad's medical record was requested but

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did not hear back from the facility. She apologized to Resident #330's son, promised to speak with the Administrator and get back with him as soon as possible. She said the son informed her that the Administrator waived the coping fee. On the same day, the Clinical Record Clerk said she spoke with the previous Administrator regarding the request of Resident #330's medical record. She said the Administrator informed her that he had meet with Resident #330, a written agreement was signed to make copies of his medical record. He also said there was no copying fees. The Clinical Records Clerk said, Resident #330's medical record was copied and pick up the same day by Resident #330's Power of Attorney (POA).

A document was present to the surveyor from the Clinical Record Clerk, the following information included:
-Re: Medical Records for Resident #330
-I am requesting a copy of my medical record from my admission through current period.
-Signed and date on 12/01/18 by Resident #330 and the previous Administrator.

The facility's policy titled Medical Records Release of Information (Last revision date: 07/13/19).
-It is the facility policy to maintain the confidentiality of the Resident's personal and clinical records and provide the right to access their own records.

Performed by: Medical Records / Business Office Personnel
-Patient, resident or resident representative has the right--upon an oral or written request, in the form and format requested by the individual, if it is

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F 573	Continued From page 8 readily producible in such form and format (including in an electronic form or format which such records are maintained electronically), or if not, in a readable hard copy form or such other form and format as agreed to by the facility and the individual, to access all records pertaining to him/her, including current clinical records within 24-hours (excluding weekends and holidays). -After receipt of his/her records for inspection, the patient, resident or resident representative may purchase at a cost not to exceed the standard photocopies upon request to obtain a copy of the records or any portions thereof (including in an electronic form or format when such records are maintained electronically) upon request and 2 working days advance notice to the facility. Complaint deficiency.	F 573		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to	F 580	1. Resident #30 Physican and Responsible Party were notified of the change in condition and current plan of care as related to open areas on 5/20/19 2. All residents are at risk for facility failing to notify physician and responsible party of resident's change in condition. 3. An audit of all residents who identified with a change in condition since May 1,2019 will be reviewed to ensure the Responsible Party (RP) and physician were notified for change in condition. Facility staff will be educated by Staff Developement Coordinator or designee on procedures for notifying the RPs and MDs. 4. The DON or designee will review 10% of residents identified with a change in condition weeky x 4 weeks then 5% x 4 weeks to ensure the RP and MD were notifications were completed. Results of audits will be reviewed for patterns and/or trends and reported to QAPI x 2 months 5. Compliance Date: June 10, 2019	

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commence a new form of treatment); or
(D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii).
(ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician.
(iii) The facility must also promptly notify the resident and the resident representative, if any, when there is-
(A) A change in room or roommate assignment as specified in §483.10(e)(6); or
(B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section.
(iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s).

§483.10(g)(15)
Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9).
This REQUIREMENT is not met as evidenced by:
Based on observation, resident interview, staff interview, facility documentation review, clinical record review, the facility staff failed to notify pertinent individuals of a change in condition for 1 of 42 Residents (Resident #30), in a survey sample.

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The facility staff failed to notify the physician and Responsible Party of Resident #30's open areas on the right lower extremity.

The findings included:

Resident #30 was admitted to the facility on 4/24/18 and readmitted on 2/19/19. Diagnoses for Resident #30 included but not limited to Diabetes Mellitus, Hypertension, and Cerebral Vascular Incident, dementia and Xerosis Cutis.

Resident #30's Quarterly Minimum Data Set with an Assessment Reference Date (ARD) of 7/02/18 coded Resident #30 as having short term and long term memory problems. With cognitive skills indicating a severe cognitive impairment.

In section "G" (Physical functioning) the resident was coded as being totally dependent with eating, locomotion, dressing, personal hygiene, bathing, bed mobility, transfers, and toileting. In section "H" Bladder and Bowel, the resident was coded as always incontinent of bowel and bladder.

On 04/29/19 09:30 AM a family interview was conducted with Resident #30's spouse. She stated that while visiting with her husband that she noticed a sore on her husband's right leg about a week ago. She stated no one called to inform her about the sore.

On 04/29/19 at approximately, 11:29 AM the surveyor asked Resident # 30's Certified Nursing Assistant (CNA) #7 to show her the resident's lower extremities. On the residents right lower leg was a kerlix dressing with no date, and no initials or time.

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On 04/29/19 at approximately, 11:37 AM, Licensed Practical Nurse-LPN #2, unit manager, was approached concerning the dressing on Resident #30's Right Lower Leg. She and Registered Nurse #3 assisted the resident with ADL care and saw the dressing on Resident's right lower extremity. Both nurses verified the attached dressing had no initials, date or time. They stated that resident gets night time dressing changes to his right lower leg.

On 04/30/19 at 12:08 PM, Physicians order sheet read to cleanse wound on right lower leg with DWC then apply Xeroform and dry bordered dressing. Verbal order read back by LPN #7 on 04/30/19 at 4:33 PM.

On 04/30/19 at 11:15 AM LPN #7 was approached concerning Resident #30 dressing on right lower extremity. LPN #7 said that the dressing on resident #30's RLE (Right Lower Extremity) was a scab. She also said that she's been applying wound cleanser, patting it dry with gauze and applying xeroform dressing. She said that it is a night time order and should be done on the night shift. She also stated that the sores come and go usually on both lower legs that "open up when he's being cleaned". "Venous issues." She said that no order was put in. The surveyor asked LPN #7 what should have been done concerning the above issue? She stated that an incident report and wound assessment should have been done and the physician and Family member should have been called.

On 04/30/19 at approximately 11:48 AM Resident #30's wife was visiting with him.

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F 580	Continued From page 12 On 05/01/19 at approximately, 11:15 AM requested clinical notes from Licensed Practical Nurse (LPN) #7. Clinical notes revealed the following: Dated 04/12/19 at 1935. States "Made aware by Aide on Pt. legs Noted. Pt.'s right lower leg was bleeding. Unaware how it happened." "Tender to the touch. Cleansed area with DWC, covered with xeroform and wrapped with kerlix." "On call MD was made aware." "Asked to place into book for Doctor's book for follow up in the morning. Will continue to monitor." Resident #30's Care Plan documented the following problem: Resident is at risk for pressure ulcers. The Goal included: Resident #30 will remain free of skin breakdown over the next 90 days. Interventions included: Check skin for redness, skin tears, swelling, or pressure areas. Report any signs of skin breakdown. The Administrator and the Director of Nursing (DON) were made aware of these findings on 05/01/19 at approximately 5:06 PM. The DON stated that the facility staff should have notified the family Representative.	F 580		
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	F 582	1. An Advanced Benificiary Notice (ABN) was issued to Resident #68 on May 20, 2019 2. All skilled residents who transition to long term care are at risk of not receiving ABN's timely. 3. Social Services Director or designee will educate staff on the process/regulation for issueing ABNs for residents. 4. Social Services Director or designee will audit 100% of skilled residents admitted since April 1, 2019 to ensure ABN notices were issued Then will audit 50% skilled residents admitted to ensure ABN notices were issued for residents transitioning to long term care x 4 weeks. Variances will be reviewed for patterns and/or trends and reported to QAPI 5. Compliance Date: June 10, 2019	

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facility offers and for which the resident may be charged, and the amount of charges for those services; and
(ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section.

§483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate.
(i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible.
(ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change.
(iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements.
(iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility.
(v) The terms of an admission contract by or on

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behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations.
This REQUIREMENT is not met as evidenced by:
Based on clinical record review, staff interviews and facility documentation, the facility staff failed to ensure Medicare Beneficiary Notices in accordance with applicable Federal regulations, were issued to 1 of 3 residents (Resident #68) in the survey sample.

The facility staff failed to issue an Advanced Beneficiary Notice (ABN) letter to Resident #68. Resident #68 was discharged from skilled services who remained in the facility with Medicare days remaining.

The findings included:

Resident #68 was admitted to the nursing facility on 03/06/19 with a diagnosis included but not limited to Amyotrophic Lateral Sclerosis (ALS).

The Minimum Data Set (MDS-an assessment protocol) with an Assessment Reference Date (ARD) of 04/04/19 coded the resident with a 12 out of a possible score of 15 on the Brief Interview for Mental Status (BIMS), which indicated moderate cognitive impairment.

On review of the Beneficiary Notification Checklists provided by the facility to surveyor, Resident #68 was not listed for having been issued the SNF ABN (Skilled Nursing Facility-Advanced Beneficiary Notice, form CMS-10055). The resident had received a NOMNC (Notice of Medicare Provider Non-Coverage-form CMS-10123); however no

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F 582	Continued From page 15 copies of the SNF ABN (CMS-10055) were provided. Resident #68 started a Medicare Part A stay on 03/06/19 and the last covered day of this stay was 04/05/19. Resident #68 was discharged from Medicare Part A services when benefit days were not exhausted and should have been issued a SNF ABN and a NOMNC. Resident #68 had only used 30 days of his Medicare Part A services. The resident/representative was not issued an ABN letter. An interview conducted with the SW on 05/01/19 at approximately 10:42 a.m., who stated, "The ABN letter was not issued because at the time of Resident #68's admission, the resident was to remain here in the facility as a Long Term Care (LTC) resident." She stated, "I'm actually reading now as we speak when to issue an ABN letter and just now realized Resident #68 should have received an ABN." The facility administration was informed of the finding during a briefing on 05/01/19 at approximately 4:45 p.m. The facility did not present any further information about the findings.	F 582		
F 583 SS=D	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits,	F 583		

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F 583	Continued From page 16 and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. This REQUIREMENT is not met as evidenced by: Based on observation during wound care and staff interviews the facility staff failed to assure privacy was maintained during the provision of care for 1 of 42 residents (Resident #67), in the survey sample. The facility staff failed to pull the privacy curtain to obscure Resident #67 from view while providing wound care and failed to wait for a response after knocking on the door before entering.	F 583	1. The situation related to pulling of privacy curtain during a procedure for resident #67 can not be remedied due to past date of the incident identified cited. LPN #6 resigned on 5/17/19 2. All residents receiving treatments or procedures are at risk not having privacy curtain pulled during a treatment and/or procedure. 3. DON, Clinical Manager or designee will eduate staff on procedure to ensure resident's personal privacy is preserved when receiving care or upon entering resident's room or treatment area(s). 4. Clinical Manager, DON or designee will audit 25% of residents 3x per week for 4 weeks, then 10% of residents x 4 weeks to ensure resident privacy is maintained. Variances identified will be corrected and staff re-educated. Results of these audits will be reviewed for patterns and/or trends and reported to QAPI monthly for 2 months 5. Compliance Date: June 10, 2019	

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The findings included:

Resident #67 was originally admitted to the facility 03/10/16 and readmitted on 03/08/19. The current diagnoses included; Multiple Sclerosis, Major Depressive Disorder, Diabetes Mellitus, Pressure Ulcers.

The Minimum Data Set (MDS) Quarterly revision showed an assessment reference date (ARD) of 09/02/18 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 15. This indicated Resident #67's cognitive abilities for daily decision making were intact.

In section "G" (Physical functioning) the resident was coded as being independent requiring set up help only with eating. Totally dependent with locomotion, dressing, personal hygiene, bathing, bed mobility, transfers, and toileting. In section "M" Skin Conditions, the resident was coded as having one or more unhealed pressure ulcers.

On 04/29/19 at approximately, 12:29 PM Licensed Practical Nurse (LPN) #6 did not close the privacy curtain while providing wound care and as a result of not closing the privacy curtain another staff member knocked on the door and entered the room while wound care was being provided. The resident yelled out "Resident Care"

On 05/01/19 at approximately, 11:00 AM a brief interview was conducted with LPN #6 and LPN #2, Unit Manager. We discussed the privacy issues concerning the wound care provided to Resident #67. They were asked what should have been done. LPN #6 stated that the staff who knocked and then walked right in should have

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F 583	Continued From page 18 waited for a response from someone stating "Patient Care" LPN #2 stated that the privacy curtain should have been closed. The DON was approached for a policy on Privacy. No policy was provided. On 05/01/19, at approximately, 5:06 PM the above findings were shared with the Administrator and Director of Nursing (DON). The DON stated the staff should have closed the privacy curtains.	F 583		
F 584 SS=E	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. (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;	F 584	1. The situation regarding providing residents with a homelike dining environment count not be remedied for residents eating meals on 4/28/19, and 4/30/19 due to the past date of the incident cited on teh CMS Form 2567 from survey ending May 1, 2019. CNA #2 will receive 1:1 education on standards of practice for creating a homelike dining experience. 2. All residents are at risk for no being provided a homelike dining experience. 3. DON, Clinical Manager,Dining Director or designee will educate staff on the standards of practice for creating a homelike dining experience. 4. Clinical Manager, Dining Director or designee will round on 25% of residents 3x per week x 4 weeks then 1x weekly x 4 weeks to ensure residents are receiving a homelike dining experience. Variances identified will be corrected and staff re-educated as necessary. Results of the audits will be reviewed for patterns and/or trends and reported to QAPI x 2 months. 5. Compliance Date: June 10, 2019	

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§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 and staff interview, facility staff failed to provide a homelike environment during the dining observation on two separate occasions on 4/28/19 and 4/30/19 in the activity room of unit one.

Facility staff served resident meals on trays during the dining observation in the unit one activity room for dinner on 4/28/19 and for lunch on 4/30/19.

The findings include:

On 4/28/19 at 5:39 p.m., observation of dining in the activity room was conducted. Four residents were observed sitting in the activity room waiting for their meals.

On 4/28/19 at 5:46 p.m., three residents were served their meals. Their meals were served on trays.

On 4/28/19 at 5:50 p.m., an aide brought in a fifth

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resident into the activity room for his meal.

On 4/28/19 at 5:59 p.m., the fifth resident was given his meal. His meal was served on a tray.

On 4/28/19 at 6:04 p.m., the fourth received her meal. Her meal was removed from the tray.

On 4/30/19 at 11:21 a.m., an interview was conducted with CNA (Certified Nursing Assistant) #2. When asked how to maintain a homelike environment in the dining room, CNA #2 stated that she would ensure everyone is asked if they want a clothes protector and would also ask if everyone was in agreement with what was on the television in the activity dining area. CNA #2 stated that she would also ensure that all residents get served their meals at one time. When asked if meals should be served on trays, CNA #2 stated that she did not see a problem with meals being served on the tray and that this also alerts other residents not to take food from others. CNA #2 clarified that the meal tray created a space/barrier to prevent residents from taking other residents food. When asked if she ate her meals on a meal tray, CNA #2 stated that she did not have a dining room table and that she did eat her food on a tray. When asked if serving meals on trays was homelike, CNA #2 stated that she thought so. CNA #2 stated that the facility always served meals on tray in the activity room.

On 4/30/19 at 12:44 p.m., observation of lunch was conducted with CNA #2 in the unit one activity room. Seven residents total were observed in the activity/dining area at this time. Six residents were observed to have their meals on the tray. One resident did not receive her meal until 1 p.m. and was this was served on a tray. All

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F 584	Continued From page 21 residents were moderately to severely impaired in cognitive function. On 5/1/19 at 2:20 p.m., ASM (administrative staff member) #1, the interim administrator and ASM #2, the interim DON (Director of Nursing) were made aware of the above concerns. A policy could not be provided related to the above concerns. No further information was presented prior to exit.	F 584		
F 600 SS=D	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on information gathered during a complaint investigation, staff interview, clinical record review, and review of the facility's policy the facility staff failed to assure residents are not deprived by caregivers of services necessary to attain physical well-being for 1 of 42 residents	F 600	1. Resident #329 expired in the facility on 9/26/19. Facility staff were educated on Abuse/Neglect by the Ombudsman on 8/29/18 and 8/30/18. Employees #50, #51 and #25 were terminated. Employee #26 and the unit secretary were suspended and upon return received 1:1 education regarding responding to falls, compassion, empathy, abuse/neglect and responding to accidents and incidents. The unit secretary interviewed on 5/1/19 will receive 1:1 re-education on abuse, neglect, empathy, compassion sensitivity and providing care for high risk residents on 5/24/19. 2. All residents living in the facility are at risk for potential abuse and neglect. 3. Administrator, Clinical Manager or designee will educate facility staff on preventing, identifying, reporting of abuse and neglect. The Ombudsman or designee will meet with facility staff to educate again on resident's rights and abuse/neglect. Facility Risk Reporting System (STARs) will be reviewed by the administrator or designee daily x 4 weeks. Allegations of neglect will be investigated and resolved as appropriate by the Administrator or DON. The Infection Control Preventionist will educate staff on appropriate Infection Control practices for caring for residents with infectious diseases. 4. Administrator, DON or designee wil audit 100% of reported abuse/neglect STARs reports and grievance logs x 4 weeks to assure compliance and appropriate follow-up for allegations of abuse/neglect. Results of audits will be reviewed for patterns and/or trends and reported to QAPI. 5. Compliance Date: June 10, 2019	

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(Resident #329), in the survey sample.

The facility's staff failed to immediately assist, assess and render care to Resident #329 after a fall resulting in injury.

The findings included:

Resident #329 was originally admitted to the facility 6/11/18 and died in the facility 9/26/18. The diagnoses included human immunodeficiency virus and adult failure to thrive.

The significant change Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 9/23/18, coded the resident as not having the ability to complete the Brief Interview for Mental Status (BIMS). The staff interview was coded for long and short term memory problems as well as severely impaired daily decision making. In section"G"(Physical functioning) the resident was coded as requiring extensive assistance of 1 person with bed mobility and locomotion, extensive assistance of two people with transfers, total care of one person with eating, personal hygiene and bathing, total care of two people with dressing, and toileting.

The resident's care plan dated 8/28/18 had a problem which read; (name of resident) has a Red (high) risk for falls (greater than 45), on the Fall risk assessment. The goal read; no falls with serious injuries thru 11/28/18. The interventions included; move the resident close to the nurse's station, fall mat if appropriate, bed in low position placed in the falling leaf program, remain with resident while toileting.

On 8/13/18 facility's documentation revealed a

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video confirmed that Resident #329 was self propelling herself down the hallway by pulling along using the hand rails. When the resident reached a doorway, she lost her balance and fell forward out of the wheelchair. A number of facility staff were in the vicinity of the fall however the video confirmed they were not looking directly at the resident at the time of her fall. The video timeline revealed at 4:47 p.m., (6 seconds) the resident falls, 4:47 p.m., (11 seconds) staff members see the resident on the floor but does not assist or assess the resident, 5:01 p.m., (11 seconds), Licensed Practical Nurse # 50 touches the resident for the first time and renders care, 5:01 p.m., (20 seconds), the resident was lifted into her chair by her assigned nurse LPN #50, without an appropriate assessment. The facility documentation based on the video revealed though the staff were aware of the resident's fall and bleeding; the Resident #329 was left on the floor without staff assistance for approximately 2 minutes. LPN #50 and LPN #51 left the unit without assisting the resident, one Certified Nurse Assistant (CNA) was observed bring the vital sign machine but stated she stopped because she realized she couldn't touch the resident until she was assessed by the LPN. The Unit secretary was also at the desk and observed the resident on the floor but resumed her task at the desk without assisting the resident.

An interview was conducted with the unit secretary 5/1/19, at approximately 5:10 p.m. The unit secretary stated she wasn't a direct care provider therefore she sent out a page regarding the fall, sat at the desk and continued her secretarial duties. The unit secretary further stated she couldn't speak for others but she didn't assist Resident #329 because she was HIV+ and

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there was a lot of blood flowing from the resident's nose and one hand. The unit secretary stated the resident was "flapping" around in the blood spreading it all around the fall site.

The nurse's note dated 8/13/18 at 5:33 p.m., stated the resident was sent to a local acute care hospital for further care. Another nurse's note dated 8/14/18 at 2:45 a.m., included the resident returned to the facility at midnight with diagnosis of a closed fracture of the nasal bone.

The facility's policy titled "Abuse: Incident-Reporting, Definitions and Screening" with a revision date of 11/21/17. The policy stated the facility will respond to allegations involving but not limited to abuse, neglect, misappropriation of resident property, and exploitation. This includes but is not limited to freedom from verbal abuse, sexual, physical and mental abuse, mistreatment, neglect, misappropriation of resident property; corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's symptoms.

On 5/1/19, the above findings were shared with the Administrator and Director of Nursing. The Administrator stated it was the facility's expectation that staff responded appropriately and with compassionately when Resident #329 fell. The Administrator further stated the staff didn't console, stay with, comfort, or appropriately assess the resident following the fall. The facility's decision was to terminate LPN #50, LPN #51 and CNA #25. CNA #26 and the unit secretary were suspended and upon returning to work the following education was required and formal counseling was provided with one to one

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F 600	Continued From page 25 education regarding responding to falls, corporate values of compassion/empathy, recognizing abuse and neglect, responding to accidents and incidents involving a resident with infectious disease, and respecting and honoring resident's rights to confidentiality. Complaint Deficiency.	F 600		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified	F 609	1. Resident #329 expired on 9/16/19 in the facility. Employees #50, #51, and #25 were terminated. Employee #26 and the unit secretary were suspended and upon return received 1:1 education regarding responding to falls, compassion/empathy, abuse and neglect and responding to accidents/incidence on 9/4/18. 2. All residents living in the facility are at risk for potential abuse and neglect. 3. Administrator or designee will educate staff on preventing, identifying and reporting abuse and neglect to include Facility Reported Incidence (FRI), and complete a 6 months retrospective review of all FRIs to ensure appropriate timeliness of FRI reporting. 4. Administrator or designee will review 50% of FRIs for timeliness in reporting of abuse/neglect (2 hours) and all others (24 hours from the time of the incident). 5. Compliance Date: June 10, 2019	

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appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by:

Based on information gathered during a complaint investigation, staff interview, clinical record review, and review of the facility's policy, the facility staff failed to report an allegation of neglect within prescribed timeframes for 1 of 42 residents (Resident #329), in the survey sample.

The facility staff failed to timely report to appropriate state agencies a caregiver's failure to provides necessary services to Resident #329 following a fall resulting in injury.

The findings included:

Resident #329 was originally admitted to the facility 6/11/18 and died in the facility 9/26/18. The current diagnoses included human immunodeficiency virus and adult failure to thrive.

The significant change Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 9/23/18, coded the resident as not having the ability to complete the Brief Interview for Mental Status (BIMS). The staff interview was coded for long and short term memory problems as well as severely impaired daily decision making. In section"G"(Physical functioning) the resident was coded as requiring extensive assistance of 1 person with bed mobility and locomotion, extensive assistance of two people with transfers, total care of one person with eating, personal hygiene and bathing, total care of two people with dressing, and toileting.

The resident's care plan dated 8/28/18 had a problem which read; (name of resident) has a

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Red (high) risk for falls (greater than 45), on the Fall risk assessment. The goal read; no falls with serious injuries thru 11/28/18. The interventions included; move the resident close to the nurse's station, fall mat if appropriate, bed in low position placed in the falling leaf program, remain with resident while toileting.

On 8/13/18 facility's documentation revealed a video confirmed Resident #329 was self propelling herself down the hallway by pulling along using the hand rails. When the resident reached a doorway, she lost her balance and fell forward out of the wheelchair. A number of facility staff were in the vicinity of the fall however the video confirmed they were not looking directly at the resident at the time of her fall. The video timeline revealed at 4:47 p.m., (6 seconds) the resident falls, 4:47 p.m., (11 seconds) staff members see the resident on the floor but does not assist or assess the resident, 5:01 p.m., (11 seconds), Licensed Practical Nurse # 50 touches the resident for the first time and renders care, 5:01 p.m., (20 seconds), the resident was lifted into her chair by her assigned nurse LPN #50, without an appropriate assessment. The facility documentation based on the video revealed though the staff were aware of the resident's fall and bleeding; the Resident #329 was left on the floor without staff assistance for approximately 2 minutes. LPN #50 and LPN #51 left the unit without assisting the resident, one Certified Nurse Assistant (CNA) was observed bring the vital sign machine but stated she stopped because she realized she couldn't touch the resident until she was assessed by the LPN. The Unit secretary was also at the desk and observed the resident on the floor but resumed her task at the desk without assisting the resident.

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An interview was conducted with the unit secretary 5/1/19, at approximately 5:10 p.m. The unit secretary stated she wasn't a direct care provider therefore she sent out a page regarding the fall, sat at the desk and continued her secretarial duties. The unit secretary further stated she couldn't speak for others but she didn't assist Resident #329 because she was HIV+ and there was a lot of blood flowing from the resident's nose and one hand. The unit secretary stated the resident was "flapping" around in the blood spreading it all around the fall site.

The nurse's note dated 8/13/18 at 5:33 p.m., stated the resident was sent to a local acute care hospital for further care. Another nurse's note dated 8/14/18 at 2:45 a.m., stated the resident returned to the facility at midnight with diagnose of a closed fracture of the nasal bone.

Resident #329's fall occurred Monday, 8/13/18 at approximately 4:47 p.m., with no service from staff until 5:01 p.m. The facility's staff didn't notify the appropriate state agencies until Thursday, 8/16/18 at 5:00 p.m., and a final follow-up report was sent to the state agencies 8/23/18.

The facility's policy titled "Abuse: Incident-Reporting, Definitions and Screening" with a revision date of 11/21/17. The policy stated the facility will respond to allegations involving but not limited to abuse, neglect, misappropriation of resident property, and exploitation. This includes but is not limited to freedom from verbal abuse, sexual, physical and mental abuse, mistreatment, neglect, misappropriation of resident property; corporal punishment, involuntary seclusion and any

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F 609	Continued From page 29 physical or chemical restraint not required to treat the resident's symptoms. On 5/1/19, the above findings were shared with the Administrator and Director of Nursing. The Administrator stated it was the facility's expectation that staff responded appropriately and with compassionately when Resident #329 fell. The Administrator further stated the staff didn't console, stay with, comfort, or appropriately assess the resident following the fall. The facility's decision was to terminate LPN #50, LPN #51 and CNA #25. CNA #26 and the unit secretary were suspended and upon returning to work the following education was required and formal counseling was provided with one to one education regarding responding to falls, corporate values of compassion/empathy, recognizing abuse and neglect, responding to accidents and incidents involving a resident with infectious disease, and respecting and honoring resident's rights to confidentiality. Complaint Deficiency.	F 609		
F 622 SS=E	Transfer and Discharge Requirements CFR(s): 483.15(c)(1)(i)(ii)(2)(i)-(iii) §483.15(c) Transfer and discharge- §483.15(c)(1) Facility requirements- (i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless- (A) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility; (B) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the	F 622		

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F 622	Continued From page 30 services provided by the facility; (C) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident; (D) The health of individuals in the facility would otherwise be endangered; (E) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or (F) The facility ceases to operate. (ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose. §483.15(c)(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care	F 622	1. The facility cannot recreate resident's #73, #32, and #70 transfer documentation/medical records related to care plans due to date of incident cited on the CMS 2567 from the survey ending May 1, 2019. 2. All residents being transferred or discharged to other levels of care are at risk for errors in transfer practice. 3. DON, Clinical Manager or designee will educate clinical staff on the required documentation and communication for all residents tranferred or discharged to alternate levels of care sites. 4. DON, Clinical Manager, or designee will audit 100% of resident discharges/transfers to alternate level of care x 4 weeks, then 50% x 2 weeks. Variances identified will be corrected and staff re-educated as necessary. Results of the audits will be reviewed for patterns and/or trends and reported to QAPI from 2 months 5. Compliance Date: June 10, 2019	

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institution or provider.
(i) Documentation in the resident's medical record must include:
(A) The basis for the transfer per paragraph (c)(1)(i) of this section.
(B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s).
(ii) The documentation required by paragraph (c)(2)(i) of this section must be made by-
(A) The resident's physician when transfer or discharge is necessary under paragraph (c) (1) (A) or (B) of this section; and
(B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section.
(iii) Information provided to the receiving provider must include a minimum of the following:
(A) Contact information of the practitioner responsible for the care of the resident.
(B) Resident representative information including contact information
(C) Advance Directive information
(D) All special instructions or precautions for ongoing care, as appropriate.
(E) Comprehensive care plan goals;
(F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care.
This REQUIREMENT is not met as evidenced by:
Based on staff interviews, clinical record review and facility documentation review the facility staff failed to send a copy of the Resident's Care Plan to include their goals for 3 of 42 residents

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(Resident #73, 32, and 70) after being transferred to the hospital.

1. The facility staff failed to ensure that Resident #73's Plan of Care Summary to include their care plan goals was sent upon transfer/discharge to the hospital on 03/25/19.

2. For Resident #32, facility staff failed to evidence that all required documentation was sent with the resident upon transfer to the hospital for a facility-initiated transfer on 2/9/19.

3. For Resident #70, the facility staff failed to include in the transfer summary indication that the facility staff conveyed to the receiving providers the resident's comprehensive care plan goals at the time of discharge to the local hospital on 6/1/18, 6/3/18, 10/5/18 and 12/21/18 or as soon as possible to the actual time of transfer.

The findings included:

1. Resident #73 was originally admitted to the facility on 05/26/15. The resident was re-admitted to the facility on 04/02/19. Diagnosis for Resident #73 included but not limited to Osteomyelitis of the left foot and ankle.

Resident #73's current Minimum Data Set (MDS), a significant change with an Assessment Reference Date (ARD) of 04/09/19 coded the resident with a 15 out of a possible score of 15 on the Brief Interview for Mental Status (BIMS) indicating no cognitive impairment

The Discharge MDS assessment dated 03/25/19-discharge return anticipated, resident re-admitted on 04/02/19.

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An interview was conducted with License Practical Nurse (LPN) #2 on 04/30/19 at approximately 10:24 a.m. The surveyor asked, "What paperwork is sent with the resident when they are being sent out to the hospital." The nurse replied, "I will send the resident's medication list, transfer summary, bed hold policy and their face sheet." The surveyor asked, "Do you send the resident's personalized care plan which includes their goals that has been set by the facility." The LPN stated, "They should send their care plan." Resident #73 was sent from his doctor's appointment on 03/25/19 to the hospital and admitted. LPN #2 was asked, "After the facility was aware that resident was transferred to the hospital following his MD appointment, did the facility forward Resident #73's care plan to the hospital?" The LPN reviewed the clinical record for Resident #73 then stated, "The last note documented for Resident #73 was written on 03/20/19 and no more until he returned to the facility on 04/03/19." The surveyor asked, "What is the purpose of the resident's person centered care plan, she replied "To let the receiving provider know what is currently going on with the resident, the care plan will show their current condition and how to manage their care they are in their care." The surveyor asked, "How would the hospital know the residents care plan goals if they did not receive the care plan" she stated, "They would not, we should have sent the care plan and also called to give them report a verbal on Resident #73."

An interview was conducted with the Administrator and Unit Manager (Unit 1) on 04/03/19 at approximately 2:30 p.m. The Administrator stated, "We are inconsistent with

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issuing the resident's care plan; she said, "If it is not documented then it was not issued."

The facility administration was informed of the finding during a briefing on 05/01/19 at approximately 4:45 p.m. The facility did not present any further information about the findings.

2. Resident #32 was admitted to the facility on 11/28/2014 and readmitted on 2/14/19 with diagnoses that included but were not limited to Huntington disease (1), protein-calorie malnutrition, anxiety disorder and vascular dementia.

Resident #32's most recent MDS (minimum data set) assessment was a significant change assessment with an ARD (assessment reference date) of 2/21/19. Resident #32 was coded as being severely impaired on the staff interview for mental status evaluation. Resident #32 was coded as being totally dependent on staff with ADLs (Activities of Daily Living).

Review of Resident #32's clinical record revealed that she had been sent out to the hospital on 2/9/19. The following note was documented: "Resident noted with restlessness an abnormal vital signs. temp (temperature): 101.1, pulse 124, B/P (blood pressure) 131/60, respirations 20. Tylenol administered. (Name of MD) called and ordered to be send to hospital. 911 called and transported patient to (Name of Hospital) at about 1915 (7:15 p.m.) (RP (Responsible Party) (Name of RP) notified.

Further review of Resident #32's notes revealed that she was on antibiotic therapy prior to this hospitalization for cellulitis.

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A nursing note dated 2/10/19 documented the following: "Called placed to ER (emergency room) for update. Pt (patient) had been admitted for Sepsis, UTI (urinary tract infection), Dehydration."

Further review of Resident #32's clinical record revealed that Resident #32 was readmitted to the facility on 2/14/19.

There was no evidence that the required documentation; contact information of the practitioner responsible for the care of the resident, resident representative information including contact information, advance directive information, all special instructions or precautions for ongoing care, as appropriate and comprehensive care plan goals were sent with the resident upon transfer to the hospital on 2/9/19.

On 4/30/19 at 9:13 a.m., an interview was conducted with RN (Registered Nurse) #1, the clinical manager. When asked what documents were sent with the resident at the time of a transfer to the hospital, RN #1 stated that the care plan, transfer summary sheet, face sheet that listed out diagnoses, code status and family contact information should be sent, and medications. When asked if the entire care plan was sent, RN #1 stated that it was. When asked if nurses sent written information about the bed hold policy, RN #1 stated that the bed hold policy was also sent with the resident. When asked if it should be documented what items were sent with the resident at the time of a facility-initiated transfer, RN #1 stated that it should be documented so that staff knows it was done. RN #1 was told about the above concerns. RN #1

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stated that she would try to figure out what documents were sent. RN #1 stated that she would also try to find a transfer sheet for Resident #32. This information could not be provided to this writer.

On 5/1/19 at 2:20 p.m., ASM (administrative staff member) #1, the interim administrator and ASM #2, the interim DON (Director of Nursing) were made aware of the above concerns.

No further information was presented prior to exit.

(1) "Huntington disease a progressive brain disorder that causes uncontrolled movements, emotional problems, and loss of thinking ability (cognition). Adult-onset Huntington disease, the most common form of this disorder, usually appears in a person's thirties or forties. Early signs and symptoms can include irritability, depression, small involuntary movements, poor coordination, and trouble learning new information or making decisions. Many people with Huntington disease develop involuntary jerking or twitching movements known as chorea. As the disease progresses, these movements become more pronounced. Affected individuals may have trouble walking, speaking, and swallowing. People with this disorder also experience changes in personality and a decline in thinking and reasoning abilities. Individuals with the adult-onset form of Huntington disease usually live about 15 to 20 years after signs and symptoms begin." This information was obtained from The National Institutes of Health. https://ghr.nlm.nih.gov/condition/huntington-disease.

3. Resident #70 was admitted to the nursing

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facility on 12/31/11 with diagnoses that included swallowing problems, stroke and Alzheimer's disease.

Resident #70's most recent Minimum Data Set (MDS) assessment was a significant change in status assessment and coded the resident with a score of 8 out of a possible score of 15 on the Brief Interview for Mental Status (BIMS) which indicated the resident was moderately impaired in the in the cognitive skills necessary for daily decision making.

The nurse's notes dated 6/1/18 indicated the resident was sent to the local hospital to have suprapubic catheter changed. He was readmitted to the nursing facility on 6/2/18. There was no documentation in the clinical record that facility staff conveyed to the receiving providers the resident's comprehensive care plan goals at the time of discharge or soon thereafter to the local hospital.

The nurse's notes dated 6/3/18 indicated due to observed blood in the tubing from the suprapubic catheter, the resident was the transported to the local hospital. Resident #70 was readmitted to the nursing facility on 6/7/18. There was no documentation in the clinical record that facility staff conveyed to the receiving providers the resident's comprehensive care plan goals at the time of discharge or soon thereafter to the local hospital.

The nurse's notes dated 10/5/18 indicated the resident was transported to the local hospital due a change in condition. The resident was readmitted to the nursing facility on 10/10/18. There was no documentation in the clinical record

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that facility staff conveyed to the receiving providers the resident's comprehensive care plan goals at the time of discharge or soon thereafter to the local hospital.

The nurse's notes dated 12/21/18 indicated the resident was transported to the local hospital due to a change in mental status and was readmitted to the nursing facility on 1/2/19. There was no documentation in the clinical record that facility staff conveyed to the receiving providers the resident's comprehensive care plan goals at the time of discharge or soon thereafter to the local hospital.

On 4/29/19 at 11:30 a.m., an interview was conducted with Registered Nurse (RN) Unit Manager #1. She stated she was not aware of the paperwork that included care plan goals and summary to be sent with the resident or forwarded to the hospital upon discharge from the facility.

On 5/1/19 at approximately 1:30 p.m., the Interim Administrator stated they had meetings with the corporation about forwarding the necessary documents upon discharge and transfer to the hospital, but training needed to take place to implement the practice by nursing staff and documentation that the care plan goals and summary sent for each respective resident.

The facility's policy and procedure titled "Discharge (Clinical)" dated 11/21/17 indicated a discharge summary will be given at the time the resident leaves the facility and will include a final summary of the resident's status from the resident's most recent comprehensive assessment and comprehensive care plan goals.

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F 622	Continued From page 39 Documentation concerning the forwarded documents must be included in the clinical record.	F 622		
F 623 SS=B	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the 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	F 623	1. A notice of discharge for Resident #73, #32 and #70 were sent to the Office of the State Long Term Care Ombudsman on 5/1/19. 2. All residents are at risk for not receiving facility initiated discharge notifications to the State Long Term Care Ombudsman. 3. Social Works were educated by Sentara Social Worker Peer Group leader on requirements to notify the State Ombudsman's Office for facility initiated discharges on 6/12/18. Facility initiated discharges from November, 2018 to April, 2019 were faxed to the Ombudsman's Office on 5/1/19. 4. The Social Services Director or designee will audit facility initiated hospital discharges to assure the notice provided to the Ombudsman is complete and accurate. Any variances identified will be corrected. The SW Director will audit 50% weekly x 4 weeks, and 10% x 2 weeks for accuracy. Any variances identified will be corrected. Results of the audits will be reviewed for patterns and/or trends and reported to QAPI x 2 months. 5. Compliance Date: June 10, 2019	

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allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;
(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or
(E) A resident has not resided in the facility for 30 days.

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

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advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act.

§483.15(c)(6) Changes to the notice.
If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available.

§483.15(c)(8) Notice in advance of facility closure
In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l).
This REQUIREMENT is not met as evidenced by:
Based on resident record review, staff interviews and facility document review, the facility failed to notify the Office of the State Long-Term Care Ombudsman in writing of hospital discharges for 3 of 42 residents (Resident #73, 32, and 70) after being transferred to the hospital.

1. The facility staff failed to notify the Office of the State Long-Term Care Ombudsman of Resident #73's discharge and admission to the hospital on 03/25/19.

2. For Resident #32, facility staff failed to evidence that the Office of the State Long-Term Care Ombudsmen received written notification that the resident was sent to the hospital on

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2/9/19.

3. The facility staff failed to notify the Office of the State Long-Term Care Ombudsman of Resident #70's discharges to the hospital/emergency room on 6/1/18, 6/3/18, 10/5/18 and on 12/21/18.

The findings included:

1. Resident #73 was originally admitted to the facility on 05/26/15. The resident was re-admitted to the facility on 04/02/19. Diagnosis for Resident #73 included but not limited to Osteomyelitis of the left foot and ankle.

Resident #73's current Minimum Data Set (MDS), a significant change with an Assessment Reference Date (ARD) of 04/09/19 coded the resident with a 15 out of a possible score of 15 on the Brief Interview for Mental Status (BIMS) indicating no cognitive impairment

The Discharge MDS assessment dated 03/25/19-discharge return anticipated, resident re-admitted on 04/02/19.

On 04/29/19 at approximately 5:55 p.m., an interview was conducted with the Social Worker (SW) who said if a resident goes out to the hospital, they are considered to be out on a Leave of Absence (LOA). She said, since the computer generate them as LOA, they would not show up as a discharge. The SW stated, "Those residents who were discharged to the hospital will not be included on the list provided to the Ombudsman because the computer identified them as being on LOA instead of being discharged from the facility. The Ombudsman was never notified of Resident #73's discharge to

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the hospital on 03/25/19.

An interview was conducted with the Administrator and Unit Manager (Unit 1) on 04/30/19 at approximately 2:30 p.m. The Administrator said the Ombudsman should be notified of all discharges including those residents who are discharged to the hospital.

The facility administration was informed of the finding during a briefing on 05/01/19 at approximately 4:45 p.m. The facility did not present any further information about the findings.

2. Resident #32 was admitted to the facility on 11/28/2014 and readmitted on 2/14/19 with diagnoses that included but were not limited to Huntington disease, protein-calorie malnutrition, anxiety disorder, vascular dementia.

Resident #32's most recent MDS (minimum data set) assessment was a significant change assessment with an ARD (assessment reference date) of 2/21/19. Resident #32 was coded as being severely impaired on the staff interview for mental status evaluation. Resident #32 was coded as being totally dependent on staff with ADLs (Activities of Daily Living).

Review of Resident #32's clinical record revealed that she had been sent out to the hospital on 2/9/19. The following note was documented: "Resident noted with restlessness an abnormal vital signs. temp (temperature): 101.1, pulse 124, B/P (blood pressure) 131/60, respirations 20. Tylenol administered. (Name of MD) called and ordered to be send to hospital. 911 called and transported patient to (Name of Hospital) at about 1915 (7:15 p.m.) (RP (Responsible Party) (Name

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of RP) notified.

A nursing note dated 2/10/19 documented the following: "Called placed to ER (emergency room) for update. Pt (patient) had been admitted for Sepsis, UTI (urinary tract infection), Dehydration."

Further review of Resident #32's clinical record revealed that Resident #32 was readmitted to the facility on 2/14/19.

There was no evidence that the Long Term Care Ombudsmen received written notification that the resident was sent to the hospital on 2/9/19.

On 4/30/19 at 9:13 a.m., an interview was conducted with RN (registered nurse) #1, the clinical manager. When asked if nursing notified the Long Term Care Ombudsman regarding a resident transfer to the hospital, RN #1 stated, "I have never heard of that."

On 4/30/19 at 10:19 a.m., an interview was conducted with OSM (other staff member) #2, admissions. When asked if she had a role when residents were sent out to the hospital for an acute change in condition, OSM #2 stated the only thing she did was follow up with the transition coordinator to see if the resident was coming back to the facility. When asked if she notified the long term care ombudsman regarding residents sent to the hospital, OSM #2 stated that she didn't.

On 4/30/19 at 1:38 p.m., an interview was conducted with OSM #1, the social worker. When asked if she notified the Long Term Care Ombudsman for acute transfers to the hospital, OSM #1 stated that when a resident was being

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sent to the hospital, it would show up on her computer system as LOA (Leave of Absence) rather than a transfer to the hospital. Because of this, OSM #1 was not notifying the long term care ombudsman when residents were being sent to the hospital. OSM #1 stated that if a resident was sent to the hospital and then didn't come back, the computer system would mark that resident has a discharge and she would then notify the LTC ombudsman.

On 5/1/19 at 2:20 p.m., ASM (administrative staff member) #1, the interim administrator and ASM #2, the interim DON (Director of Nursing) were made aware of the above concerns.

No further information was presented prior to exit.

3. Resident #70 was admitted to the nursing facility on 12/31/11 with diagnoses that included swallowing problems, stroke and Alzheimer's disease.

Resident #70's most recent Minimum Data Set (MDS) assessment was a significant change in status assessment and coded the resident with a score of 8 out of a possible score of 15 on the Brief Interview for Mental Status (BIMS) which indicated the resident was moderately impaired in the in the cognitive skills necessary for daily decision making.

The nurse's notes dated 6/1/18 indicated the resident was sent to the local hospital to have suprapubic catheter changed. He was readmitted to the nursing facility on 6/2/18. There was no documentation that the local Ombudsman was notified of this transfer to the hospital.

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The nurse's notes dated 6/3/18 indicated due to observed blood in the tubing from the suprapubic catheter, the resident was the transported to the local hospital. Resident #70 was readmitted to the nursing facility on 6/7/18. There was no documentation that the local Ombudsman was notified of this transfer to the hospital.

The nurse's notes dated 10/5/18 indicated the resident was transported to the local hospital due a change in condition. The resident was readmitted to the nursing facility on 10/10/18. There was no documentation that the local Ombudsman was notified of this transfer to the hospital.

The nurse's notes dated 12/21/18 indicated the resident was transported to the local hospital due to a change in mental status and was readmitted to the nursing facility on 1/2/19. There was no documentation that the local Ombudsman was notified of this transfer to the hospital.

On 4/29/19 at 5:55 p.m., an interview was conducted with the social worker. She stated only discharges home notices were sent to the local Ombudsman on a monthly basis and that when the resident goes out to the hospital is registered LOA (Leave of Absence) and they are not included on the list of discharges at the end of each month.

On 5/1/19 at approximately 1:30 p.m., the Interim Administrator stated they had meetings with the corporation's social workers about forwarding the necessary documents upon discharge and transfer to the local Ombudsman, but she could not explain why the practice was not carried through from the executive meetings. The

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F 623	Continued From page 47 Interim Administrator presented a fax confirmation dated 5/1/19 that informed the local Ombudsman of Resident #70's past discharges to the hospital. The Interim Administrator stated, "I know this does not take it away, but it will be fixed from here on out." The facility's policy and procedure titled "Transfers, Discharges and Room Change-Documentation" dated 11/21/17 indicated that the facility, in addition to 30 day notices, the facility must send a copy of the discharge and transfers to the State Long-Term Care Ombudsman, as well as emergency transfers on a monthly basis.	F 623		
F 625 SS=E	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section.	F 625	1. The Bed Hold Policy was provided to resident #73 on 3/27/19. Resident #32 received a bedhold notice on 2/11/19. Resident # 32, bed hold notices were not able to be recreated due to the date of incident cited for 6/1/18 and 6/3/18. Bedhold notices were provide to resident on 10/9/18 and 12/24/18. 2. All Residents are at risk for not receiving bedhold notices when being transferred to the hospital. 3. Social Services Director and License Nurses will be educated on the Bed Hold Policy and divisional practices of providing a written copy to residents and/or representatives upon transfer to the hospital by the Administrator, Social Worker Peer Group Leader or designee. 4. Adminstrator, Social Worker Director will audit 100% of the daily discharge report 3x per week x 4 weeks to ensure discharges / transfers have the required documentation of bed hold notices were provided to the resident or resident representative. Variances identified will be corrected and staff re-educated. Results of audits will be reviewed for patterns and/or trends and reported to QAPI monthly x 2 months. 5. Compliance Date: June 10, 2019	

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§483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section.
This REQUIREMENT is not met as evidenced by:
Based on staff interviews, facility documentation review and clinical record review the facility staff failed send a copy of the Bed-Hold Policy for 3 of 42 residents (Resident #73, 32 and 70) after being transferred to the hospital.

1. The facility staff failed to issue the resident/representative with a written copy of bed hold policy for Resident #73. Resident #73 went to his doctor's appointment and was transferred to the local hospital and admitted on 03/25/19.

2. Facility staff failed to evidence that written bed hold notification was provided to the resident/responsible party at the time of a facility initiated transfer to the hospital on 2/9/19.

3. The facility staff failed to ensure Resident #70 or Resident Representative (RR) was issued a written notice of the bed hold reserve policy upon transfer to the local hospital on 6/1/18, 6/3/18, 10/5/18 and on 12/21/18.

The findings included:

1. Resident #73 was originally admitted to the facility on 05/26/15. The resident was re-admitted to the facility on 04/02/19. Diagnosis for Resident #73 included but not limited to

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Osteomyelitis of the left foot and ankle.

Resident #73's current Minimum Data Set (MDS), a significant change with an Assessment Reference Date (ARD) of 04/09/19 coded the resident with a 15 out of a possible score of 15 on the Brief Interview for Mental Status (BIMS) indicating no cognitive impairment

The Discharge MDS assessment dated 03/25/19-discharge return anticipated, resident re-admitted on 04/02/19.

An interview was conducted with the License Practical Nurse (LPN) #2 on 04/30/19 at approximately 10:24 a.m. The surveyor asked, "If Resident #73 was sent to the local hospital from his doctor's appointment and admitted on 03/25/19, should a written copy of the bed hold policy be sent or faxed to the hospital/resident/representative once the facility was aware Resident #73 was admitted," She replied, "It should have been." The LPN reviewed the clinical record for Resident #73 then stated, "The last note documented for Resident #73 was written on 03/20/19 and no more until he returned to the facility on 04/03/19. The LPN said she can not say the bed hold policy was issued.

An interview was conducted with the Administrator and Unit Manager for Unit 1 on 04/30/19 at approximately 2:30 p.m. The Administrator stated, "The bed hold notice should be documented in the residents medical; if it wasn't documented; it wasn't given."

The facility administration was informed of the finding during a briefing on 05/01/19 at approximately 4:45 p.m. The facility did not

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present any further information about the findings.

2. Resident #32 was admitted to the facility on 11/28/2014 and readmitted on 2/14/19 with diagnoses that included but were not limited to Huntington disease, protein-calorie malnutrition, anxiety disorder, vascular dementia. Resident #32's most recent MDS (minimum data set) assessment was a significant change assessment with an ARD (assessment reference date) of 2/21/19. Resident #32 was coded as being severely impaired on the staff interview for mental status evaluation. Resident #32 was coded as being totally dependent on staff with ADLs (Activities of Daily Living).

Review of Resident #32's clinical record revealed that she had been sent out to the hospital on 2/9/19. The following note was documented: "Resident noted with restlessness an abnormal vital signs. temp (temperature): 101.1, pulse 124, B/P (blood pressure) 131/60, respirations 20. Tylenol administered. (Name of MD) called and ordered to be send to hospital. 911 called and transported patient to (Name of Hospital) at about 1915 (7:15 p.m.) (RP (Responsible Party) (Name of RP) notified.

Further review of Resident #32's notes revealed that she was on antibiotic therapy prior to this hospitalization for cellulitis.

A nursing note dated 2/10/19 documented the following: "Called placed to ER (emergency room) for update. Pt (patient) had bee admitted for Sepsis, UTI (urinary tract infection), Dehydration."

Further review of Resident #32's clinical record revealed that Resident #32 was readmitted to the

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facility on 2/14/19.

There was no evidence that written bed hold notification was provided to the resident/responsible party at the time of a facility initiated transfer to the hospital on 2/9/19.

On 4/30/19 at 9:13 a.m., an interview was conducted with RN (Registered Nurse) #1, the clinical manager. When asked what documents were sent with the resident at the time of a transfer to the hospital, RN #1 stated that the care plan, transfer summary sheet, face sheet that listed out diagnoses, code status and family contact information should be sent, and medications. When asked if the entire care plan was sent, RN #1 stated that it was. When asked if nurses sent written information about the bed hold policy, RN #1 stated that the bed hold policy was also sent with the resident. When asked if it should be documented what items were sent with the resident at the time of a facility-initiated transfer, RN #1 stated that it should be documented so that staff knows it was done. RN #1 was told about the above concerns. RN #1 stated that she would try to figure out what documents were sent. This information could not be provided to this writer.

On 4/30/19 at 1:38 p.m., an interview was conducted with OSM #1, the social worker. When asked her role when a resident is sent out to the hospital for an acute transfer, OSM #1 stated that the nurses will send a bed hold policy with the resident upon transfer and that she will contact the resident and/or family member (usually the next day) to follow up to see if they would like the bed held.

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On 5/1/19 at 2:20 p.m., ASM (administrative staff member) #1, the interim administrator and ASM #2, the interim DON (Director of Nursing) were made aware of the above concerns.

No further information was presented prior to exit.

3. Resident #70 was admitted to the nursing facility on 12/31/11 with diagnoses that included swallowing problems, stroke and Alzheimer's disease.

Resident #70's most recent Minimum Data Set (MDS) assessment was a significant change in status assessment and coded the resident with a score of 8 out of a possible score of 15 on the Brief Interview for Mental Status (BIMS) which indicated the resident was moderately impaired in the in the cognitive skills necessary for daily decision making.

The nurse's notes dated 6/1/18 indicated the resident was sent to the local hospital to have suprapubic catheter changed. He was readmitted to the nursing facility on 6/2/18. There was no documentation that a written notice of the bed hold reserve policy was issued to the RR upon transfer to the local hospital.

The nurse's notes dated 6/3/18 indicated due to observed blood in the tubing from the suprapubic catheter, the resident was the transported to the local hospital. Resident #70 was readmitted to the nursing facility on 6/7/18. There was no documentation that a written notice of the bed hold reserve policy was issued to the RR upon transfer to the local hospital.

The nurse's notes dated 10/5/18 indicated the

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F 625	Continued From page 53 resident was transported to the local hospital due a change in condition. The resident was readmitted to the nursing facility on 10/10/18. There was no documentation that a written notice of the bed hold reserve policy was issued to the RR upon transfer to the local hospital. The nurse's notes dated 12/21/18 indicated the resident was transported to the local hospital due to a change in mental status and was readmitted to the nursing facility on 1/2/19. There was no documentation that a written notice of the bed hold reserve policy was issued to the RR upon transfer to the local hospital. On 5/1/19 at approximately 1:30 p.m., the Interim Administrator stated they had not been issuing the bed hold notice upon resident discharge only on admission to the facility and a follow-up call to inquire about holding the bed. She stated training would be forthcoming to the nurses with the necessary documentation in the clinical record. The facility's policy and procedure titled "Bed Hold" dated 12/19/18 indicated the resident or the resident representative would be provided a "Notice of Bed Hold" letter at the time of discharge/transfer. If not immediately as possible and the bed hold policy would be provided with the transfer documentation.	F 625		
F 645 SS=E	PASARR Screening for MD & ID CFR(s): 483.20(k)(1)-(3) §483.20(k) Preadmission Screening for individuals with a mental disorder and individuals with intellectual disability. §483.20(k)(1) A nursing facility must not admit, on	F 645		

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F 645	Continued From page 54 or after January 1, 1989, any new residents with: (i) Mental disorder as defined in paragraph (k)(3)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission, (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services; or (ii) Intellectual disability, as defined in paragraph (k)(3)(ii) of this section, unless the State intellectual disability or developmental disability authority has determined prior to admission- (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services for intellectual disability. §483.20(k)(2) Exceptions. For purposes of this section- (i)The preadmission screening program under paragraph(k)(1) of this section need not provide for determinations in the case of the readmission to a nursing facility of an individual who, after being admitted to the nursing facility, was transferred for care in a hospital. (ii) The State may choose not to apply the preadmission screening program under paragraph (k)(1) of this section to the admission to a nursing facility of an individual-	F 645	1. Residents #18 and #32 were referrals to Dear Oaks for Level 2 PASRR assessments on 5/7/19. 2. All residents are at risk for missed screenings 3. Admissions Director or designee will educate Social Services and admissions staff on the required PASRR Level 1 and Level 2 Assessments. An audit will be completed on all residents living in the facility to ensure appropriate PASSR assessments have been completed or referred for further assessments. 4. Social Services Director or designee will audit all residents admitted to facility for appropriate PASRR assessments x 4 weeks, then 50% x 2 weeks. Variances will be reviewed for patterns and/or trends and results will be reported to QAPI. 5. Compliance Date: June 10, 2019	

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(A) Who is admitted to the facility directly from a hospital after receiving acute inpatient care at the hospital,
(B) Who requires nursing facility services for the condition for which the individual received care in the hospital, and
(C) Whose attending physician has certified, before admission to the facility that the individual is likely to require less than 30 days of nursing facility services.

§483.20(k)(3) Definition. For purposes of this section-
(i) An individual is considered to have a mental disorder if the individual has a serious mental disorder defined in 483.102(b)(1).
(ii) An individual is considered to have an intellectual disability if the individual has an intellectual disability as defined in §483.102(b)(3) or is a person with a related condition as described in 435.1010 of this chapter.
This REQUIREMENT is not met as evidenced by:
Based on observations, clinical record review, staff interviews and facility documentation, the facility staff failed to ensure a Level II PASRR (Preadmission Screening and Resident Review) was conducted for 2 of 40 residents (Resident #18 and #32) in the survey sample with diagnoses of either a mental disorder and or intellectual disability.

1. The facility staff failed to ensure Resident #18, who was identified with a mental illness and had a Level I PASRR screening with recommendation for a Level II assessment, had the Level II conducted per standard protocol.

2. The facility staff failed to ensure a Level II

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PASRR was completed for Resident #32.

The findings include:

1. Resident #18 was admitted to the nursing facility on 3/4/17 with diagnoses that included obsessive compulsive personality disorder and major depressive disorder.

The most recent Minimum Data Set (MDS) assessment was a quarterly assessment dated 4/27/19 and coded the resident with a score of score of 13 out of a possible score of 15 the Brief Interview for Mental Status (BIMS), which indicated the resident was intact with the skills needed for daily decision making. The resident was assessed to have an active diagnosis to include psychotic disorder.

The care plan dated as initiated on 4/29/19 identified the resident had a psychotic disorder, anti-anxiety disorder and major depressive disorder. Some of the approaches the staff would implement to manage these disorders included refer to psychologist and psychiatrist as needed.

On 4/30/19 at 2:20 p.m., Resident #18 was observed in his room watching television in his wheelchair. He stated he did what he wanted to do when he wanted to do it and the staff would have to adjust to his ways of doing things. The resident possessed a musty body odor. The Certified Nursing Assistant (CNA) #3 stated, "The resident refused showers most of the time and is non-compliant with bed baths, but we tell the nursing staff and on occasion we are successful."

On 2/14/19 a Level I PASRR conducted indicated

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his disorders resulted in areas that included substantial limitations in the areas of self-care understanding, use of language, and self direction. The recommendations were to refer for a Level II secondary assessment from an assessment management support services agency.

On 4/29/19 at 11:00 a.m., the social worker stated she was the person who would be able to provide any requested PASRR screenings. On 4/29/19 at 1:00 p.m., and 3:00 p.m., the social worker stated she was still trying to locate the Level II PASRR for Resident #18.

An interview was conducted with the Interim Administrator on 4/29/19 at 4:45 p.m. She stated an audit was conducted on 2/14/19 and Resident #18 was missed during an audit to determine compliance with the regulation. She stated the social worker was not able to locate the Level II PASRR and called the assessment management support services agency on 4/29/19 to have them come to the nursing facility to complete the Level II assessment.

2. Resident #32 was admitted to the facility on 11/28/2014 and readmitted on 2/14/19 with diagnoses that included but were not limited to Huntington disease (1), protein-calorie malnutrition, anxiety disorder, vascular dementia. Resident #32's most recent MDS (minimum data set) assessment was a significant change assessment with an ARD (assessment reference date) of 2/21/19. Resident #32 was coded as being severely impaired on the staff interview for mental status evaluation. Resident #32 was coded as being totally dependent on staff with ADLs (Activities of Daily Living). Review of

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Section A1500 (Identification Information) documented that Resident #32 was not currently considered by the state level II PASRR process to have serious mental illness and/or intellectual disability or a related condition.

Review of Resident #32's level one PASRR completed 2/14/19, documented the following under number "5. RECOMMENDATION": "a. Refer to secondary assessment (NF (nursing facility) placement = Level II refer to (Name) Management." A circle was marked around letter "a." documenting that a level two PASRR assessment needed to be completed.

The facility staff could not provide a level II PASRR assessment for Resident #32.

On 4/30/19 at 10:52 a.m., an interview was conducted with OSM (other staff member) #2, admissions. When asked the process of completing a Level II PASRR. OSM #2 stated that she did the DMAS-95 and 96. OSM #2 stated that the facility hadn't been completing the PASRR II and that the admission team completed an audit to see which residents still needed a PASRR II. OSM #2 stated that the MDS nurse (a nurse who was part of the admission's team) would be able to answer additional question regarding the PASRR II.

On 4/30/19 at 10:59 a.m., an interview was conducted with OSM #10, the MDS nurse. When asked the process of completing a level II PASRR, OSM #10 stated that admissions will complete the level one PASRR and if the assessment determines the resident needs a level II, that assessment would be passed on to the director of the admissions team. OSM #10

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stated that the director of the admissions team did not work in the facility. OSM #10 stated that the level II PASRR was usually completed prior to the resident arriving to the facility. OSM #10 stated that the admissions team had done an audit of residents who did have a level two PASRR, but that she was not involved in that audit. When asked the purpose of the level II PASRR, OSM #10 stated that the purpose was to see if the resident needed a higher level of care and to determine if nursing home placement was appropriate.

The director of the admissions team could not be reached for an interview.

The facility audit conducted 2/14/19, to determine residents who did not receive a PASRR level II revealed that Resident #32 was missed during this audit.

On 5/1/19 at 2:20 p.m., ASM (administrative staff member) #1, the interim administrator and ASM #2, the interim DON (Director of Nursing) were made aware of the above concerns.

(1) "Huntington disease a progressive brain disorder that causes uncontrolled movements, emotional problems, and loss of thinking ability (cognition). Adult-onset Huntington disease, the most common form of this disorder, usually appears in a person's thirties or forties. Early signs and symptoms can include irritability, depression, small involuntary movements, poor coordination, and trouble learning new information or making decisions. Many people with Huntington disease develop involuntary jerking or twitching movements known as chorea.

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F 645	Continued From page 60 As the disease progresses, these movements become more pronounced. Affected individuals may have trouble walking, speaking, and swallowing. People with this disorder also experience changes in personality and a decline in thinking and reasoning abilities. Individuals with the adult-onset form of Huntington disease usually live about 15 to 20 years after signs and symptoms begin." This information was obtained from The National Institutes of Health. https://ghr.nlm.nih.gov/condition/huntington-disease.	F 645		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR	F 656	1. The comprehensive care plan for resident #6 was revised to include the diagnosis of depression and use of psychotrophic medications on 4/29/19. 2. Residents with diagnosis of depression are at risk for inaccurate comprehensive care plans 3. DON, Clinical Manager or designee will educate the interdisciplinary team on strategies and accuracy for completion of person-centered comprehensive care planning. MDS Coordinators or designee will review the care plans for all residents identified with a diagnosis of depression for person centered approaches and comprehensiveness. 4. DON, Clinical Managers, MDS Coordinators or designee will audit care plans for residents with diagnosis of depression to assure comprehensiveness and person centered approaches included in the care plan, 50% x 4 weeks, then 25% x 2 weeks. Variances and results will be reviewed for patterns and/or trends and reported to QAPI for input and guidance. 5. Compliance Date: June 10, 2019	

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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 staff interviews, clinical record review and facility documentation the facility staff develop a comprehensive personal centered care plan for 1 of 42 residents (Resident #6) in the survey sample.

The facility staff failed to develop a person-centered care plan to include the diagnosis of depression with the use of a psychoactive medication (*Zoloft).

The findings included:

Resident #6 was originally admitted to the nursing facility on 02/08/18. Diagnosis for Resident #6 included but was not limited to *Depressive Disorder.

The current Minimum Data Set (MDS) was a significant change assessment with an

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Assessment Reference Date (ARD) of 01/17/19. The MDS coded the resident with short and long-term memory problems and cognitive skills severely impaired-never/rarely made decisions. The residents MDS was coded for the usage of antidepressant medication. Section "N" on the MDS under medications read as follows: Indicate the number of DAYS the resident receiving the medication during the last 7 days, the resident was coded for receiving an antidepressant for 7 days.

The review of Resident #6's Resident Medication Profile indicated the following antidepressant was order: Sertraline (Zoloft) 100 mg (milligrams) (1) tablet via g-tube (feeding tube) daily starting on 03/20/19.

The review of the Resident #6's comprehensive care plan did not include a care plan for a diagnosis of depression with use a psychoactive medication.

An interview was conducted with the MDS Coordinator #2 on 04/30/19 at approximately 12:30 p.m. The surveyor asked, "Should Resident #6's person-centered care plan include the diagnosis of depression with the use of an antidepressant?" MDS Coordinator #2 stated, "Most definitely, there should be a care plan to address his diagnosis of depression with the use of an antidepressant."

The facility administration was informed of the finding during a briefing on 05/01/19 at approximately 4:45 p.m. The facility did not present any further information about the findings.

The facility's policy title Life Care-Comprehensive

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F 656	Continued From page 63 care Plan (Revision date: 01/22/18). -Purpose: Established, periodic review of current person-centered plan of care for each resident to assure a systematic, comprehensive approach to assessing, planning, and periodic review in meeting the resident's needs. IDT (Interdisciplinary Team) Responsibilities (Activities, Nursing, Dietary, Therapy, MDS and Social Services): -Care plans will be reviewed and updated as needed to reflect changes. Definitions: -Zoloft is an antidepressant belonging to a group of drugs called selective serotonin reuptake inhibitors (SSRIs). Zoloft affects chemicals in the brain that may be unbalanced in people with depression, panic, anxiety, or obsessive-compulsive symptoms (www.drugs.com). -Depression disorder is a chronic (ongoing) type of depression in which a person's moods are regularly low (Mosby's Dictionary Medicine, Nursing & Health Professions 7th edition).	F 656		
F 657 SS=E	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	F 657		

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F 657	Continued From page 64 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, clinical record review and facility document review, it was determined that facility staff failed to review and revise the care plan for five (5) of 42 residents in the survey sample, Resident # 71, #58, #32, #6 and #73. 1. For Resident #71, facility staff failed to revise the care plan when she was diagnosed with MRSA (Methicillin-resistant Staphylococcus aureus) in her sputum. 2. For Resident #58, facility staff failed to revise the care plan when she was diagnosed with pneumonia and receiving antibiotic therapy. 3. For Resident #32, facility staff failed to revise the care plan when a stage II pressure ulcer was found to her right hip; and a wound from trauma was found to her left lateral ankle on 4/2/19.	F 657	1. Resident Centered Care Plans were revised for the following residents: Resident #71 was discharged on 5/3/19 Resident #58 for Antibiotics and pneumonia on 5/20/19 Resident #32 for Pressure Injury on 5/1/19 Resident #6 for DTI on 4/29/19 Resident # 73 for IV Antibiotics on 4/30/19 2. All residents are at risk for care plans not being revised or updated to reflect current care provided. 3. Resident centered care plans will be completed for completeness on all residents living in the facility on 5/20/19 to reflect changes in the care and services provided or requested by the resident. Administrator, DON, Staff Educator or designee will educate the Interdisciplinary team on strategies for person centered comprehensive care planning. Care plans for all residents living in the facilty on 5/20/19 will be reviewed by the MDS coordinators, clinical managers or designee for completeness. 4. Clinical Managers, DON, MDS Coordinators or designee will audit resident care plans to assure comprehensiveness and person centered approaches are included in care plans 25% X 4 weeks, then 10% x 2 weeks. Results of audits will be reviewed for patterns and/or trends and reported to QAPI for input and guidance, 5. Compliance Date: June 10, 2019	

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4. For Resident #6, the facility staff failed to revise the person centered care plan to include a Deep Tissue Injury (DTI), pressure ulcer to the right heel.

5. For Resident #73, the facility staff failed to revise the person centered care plan to include contact precaution and the use of IV antibiotics being administered at an external provider (Dialysis).

The findings include:

1. Resident #71 was admitted to the facility on 3/28/19 with diagnoses that included but were not limited to MRSA (1) in sputum, anxiety disorder, heart failure, and bipolar disorder. Residents #71's most recent MDS (Minimum data set) was an admission assessment with an ARD (assessment reference date) of 4/5/19. Resident #71 was coded as being cognitively intact in the ability to make daily decisions scoring 14 out of 15 on the BIMS (Brief Interview for mental status) exam.

On 4/28/19 at 1:28 p.m., a tour of the facility was conducted. Resident #71 was observed to have personal protective equipment hanging on her door.

Review of Resident #71's clinical record revealed the following orders:

1) "Bactrim DS (2) 800 mg-160 mg (milligram) tablet (one tablet) TABLET Oral- Pneumonia." This antibiotic was originally started on 4/12/19, and re-started on 4/26/19.
2) "Droplet precautions." This order was initiated

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Further review of her clinical record revealed the following note from PACE (Program of All Inclusive Care for the Elderly) dated 4/24/19; that documented in part, the following:
" ...Sputum culture still positive for MRSA, but she is colonized. Recent Cxr (chest x-ray) still positive for pneumonia. Will give second course of Bactrim DS and repeat Cxr. Would not repeat respiratory culture ...There was no repeat x-ray only a repeat sputum cx (culture). That's what prompted the extension of the ABX (antibiotic)."

Review of Resident #71's care plan dated 4/10/19, failed to reflect her diagnosis of MRSA in her sputum.

On 4/30/19 at 9:13 a.m., an interview was conducted with RN (Registered Nurse) #1, the unit manager. When asked the purpose of the care plan, RN #1 stated the purpose of the care plan was to reflect the entire care of the resident such as diagnoses, medications, nutrition etc. When asked when the care plan was updated, RN #1 stated that the care plan was updated with new changes with the resident such as new orders. When asked if it was important for the care plan to be accurate, RN #1 stated that it was. When asked who updates the care plan, RN #1 stated that nurses were required to update the care plan with new changes to the resident's care.

On 5/1/19 at 1:33 p.m., further interview was conducted with RN #1. When asked if a resident has an infection if that should be reflected on the care plan, RN #1 stated that it should. When asked if she could find anything that addressed

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Resident #s 71's MRSA, RN #1 looked through Resident #71's care plan and stated that she did not see anything.

On 5/1/19 at 2:20 p.m., ASM (administrative staff member) #1, the interim administrator and ASM #2, the interim DON (Director of Nursing) were made aware of the above concerns.

(1) MRSA (Methicillin-resistant Staphylococcus aureus) - "a staph infection that is resistant to several common antibiotics. There are two types of infection. Hospital-associated MRSA happens to people in health care settings. Community-associated MRSA happens to people who have close skin-to-skin contact with others, such as athletes involved in football and wrestling. Infection control is key to stopping MRSA in hospitals." This information was obtained from The National Institutes of Health. https://medlineplus.gov/mrsa.html.

(2) Bactrim DS- is a synthetic antibacterial combination product available in DS (double strength) tablets. This information was obtained from The National Institutes of Health. https://aidsinfo.nih.gov/drugs/401/sulfamethoxazole---trimethoprim/43/professional.

According to Fundamentals of Nursing Lippincott Williams and Wilkins 2007 pages 65-77 documented, "A written care plan serves as a communication tool among health care team members that helps ensure continuity of care...The nursing care plan is a vital source of information about the patient's problems, needs, and goals. It contains detailed instructions for achieving the goals established for the patient and is used to direct care...expect to review,

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revise and update the care plan regularly, when there are changes in condition, treatments, and with new orders..."

2. For Resident #58, facility staff failed to revise the care plan when she was diagnosed with pneumonia and receiving antibiotic therapy.

Resident #58 was admitted to the facility on 11/5/18 with diagnoses that included but were not limited to dementia without behavioral disturbances, muscle weakness, major depressive disorder, psychosis and paranoid schizophrenia. Resident #58's most recent MDS (minimum data set) assessment was a quarterly assessment with an ARD (assessment reference date) of 3/27/19. Resident #58 was coded as being severely impaired in cognitive function scoring 99 on the BIMS (Brief Interview for Mental Status) exam.

Review of Resident #58's POS (physician order summary), revealed that she was placed on Augmentin (oral antibiotic) (1) 875 mg (milligrams) two times a day for 10 days for a diagnosis of pneumonia. This order was dated 4/24/19.

The following chest x-ray result dated 4/22/19 and signed by the physician on 4/25/19, documented the following: "Slight left lower lobe and right upper lope infiltrates...Continue Augmentin ordered yesterday 4/24/19. Repeat CXR (chest x-ray) in 4 weeks.

Review of Resident #58's care plan dated 3/28/19 failed to reflect her pneumonia and antibiotic therapy.

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On 4/30/19 at 9:13 a.m., an interview was conducted with RN (Registered Nurse) #1, the unit manager. When asked the purpose of the care plan, RN #1 stated the purpose of the care plan was to reflect the entire care of the resident such as diagnoses, medications, nutrition etc. When asked when the care plan was updated, RN #1 stated that the care plan was updated with new changes with the resident such as new orders. When asked if it was important for the care plan to be accurate, RN #1 stated that it was. When asked who updates the care plan, RN #1 stated that nurses were required to update the care plan with new changes to the resident's care.

On 4/30/19 at 11:07 a.m., an interview was conducted with LPN (Licensed Practical Nurse) # 5, Resident #58's nurse. When asked who was responsible for updating the care plan, LPN #5 stated that MDS, the clinical managers or floor nurses can update the care plan. When asked when the care plan was updated, LPN #5 stated that nurses update the care plan with any new changes in the resident's care. When asked if a resident was placed on antibiotic therapy for an infection, if she would expect to see that on the care plan, LPN #5 stated that she would. LPN #5 looked through Resident #58's care plan and stated, "It was not updated." LPN #5 stated, "That is normally done upon the first day of antibiotic therapy."

On 5/1/19 at 2:20 p.m., ASM (administrative staff member) #1, the interim administrator and ASM #2, the interim DON (Director of Nursing) were made aware of the above concerns.

(1)

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https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=d567412a-e5ed-4c7f-90f0-ea3039786480.

3. For Resident #32, facility staff failed to revise the care plan when a stage II pressure ulcer was found to her right hip and a wound from trauma was found to her left lateral ankle on 4/2/19.

Resident #32 was admitted to the facility on 11/28/2014 and readmitted on 2/14/19 with diagnoses that included but were not limited to Huntington disease (1), protein-calorie malnutrition, anxiety disorder, vascular dementia. Resident #32's most recent MDS (minimum data set) assessment was a significant change assessment with an ARD (assessment reference date) of 2/21/19. Resident #32 was coded as being severely impaired on the staff interview for mental status evaluation. Resident #32 was coded as being totally dependent on staff with ADLs (Activities of Daily Living).

Review of Resident #32's clinical record revealed that she obtained two wounds on 4/2/19. The following note by the wound care physician was documented: "...a thorough wound care assessment and evaluation was performed today. She has a stage 2 (2) pressure wound of the right hip for at least 1 days duration...Wound size (L (length) x W (width) x D (depth)): 4 x 4 x 0 cm (centimeters)...Exudate: none...Dressing treatment plan, Foam with border apply three times a day for 30 days...

Wound of Left, Lateral Ankle. Duration greater than 1 days. Wound size: 1 x 2 x 0.1 cm, Exudate: light serosanguinous...Dressing

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treatment plan, Foam with border apply three times a day for 30 days..." Further review of Resident #32's clinical record revealed that this wound had reopened on 4/2 and was initially found on 3/12/19.

Review of Resident #32's skin care plan dated 2/25/19, failed to reflect the above wounds discovered on 4/2/19. The following was documented: "(Name of Resident #32) is at risk for impaired skin integrity r/t (related to) involuntary movements 2/2 (secondary) to Huntington's disease."

On 4/30/19 at 9:13 a.m., an interview was conducted with RN (Registered Nurse) #1, the unit manager. When asked the purpose of the care plan, RN #1 stated the purpose of the care plan was to reflect the entire care of the resident such as diagnoses, medications, nutrition etc. When asked when the care plan was updated, RN #1 stated that the care plan was updated with new changes with the resident such as new orders. When asked if it was important for the care plan to be accurate, RN #1 stated that it was. When asked who updates the care plan, RN #1 stated that nurses were required to update the care plan with new changes to the resident's care. When asked if she would expect to see a pressure area added to the care plan if a resident obtains a new pressure ulcer, RN #1 stated that she would expect to see that. RN #1 confirmed that Resident #32's new pressure ulcers were not added to the care plan.

On 5/1/19 at 2:20 p.m., ASM (administrative staff member) #1, the interim administrator and ASM #2, the interim DON (Director of Nursing) were made aware of the above concerns.

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(1) Huntington disease is an inherited condition that causes progressive degeneration of neurons in the brain. Signs and symptoms usually develop between ages 35 to 44 years and may include uncontrolled movements, loss of intellectual abilities, and various emotional and psychiatric problems. People with HD usually live for about 15 to 20 years after the condition begins. This information was obtained from The National Institutes of Health. https://rarediseases.info.nih.gov/diseases/6677/huntington-disease.

(2) Stage II pressure Ulcer is partial thickness loss of dermis presenting as a shallow open ulcer with a red pink wound bed, without slough. May also present as an intact or open/ruptured serum-filled blister. Further description: Presents as a shiny or dry shallow ulcer without slough or bruising.* This stage should not be used to describe skin tears, tape burns, perineal dermatitis, maceration or excoriation. *Bruising indicates suspected deep tissue injury." This information was obtained from the National Pressure Ulcer Advisory Panel website at http://www.npuap.org/pr2.htm.

4. Resident #6 was originally admitted to the nursing facility on 02/08/18. Diagnosis for Resident #6 included but not limited to *Cerebral Vascular Accident (CVA) with right *hemiplegia. The current Minimum Data Set (MDS) a significant change with an Assessment Reference Date (ARD) of 01/17/19 coded the resident with short and long-term memory problems and cognitive skills severely impaired-never/rarely made decisions. In addition, the MDS coded Resident #6 requiring total dependence of two

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with bathing and transfers, total dependence of one with dressing, hygiene, bed mobility and toilet use, and extensive assistance of one with eating. The MDS was also coded under functional limitation in Range of Motion (ROM) was coded for impairment on one side to upper extremity and impairment on both sides his lower extremities.

The review of Resident #6's comprehensive person care plan did not include the following wound: Right medial *Deep Tissue Injury (DTI)

The review of Resident #6's April 2019, Treatment Administration Record (TAR) included the following order written on 04/09/19: Right medial heel wound, apply betadine and leave open to air, twice daily.

An interview was conducted with the MDS Coordinator #2 on 04/29/19 at approximately 11:45 a.m. The surveyor asked, "Should Resident #6's person-centered care plan include the pressure ulcer to his right heel?" MDS Coordinator #2 stated, "Most definitely, all pressure ulcer should be reflected on the resident's care plan.

On 04/29/19, a revised care plan was presented to include: actual alteration in skin integrity related to unstageable necrotic bruise to right heel. The goal: promote wound healing and prevent infection. Some of the interventions to manage goal to include but not limited to: monitor healing or lack there of, and notify MD for order changes if needed, apply skin prep to heels and monitor skin for further reddened, open, or irritated areas.

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The facility administration was informed of the finding during a briefing on 05/01/19 at approximately 4:45 p.m. The facility did not present any further information about the findings.

Definition:

-CVA is a medical emergency. Strokes happen when blood flow to your brain stops. Within minutes, brain cells begin to die (https://medlineplus.gov/stroke.html).

-Hemiplegia is the loss of muscle function on one side of the body (https://medlineplus.gov/druginfo/meds/a682514.html).

-Deep Tissue Pressure Injury (DTI): Persistent non-blanchable deep red, maroon or purple discoloration. Intact or non-intact skin with localized area of persistent non-blanchable deep red, maroon, purple discoloration or epidermal separation revealing a dark wound bed or blood filled blister. Pain and temperature change often precede skin color changes. Discoloration may appear differently in darkly pigmented skin. This injury results from intense and/or prolonged pressure and shear forces at the bone-muscle interface. The wound may evolve rapidly to reveal the actual extent of tissue injury, or may resolve without tissue loss. If necrotic tissue, subcutaneous tissue, granulation tissue, fascia, muscle or other underlying structures are visible, this indicates a full thickness pressure injury (Unstageable, Stage 3 or Stage 4). Do not use DTPI to describe vascular, traumatic, neuropathic, or dermatologic conditions (http://www.npuap.org/resources/educational-and

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-clinical-resources/npuap-pressure-injury-stages).

5. Resident #73 was originally admitted to the facility on 05/26/15. Diagnosis included but not limited to Osteomyelitis (infection in the bone) of left foot. The current Minimum Data Set (MDS) a significant change assessment with an Assessment Reference Date (ARD) of 04/9/19 coded the resident with a 15 out of a possible score of 15 on the Brief Interview for Mental Status (BIMS), indicating no cognitive impairment. In addition, under section I-Active Diagnosis was coded Septicemia and in M-Skin problems under foot problems was coded for Infection.

The review of Resident #73's comprehensive person care plan did not include isolation precautions for Vancomycin resistant enterococcus (VRE) in left foot wound. Resident also receives antibiotic (Vancomycin) at dialysis center.

An interview was conducted with the MDS Coordinator #2 on 04/29/19 at approximately 11:45 a.m. The surveyor asked, "Should Resident #73's person-centered care plan include Resident #73's contact precautions and antibiotics being received at dialysis. MDS Coordinator #2 stated, "Most definitely , the contact precautions should be care planned as well as the antibiotic being administered at dialysis.

On 04/30/19, a revised care plan was given to the surveyor with the updated information:

Resident #73's person-comprehensive care plan

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with a revision date of 04/30/19 included the following: Isolation Precautions for VRE in left foot wound. The goal: No complications from within next 90 days. The interventions included but not limited to explained the need for isolation precautions to resident and family, staff education in isolation procedures as needed, lab tests as ordered by physician and report results of cultures and treat as ordered.

Resident #73's person-comprehensive care plan with a revision date of 04/30/19 included the following: resident receive ABT at dialysis from 04/03-05/10/19. The goal: Resident will be assessed for signs and symptoms of infection for 38 days and as needed. The interventions included assess Resident for any symptoms of confusion change in mental status, delirium or confusion as these may indicate infection process and follow policy for reportable conditions.

The facility administration was informed of the finding during a briefing on 05/01/19 at approximately 4:45 p.m. The facility did not present any further information about the findings.

The facility's policy title Life Care - Comprehensive care Plan (Revision date: 01/22/18).
-Purpose: Established, periodic review of current person-centered plan of care for each resident to assure a systematic, comprehensive approach to assessing, planning, and periodic review in meeting the resident's needs.

IDT Responsibilities (Activities, Nursing, Dietary, Therapy, MDS and Social Services):
-Care plans will be reviewed and updated as needed to reflect changes.

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F 677 SS=E	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interviews and clinical record review the facility staff failed to provide personal care to include showers for one resident in the survey sample (Resident #62) who was unable to independently carry out activities of daily living (ADL's). The facility staff failed to ensure Resident #62 was offered and received scheduled twice-weekly showers to maintain good personal hygiene. The findings included: Resident #62 was admitted to the facility on 05/24/18. Diagnosis for Resident #62 included but not limited to Difficulty waking and Muscle weakness. Resident #62's Minimum Data Set (an assessment protocol) with an Assessment Reference Date (ARD) of 04/01/19 coded the resident's Brief Interview for Mental Status (BIMS) score 15 of a possible 15 with no cognitive impairment. In addition, the MDS coded Resident #62 requiring extensive assistance of one with toilet use, limited assistance of one with transfer, dressing, hygiene, bed mobility and bathing with Activities of Daily Living care. Resident #62 was coded for the use of indwelling catheter (suprapubic).	F 677	1. Resident #62 was provided personal care to include shower/bath as soon as issue was identified. 2. Residents in the facility who are unable to carry out activities of daily living are at risk for not receiving showers/baths twice weekly. 3. Residents in the facility will receive shower/baths of their preference. License nurse or designee will educate Certified Nursing Assistants on Standards of practice for ADL Care. 4. DON, Clinical Manager or designee will audit resident records to assure ADL/Shower/Baths is provided 25% of residents x 4 weeks, then 10% x 2 weeks. Results of audits will be reviewed for patterns and/or trends and reported to QAPI x 2 months for input and guidance 5. Compliance Date: June 10, 2019	

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The comprehensive care plan with a revision date of 04/04/19 documented Resident #62 at risk for further impaired skin integrity due to impaired mobility and suprapubic catheter. The goal: skin will be clean, dry and odor free over the next 90 days. One of the interventions to manage goal include monitor skin for further reddened, open, or irritated area.

During the initial tour on 04/28/19 at approximately 2:48 p.m., Resident #62 stated, "I'm not getting my showers; I have not had a shower for a while now." The surveyor asked, "When was the last time you received a shower" the resident stated, "I can't remember but it's been a while." The surveyor asked, "Are you being offered showers" he replied, "No, they will give me water to bath myself but they do not give me shower." The surveyor asked, "Do want showers" he said, "Of course I do." Resident observed with a suprapubic catheter. The resident said the catheter would leak and (urine) will go everywhere; a shower would make me feel a lot cleaner.

The review of Unit 2's shower schedule indicated that Resident #62 was scheduled to receive his shower once a week on Wednesday (7-3 shift), according to his room number (number) B.

Review of Resident 62's ADL Verification Worksheet revealed the following: Showers were not given on the following shower days:

January 2019 (1/5, 1/12, 1/16, 1/19, 1/26, 1/30)
February 2019 (2/6, 2/9, 2/13, 2/16, 2/20, 2/23, 2/27)
March 2019 (3/2, 3/6, 3/9, 3/13, 3/16, 3/20, 3/23, 3/27)

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April 2019 (4/3, 4/06, 4/10, 4/13, 4/17, 4/20, 4/24 and 4/27), a shower was given on 04/25/19.

The shower schedule was reviewed with License Practical Nurse (LPN) #8 on 04/28/19 at approximately 10:45 a.m. The surveyor asked, "When does Resident #62, in room (number) receive his showers." The LPN looked at the schedule again, on Wednesday and it should be on Saturdays but the schedule has room (number) A down twice, it should be room (number) B. The LPN stated, "If you don't see the room number, the shower could get missed."

The shower schedule was reviewed with Certified Nursing Assistant (CNA) #4 on 04/28/19 at approximately 2:15 p.m. The surveyor asked, "When does Resident #62, in room (number) B receive his showers." She said on Wednesday's, the Saturday shower is missing. She said (room number) A is there twice; it should be (number)-B. The CNA said the shower sheet is wrong, Resident #62's should get his showers on Wednesday and Saturday. She said Resident #62, is going to miss that Saturday shower.

An interview was conducted with CNA #7 on 04/30/19 at approximately 12:00 p.m. The surveyor reviewed the shower schedule and the ADL Verification Worksheet with the CNA. The surveyor asked, "Were you assigned to provide Resident #62 a shower on some of the missed shower days" she replied, "Yes." She said sometimes Resident #62 will refuse his shower. The surveyor asked, "What is the process if a resident refuses their shower" she replied, "It should be documented but we a problem with documenting, we rarely have time to document; somebody always need assistance on this unit

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F 677	Continued From page 80 (skill unit) it is so busy over here." She said the shower schedule should be accurate, that is what we go by especially having Resource Pool using CNA's; if the shower schedule is not correct then the resident is going to miss his shower. On 04/30/19 at approximately 10:17 a.m., an interview was conducted with LPN #2. She reviewed the shower schedule for room (number)-B. She said Resident #62 is down for showers on Wednesday only according to the shower schedule. She said the shower schedule in not correct; room (number)-B (Resident #62's) room should be every Wednesday and Saturday. The surveyor asked, "Why should the shower schedule be correct" she replied, "To make sure Resident #62 received his showers twice a week." The ADL verification worksheets were reviewed from 11/01/19 through 04/29/19 with LPN #2. The LPN reviewed Resident #62's medical record for the documentation so show Resident #62 refused his showers. After the clinical notes were reviewed, she stated, "There is no documentation to prove his showers were offered or refused." The facility administration was informed of the finding during a briefing on 05/01/19 at approximately 4:45 p.m. The facility did not present any further information about the findings. A copy of the facility's Showers/Bathing/ADL policy was requested but not provided.	F 677		
F 686 SS=G	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.	F 686		

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F 686	Continued From page 81 Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interviews, clinical record review, and review of the facility policy the facility staff failed to identify a pressure ulcer and institute appropriate interventions, care and treatment for 1 of 42 residents (Resident #44), in the survey sample. The facility staff failed to identify Resident #44's sacral pressure ulcer prior to it advancing to a stage three pressure ulcer; which presented with 70% slough (non-viable) tissue, 30% granulation tissue and measured 0.8 centimeters x 1.0 centimeters x 0.1 centimeters, requiring surgical debridement (removal) to promote healing, which constituted harm. The findings included: Resident #44 was admitted to the nursing facility on 5/3/17, and re-admitted to the facility 4/13/19, after an acute hospital stay. The current diagnoses included heart failure and asthma. Resident #44's annual Minimum Data Set (MDS) assessment with an assessment reference date	F 686	1. Resident #44 received a wound assessment by the wound physician during survey and wound treatments were implemented on 4/30/19. Resident was provided with a pressure relief mattress from 5/1/19 to 5/6/19 however, due to resident preference, mattress was removed on 5/6/19. 2. All residents are at risk for potential impaired skin integrity. 3. DON or designee will complete skin assessments on all residents living in facility by June1, 2019. Any skin concerns identified will be appropriately be assessed, staged and practitioners will be notified for appropriate treatment plan. DON or designee will educate licensed nursing staff and validate competencies on identification, assessment, treatment, documentation and monitoring of pressure injury and other skin conditions. DON or designee will educate CNAs on prevention of impaired skin integrity and the facility's policy and practice for completion of weekly skin assessments and weekly acquired pressure injuries will be logged into the facility risk management tool and will be reported in morning meeting and standards of care meetings for follow-up. Risk Assessments will be completed weekly x 4 weeks on new admissions, on readmissions, quarterly and with significant change. This information will be used to develop a person centered care plan to prevent and or treat pressure injuries. 4. DON or designee will complete 4 observations (rounding) per week x 4 weeks for residents who have been identified with pressure injuries that are ordered and care planned. Clinical Managers or designee will audit weekly skin assessments for completion and accuracy 25% X 4 weeks, then 10% x 2 weeks. Variances observed during treatment observations and audits will be investigated and feedback provided to the responsible staff member, corrections/clarifications will be made as needed. The summary of above audits will be presented to the QAPI committee for additional oversight and recommendation. 5. Compliance Date: June 10, 2019	

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(ARD) of 3/15/19, coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 14 out of a possible 15. This indicated Resident #44's cognitive abilities for daily decision making were intact. The 3/15/19, MDS was coded for no mood or behavior problems. In section "G" (Physical functioning) the resident was coded as requiring total care of one person with bathing, extensive assistance of one person with personal hygiene, dressing, and toileting and supervision of one person with eating.

An interview was conducted with Resident #44 on 4/29/19 at approximately 11:00 a.m. The resident stated she was supposed to have a cream applied between her legs but it hadn't come in and the area was bothering her.

On 4/29/19 at approximately 1:00 p.m. an observation was made of Resident #44's skin assessment performed by Licensed Practical Nurse-LPN #1, assisted by Certified Nursing Assistant-CNA #2. The skin assessment revealed a reddened rash in the groin area and to bilateral upper thighs; an open area was also observed to the resident's sacrum. The open area to the sacrum was very wet with whitish tissue surrounded by red tissue and yellowish slough tissue within the wound bed. The LPN #1 stated he would have the wound care nurse to thoroughly assess the opened sacral wound.

Review of the physician order summary for April 2019 revealed an order dated 4/22/19 for Nystatin 100,000 units/gram topical ointment. Apply to affected area four times daily. The Nystatin order was on the Medication Administration Record (MAR) and documented as administered on

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4/16/19 and 4/22/19 at 9 a.m. Being at 1 p.m. on 4/22/19 there were notes stating medication not administered/not available. An interview was conducted with LPN #1. He stated the Nystatin had not been available for application and he had spoken with a pharmacy representative last on 4/29/19 concerning the order. The pharmacy representative asked "do you still need it?" LPN #1 responded yes and the pharmacy representative stated they would send it on the next run arriving 4/30/19.

No pressure ulcer wound care orders were on the physician order summary until 4/30/19.

The active care plan dated 3/18/19, had a problem which read; (name of resident) is at risk for pressure ulcer. Had actual pressure stage 3 sacral ulcer 12/11/18. The goal read; (name of resident) will remain free of skin breakdown over the next 90 days through 6/18/19. The interventions included; check skin for redness, skin tears, swelling, or pressure areas. Report any signs of skin breakdown. Use pillows, pads, or wedges to reduce pressure on heels and pressure points. Turn/reposition. Do not massage skin over pressure areas. Perform nutritional screening, adjust diet/supplements as indicated to reduce the risk of skin breakdown.

The Braden scale for predicting pressure ulcer risk dated 4/14/19 was 19, indicated the resident was a very high risk for the development of pressure ulcers.

The re-admission nursing assessment dated 4/14/19, read the resident had good skin turgor, the skin was warm and dry, was without skin lesions, had no pressure ulcers, no stasis ulcers

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and no surgical wounds.

The weekly skin assessment dated 4/14/19, revealed no pressure ulcers. The weekly skin assessment dated 4/18/19, revealed no pressure ulcers. The weekly skin assessment dated 4/26/19, revealed no pressure ulcers.

An interview was conducted with the wound care nurse 4/29/19 at approximately 4:35 p.m. The wound care nurse stated the wound care physician would be in 4/30/19 to assess the wound and implement the most appropriate treatment. A low air loss mattress was ordered 4/29/19.

On 4/30/19 an interview was conducted with the wound care physician who stated the resident had a previous sacral pressure ulcer which had healed and took an extended period of time to heal. The wound care physician further stated the current sacral pressure ulcer appeared worse than it had ever presented but she was certain they would get it healed.

The wound care physician's assessment of the sacral pressure ulcer is a follows; "stage 3 pressure wound of the sacrum measuring (Length x Width x Depth) 0.8 centimeters x 1.0 centimeter x 0.1 centimeter with 70% slough tissue, 30 % granulation tissue and a light serous exudate. The wound care physician cleaned the sacral pressure ulcer with normal saline and anesthesia was achieved using topical benzocaine, then with clean surgical technique curette was used to surgically excise 0.56 cubic centimeters of devitalized tissue including slough, biofilm and non-viable subcutaneous fat and surrounding connective tissue was removed at a

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depth of 0.1 centimeter and healthy bleeding tissue was observed. Homeostasis was achieved and a clean dressing was applied. Post-operative recommendations and updates to the plan of care are documented in the assessment and plan section."

The wound care physician pressure ulcer dressing wound care plan was for Hydrocolloid (absorb exudate) sheet (thin), apply three times per week for thirty days, off-load the wound, reposition per facility protocol and follow-up by the wound care physician within seven days.

An interview was conducted with the Director of Nursing on 5/1/19, at approximately 4:45 p.m. The Director of Nursing stated the expectation is for staff who care for the resident while bathing, providing incontinence care, and turning and repositioning to identify changes in the skin and report it immediately to the nurse on duty. The Director of Nursing also stated they have the Stop and Watch program to aid staff in reporting changes with a resident. The Director of Nursing further stated every Certified Nursing Assistant had been educated and know it is the facility's expectation to monitor for and report skin impairment. The Director of Nursing also stated the licensed nurses assess all resident's skin on admission and weekly to assure resident's skin is remains intact. The Director of Nursing stated Resident #44's last 4 weekly skin assessment had be viewed and neither identified any type of skin impairment.

Stage 3 Pressure Injury: Full-thickness skin loss Full-thickness loss of skin, in which adipose (fat) is visible in the ulcer and granulation tissue and epibole (rolled wound edges) are often present.

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F 686	Continued From page 86 Slough and/or eschar may be visible. The depth of tissue damage varies by anatomical location; areas of significant adiposity can develop deep wounds. Undermining and tunneling may occur. Fascia, muscle, tendon, ligament, cartilage and/or bone are not exposed. If slough or eschar obscures the extent of tissue loss this is an Unstageable Pressure Injury. (National Pressure Ulcer Advisory Panel/NPUAP www.npuap.org). The facility's policy titled "Registered Nurse and Licensed Practical Nurse Guidelines for Skin Integrity" dated 3/6/17, read; Ensure completion of the Nursing Admission process and evaluate resident's risk factors by completing the Braden Risk Scale, Complete Weekly skin assessments for skin turgor, temperature, color and type, identification of skin lesions or open wounds, pressure ulcers/injury, stasis ulcer, surgical wounds or other skin problems. Under repositioning and mobilization the policy read; relieve pressure from bony prominences by assisting with turning and repositioning resident's at risk for pressure injury. Avoid positioning the resident on body areas with existing pressure injury. Choose a frequency for turning based on the support surface in use, the tolerance of skin for pressure and the individual's preferences. On 5/1/19, the above findings were shared with the Administrator and Director of Nursing. The Director of Nursing stated it was never reported and they were unaware the resident had the sacral pressure ulcer.	F 686		
F 698 SS=E	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis.	F 698		

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F 698	Continued From page 87 The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interviews, clinical record review and facility documentation review the facility staff failed to communicate ongoing assessments for Resident #73 for the monitoring of complications after dialysis treatment. The facility staff failed to ensure ongoing communication and assessments with the dialysis center for Resident #73 who attended an outpatient dialysis three days per week every Tuesday, Thursday and Saturday. The findings included: Resident #73 was originally admitted to the facility on 05/26/15. Diagnosis included but not limited to *End Stage Renal Disease (ESRD) (Chronic irreversible kidney failure). The resident was receiving *hemodialysis treatments three times a week every Tuesday, Thursday and Saturday. The current Minimum Data Set (MDS) a significant change assessment, with an Assessment Reference Date (ARD) of 04/9/19 coded the resident with a 15 out of a possible score of 15 on the Brief Interview for Mental Status (BIMS), indicating no cognitive impairment. In addition, under section (O) for Special Treatments, Procedures and Programs was coded for dialysis.	F 698	1. Resident #73 dialysis notes from November, 2018 to April, 2019 were requested from dialysis center on 4/30/19. 2. All residents receiving dialysis living in facility are at risk for missing notes. 3. DON, Clinical Manager, Staff Educator or designee will educate facility nursing staff and dialysis center on continuity of care between dialysis center and facility to include pre and post dialysis communication form completion. A request will be sent to dialysis regarding entering an order requiring dialysis staff to complete dialysis communication flow sheet to assure appropriate communication between facility and dialysis center. 4. Clinical Manager, medical records clerk or designee will complete audits of all dialysis flow sheets to assure continunity and completeness of communication between facilty and dialysis center 100% weekly x 4 weeks. Audits results to be reviewed for patterns/trends and reported to QAPI for input and guidance 5. Compliance Date: June 10, 2019	

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Resident #73's person-comprehensive care plan indicated resident requires dialysis. The goals the facility staff set for the resident is to have no complications or infected access site of the next 90 days. Some of the interventions included but not limited to monitor right upper extremity shunt for bruit/thrill and to monitor resident for increased complications from dialysis-report abnormal findings to MD.

Resident #73's physician orders contained the following orders: (1) Dialysis on Tuesday, Thursday and Saturday. (2) Assess dialysis shunt for bruit and thrill, s/s of infection, numbness, tingling, color/temperature change and edema and (3) Assess dialysis catheter dressing for integrity and surrounding skin for s/s infection or complication.

The dialysis binder content was reviewed for information from 11/01/18 to 04/29/19. Resident #73 goes to dialysis three times a week. The information on the "Dialysis Communication Sheet" was to be completed by dialysis. The information to include was the residents pre and post weight, comments and vital signs. Resident 73's Communication Sheet included the following:

The review of Resident #330's November 2018 Dialysis pre and post weights sheet included the following day with weights only: 11/17/18.

The review of Resident #330's December 2018 Dialysis pre and post weights included the following days with weights and vital signs: 12/08, 12/13,12/18 and 12/29/18.

The review of Resident #330's January 2019 Dialysis pre and post weights included the

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following days with weights, comment and vital signs: 01/01 and 01/10/19.

The review of Resident #330's February 2019 Dialysis pre and post weights included the following days with weights and vital signs: 02/16 and 02/19/19.

The review of Resident #330's March 2019 Dialysis pre and post weights included the following days with weights and vital signs: 03/12 and 03/14/19.

The review of Resident #330's April 2019 Dialysis pre and post weights included the following days with weights: No weights or vital signs were document for the entire month April.

An interview was conducted with License Practical Nurse (LPN) #8 on 04/28/19 at approximately 6:00 p.m. The surveyor asked, "If Resident #73 had any type of complication or issue at dialysis, how would you know if there is not ongoing communication with the dialysis? The LPN stated, "If you don't hear anything, I assume everything went fine." She said sometimes their dialysis machine will break, the resident will return to the facility but does not always receiving a call from the dialysis center; we will call the dialysis center if we are not too busy.

On 04/29/19 at approximately 5:50 p.m., the Medical Records clerk provided a Blood Pressure Monitoring sheet from (Name) Greater Portsmouth Dialysis. The sheet included all Resident #73's vital signs from 10/02/18 through 04/27/19. The blood pressure monitoring sheet had a fax confirmation with a date and time of

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4/29/19 at 5:30 p.m. (time received).

An interview was conducted with Unit Manager (UM) on Unit II on 04/30/19 at approximately 10:17 a.m. The surveyor reviewed Resident #73's Dialysis Communication Sheet with the UM from 11/2018 through 04/19. The surveyor asked if Resident #73 should return from dialysis with his communication sheet completed with pre/post weights and vital signs. She said Resident #73 should return after each dialysis his visit (three times per week) with the communication sheet completed. The surveyor asked, "What is the expectations of the nurses if Resident #73 returned from dialysis without the communication book or the communication sheet not competed?" She said, "They need to call the dialysis center and request the pre/post weights and vital signs." The surveyor asked, "How do you know if Resident had any complications while at dialysis if the communication sheet comes back empty" she replied," We don't." The surveyor asked, "Would you want to know if Resident #73 had any complications or issues while at dialysis" the UM replied, "Yes."

The facility administration was informed of the finding during a briefing on 05/01/19 at approximately 4:45 p.m. The facility did not present any further information about the findings.

The facility's policy tiled Life Care-Dialysis-Guidelines of Care (Revision date: 01/22/18).

-Policy statement: The facility will provide patients and residents who require renal dialysis services that are consistent with professional standards of care.

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When a resident requires dialysis service, the resident must leave the facility to obtain dialysis. the facility will have an agreement or arrangement (contract) with an outside entity providing dialysis services.

-This agreement will address at least:
Interchange of information necessary for the resident's care.

Definitions:
*ESRD is the last stage of chronic kidney disease. When your kidneys fail, it means they have stopped working well enough for you to survive without dialysis or a kidney transplant (www.kidneyfund.org/kidney-disease/kidney-failure).

*Hemodialysis-cleans blood by removing it from the body and passing it through a dialyzer, or artificial kidney. The process of removing blood from the body, filtering it and returning it takes time. Hemodialysis treatment usually takes three to five hours and is repeated three times a week.

*For dialysis, a catheter is inserted into a large vein in either the neck or chest. A catheter is usually a short-term option; however, in some cases a catheter is used as a permanent access. With most dialysis catheters, a cuff is placed under the skin to help hold the catheter in place. The blood flow rate from the catheter to the dialyzer may not be as fast as for an AV graft or AV fistula; therefore, the blood may not be cleaned as thoroughly as with an arteriovenous access (https://www.davita.com/kidney-disease/dialysis/treatment/arteriovenous-av-fistula-

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F 698	Continued From page 92 %2597-the-gold-standard-hemodialysis-access/e/1301). *Bruit is listening for adequate bruit with a *stethoscope. A continuous low pitched bruit should be present (www.laminatemedical.com/assessment-and-monitoring-of-av-fistulas-for-new-dialysis). *Stethoscope is an instrument used to detect and study sounds produced in the body that are conveyed to the ears of the listener through rubber tubing connected with a usually cup-shaped piece placed upon the area to be examined. (Source: http://c.merriam-webster.com/medlineplus/stethoscope). *Thrill-Check the pulse in your access arm. You should feel blood rushing through that feels like a vibration. This vibration is called a "thrill."(Source: https://medlineplus.gov/ency/patientinstructions/000705.htm)	F 698		
F 727 SS=D	RN 8 Hrs/7 days/Wk, Full Time DON CFR(s): 483.35(b)(1)-(3) §483.35(b) Registered nurse §483.35(b)(1) Except when waived under paragraph (e) or (f) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. §483.35(b)(2) Except when waived under paragraph (e) or (f) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. §483.35(b)(3) The director of nursing may serve	F 727		

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F 727	Continued From page 93 as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and facility document review, the facility staff failed to ensure there was Registered Nurse (RN) coverage for 8 hours, 7 days a week. The facility staff failed to ensure there was RN coverage for 8 hours on 3/2/19. The findings included: On 05/01/19 at approximately 2:30 PM, the facility's actual worked schedule was reviewed and revealed there was no RN coverage for 03/02/2019. On 05/01/19 at approximately 2:39 PM, an interview was conducted with the Operations Coordinator. She was asked to explain the RN weekend schedule. She stated that RN's (Registered Nurses) are hired for weekend coverage. If no one is here we ensure that we have RN coverage. She was asked if RN on call coverage suffices for RNs not being in the building? She replied "no!" She also stated that the Registered Nurse scheduled to come in on 03/02/19 on the 7:00 PM -7:00 AM shift called out, and there was not an on call Registered Nurse that could be reached by phone. On 05/01/19 at approximately 5:06 PM an interview was conducted with The Director of Nursing (DON) and the facility Administration concerning the above issue. The DON stated that the scheduling coordinator should have called in additional RN (Registered Nurse) coverage.	F 727	1. The situation of providing 8 hour RN coverage could not be remedied due to date cited (3/2/19) on the CMS Form 2567 from survey ending May 1, 2019. 2. The facility is at risk for not being able to provide 8 hour RN coverage when RN staff call out and/or when RN staff positions are vacant. 3. Corporate leadership team and facility leadership team are examining RN staffing models and monitoring to ensure RN coverage are scheduled and assigned to care for facility residents. Corporate leadership team has interfaced with HR and several key areas were identified and implimented: divisional removal of BSN requirement for RNs, financial incentives for recruitment, plans for targeted digital advertising including social media to help increase awareness of RN opportunities and benefits and collaborating with nursing agencies for RN staff coverage. Divisional HR will hold a recruitment event on May 28, 2019. Administrative team to hold staff meeting to instill a sense of renewed responsibility, expectations and accountability for work habits including attendance policy. 4. Admininstrator, DON or designee will monitor the established staffing schedule to ensure that sufficient RN staff are scheduled to meet the needs of the facility. The facility leadership team will review open positions, recruitment /retention efforts and trends for "call-outs" weekly and report to corporate leadership team. A report on staffing will be provided to QAPI for additional oversight and monitoring. 5. Compliance Date: June 10, 2019	

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F 727	Continued From page 94 On 05/01/19, the DON was asked for a policy on RN coverage. The administrator stated there was no policy because "We follow Federal Regulations concerning the RN 8 hour coverage." The DON nodded in agreement.	F 727		
F 755 SS=E	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in	F 755	1. The medication for Resident #44 was received in the facility and treatment initiated on 4/24/19 at 2100. Resident #44 care plan was updated to include the prescribed treatment. 2. All residents are at risk for errors in medication. 3. DON, CM or designee will educate nursing on protocols for notifying pharmacy when prescribed medication is not available. 4. DON, CM or designee will audit the 24 hour report to identify any missed medications 5x per week x 4 weeks. Variances will be reviewed for patterns and/or trends and reported to QAPI for input and guidance, 5. Compliance Date: June 10, 2019	

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order and that an account of all controlled drugs is maintained and periodically reconciled.
This REQUIREMENT is not met as evidenced by:
Based on observation, resident interview, staff interview, clinical record review, and review of the facility's policy the facility staff failed to acquire medications needed to meet each resident's needs for 1 of 42 residents (Resident #44), in the survey sample.

The facility's staff failed to obtain Nystatin ointment (an antifungal) ordered for Resident #44 on 4/22/19.

The findings included:

Resident #44 was admitted to the nursing facility on 5/3/17, and re-admitted to the facility on 4/13/19, after an acute hospital stay. The current diagnoses included heart failure and asthma.

Resident #44's annual Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 3/15/19, coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 14 out of a possible 15. This indicated Resident #44's cognitive abilities for daily decision making were intact. The 3/15/19, MDS was coded for no mood or behavior problems. In section "G" (Physical functioning) the resident was coded as requiring total care of one person with bathing, extensive assistance of one person with personal hygiene, dressing, and toileting and supervision of one person with eating.

An interview was conducted with Resident #44 4/29/19, at approximately 11:00 a.m. The resident

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stated she was supposed to have a cream applied between her legs but it hadn't come in and the area was bothering her.

Observation of Resident #44's skin assessment revealed a redden rash in the groin area and to bilateral upper thighs also an open area was observed to the resident's sacrum. The open area to the sacrum was very wet with whitish tissue surrounded by red tissue and yellowish slough tissue within the wound bed.

Review of the physician order summary for April 2019 revealed an order dated 4/22/19 for Nystatin 100,000 units/gram topical ointment. Apply to affected area four times daily.

The active care plan dated 3/18/19, didn't include the Nystatin ointment or the groin/thigh rash.

Review of the Medication Administration record for the Nystatin ointment revealed notes dated 4/22/19 through 4/29/19, which read; "Not administered, medication not available".

An interview was conducted with Licensed Practical Nurse (LPN) #1, at approximately 1:15 p.m., on 4/29/19. LPN #1 stated calls had been made to the pharmacy regarding Resident #44's Nystatin ointment and the pharmacy staff stated the Nystatin ointment would arrive on 4/30/19.

On 5/1/19, the above findings were shared with the Administrator and Director of Nursing. The Administrator stated it was was the facility's expectation for medications to arrive on the next run or within 24 hours from the time the facility sent the order to the pharmacy. The facility's policy titled "Dispensing Pharmacy

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F 755	Continued From page 97 Requirements" with a revision dated of 2/15/18 read; the dispensing pharmacy agrees to perform the following Pharmaceutical services including but not limited to; providing routine and timely pharmacy and emergency pharmacy service 24 hours per day, seven days per week.	F 755		
F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record.	F 756	1. The diagnosis and end date for the use of Valtrex was updated in the EMR for resident #47 on 5/15/19 2. All residents are at risk for inaccurate diagnosis coding and recommended end date for prescribed medication(s). 3. DON, CM or designee will educate clinical staff on: order entry for medications to include appropriate diagnosis,end/stop dates and on Medication Regimen Review process and follow-up to ensure Medication Irregularities identified are addressed appropriately. 4. DON or designee will audit Pharmacy Medication Regimen Review reports x 2 months to ensure pharmacy medication irregularities identified are completed and recommendations are documented. Variances will be reviewed for patterns and/or trends and reported to QAPI for input and guidance. 5. Compliance Date: June 10, 2019	

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§483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident.
This REQUIREMENT is not met as evidenced by:
Based on clinical record review and staff interviews the facility staff failed to ensure that the medication irregularities identified by the Pharmacist during the Drug Regimen Review were acted upon for 1 of 42 residents (Resident #47) in the survey sample.

The facility staff failed to ensure medication irregularities identified by the Pharmacist during the Drug Regimen Review were acted upon for Resident #47.

The findings included:

Resident #47 was admitted to the facility on 07/25/2016. Diagnoses included but were not limited to, Heart Failure and Diabetes Mellitus. Resident #47's Minimum Data Set (MDS- an assessment protocol) with an Assessment Reference Date of 03/18/2019 was coded with a BIMS (Brief Interview for Mental Status) score of 15 indicating no cognitive impairment. In addition, the Minimum Data Set coded Resident #47 as requiring limited assistance of 1 with activities of daily living.

Resident #47's Clinical Record was reviewed on 04/29/2019 and the Physician's Order Sheet revealed a medication order for Valacyclovir

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(Valtrex) 500 MG (Milligram) tablet (1 tablet) three times weekly, ordered on 02/12/2019.

Pharmacy Notes for 04/09/2019 was reviewed and revealed a Medication Regimen Review was conducted and is documented in part, as follows: "Medication Irregularities Identified: Update diagnosis and stop date for Valtrex."

On 04/29/2019 at approximately 3:00 p.m., the surveyor asked Licensed Practical Nurse (LPN) #2, "Why is Resident #47 receiving Valtrex?" LPN #2 stated, "I'm not sure. I've only been in this position for about 1 month. I will check and find out why she is on it."

On 04/29/2019 at approximately 4:00 p.m., the surveyor asked Registered Nurse (RN) #1, "What is the process for notifying the physician after the Pharmacist conducts a Medication Regimen Review and there are documented irregularities?" RN #1 stated, "I'm not sure."

On 04/30/2019 at 3:15 p.m., an interview was conducted with the Interim Director of Nursing (DON) and he was asked, "What is the process for contacting the physician after the Pharmacist conducts the monthly Medication Regimen Review and there are documented irregularities?" The Interim DON stated, "I don't know." The Surveyor informed the Interim DON of the Pharmacy note dated 04/09/2019 documenting the Medication Regimen Review was conducted with identified medication irregularities. The Interim Director of Nursing stated, "I will find out what I can."

Resident #47's Clinical Record was reviewed on 05/01/2019 at 10:30 a.m. and revealed

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F 756	Continued From page 100 Physician's Clinical Note entry dated 05/01/2019 at 6:47 a.m. The Physician documented in part, as follows: "I was able to clarified the reason for her being on Valacyclovir thru family; Indefinite treatment was recommended by a previous provide for prophylaxis against recurrent genital herpes." The Interim Administrator was informed of the findings on 05/01/2019 at approximately 2:50 P.M. The Interim Administrator stated, "The staff should have placed a note in the binder on the unit notifying the Physician of the Pharmacist recommendations." The facility staff did not present any further information about the findings.	F 756		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and	F 761	1. The narcotic medication box was reattached and secured inside the refrigerator on unit 1 as soon as it was identified during the survey. 2. All residents taking refrigerated controlled medications are at risk for unsecured storage of said medication. 3. DON, CM, Staff Educator or designee will educate license nursing staff on appropriate storage of medication to include refrigerated controlled medications. Issues identified will be corrected immediately. 4. CM or designee will audit medication refrigerators 5x per week to ensure the security of controlled medications. Variances will be reviewed for patterns and/or trends and reported to QAPI for input and guidance. 5. Compliance date: June 10, 2019	

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Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.
This REQUIREMENT is not met as evidenced by:
Based on observation and inspection of 1 of 2 medication rooms (Unit II), the facility staff failed to ensure provision of a separately locked, permanently affixed compartment for the storage of controlled drugs or drugs subject to abuse.

The findings include:

On 4/29/19 at 11:15 a.m., the medication room on Unit II was inspected with the assistance of Licensed Practical Nurse (LPN) #8. Upon entry, the door to the medication room was locked. The refrigerator was not locked and a small 8 inch by 5 inch metal box sat on the bottom shelf that was lifted out and sat on the counter. The items in the box included three 30 milliliters (ml) boxes of 2 milligram (mg) per ml *Ativan/ Lorazepam. This LPN did not recognize that the drugs were not double locked and that the metal box was not affixed and could be easily removed from the medication room. A Registered Nurse (RN) #3 entered the room and stated, "There were screws that secured the box in the refrigerator. I will take care of that right now!"

*Lorazepam belongs to a class of drugs known as benzodiazepines which is a schedule IV controlled substance that act on the brain and nerves (central nervous system) to produce a calming effect (https://www.webmd.com/drugs/2/drug-6685/ativan-oral/details).

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F 761	Continued From page 102 On 5/1/19 at 1:30 p.m., during interview with the Administrator and the Director of Nursing (DON), they stated the metal box should have been secured affixed in the refrigerator and they were informed of the problem after this surveyor inspected the medication room and refrigerator. The facility's policy and procedure titled "Storage of Medications" dated 2/15/18 indicated schedule II-IV controlled medications are stored separately from other medication in a locked drawer or compartment affixed and designated for that purpose.	F 761		
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, facility documentation review, the facility staff failed to ensure the	F 868	1. The situation regarding missing signature sheets as proof of previous quarterly QAPI meetings could not be remedied due to dates cited on CMS Form 2567. 2. The facility is at risk when proof of QAPI meetings isn't in place. 3. Administrator or designee will educate facility staff on the required attendance and documentation of QAPI meetings. 4. Administrator will audit the documentation of the QAPI meetings to ensure attendance of QAPI committee members is met x 2 quarters (6 months). 5. Compliance Date: June 10, 2019	

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Quality Assessment and Assurance (QAA) committee met at least quarterly and the required members attended.

The facility staff failed to consistently have the required members at each quarterly Quality Assessment and Assurance Committee (QAA) meeting and failed to meet on a quarterly basis for one year.

The findings included:

On 05/01/19 at approximately 1:11 p.m., the Quality Assurance (QA) review was conducted with the Administrator. The surveyor requested the QAPI (QA Performance Improvement) meeting sign-in sheets for the last 4 quarters. The Administrator stated, "I searched prior to this meeting for the QAPI sign-in-sheets but could only locate sign-in-sheets for 03/27/19 and 09/27/18. She stated, "I'm not sure where the previous Administrator could have put the sign-in-sheets but they should be in the QA book. The Administrator started going through the QA book then stated, "You can tell the meetings was held because the QA paperwork is here." The surveyor asked, "Do you have the signature sign-in-sheets validating the QAPI Meetings were held in June and December 2018", she replied, "No, I was not able locate the sign-in-sheets."

The sign-in sheet reviewed, the sign-in-sheet for 09/27/18, it was identified that the Administrator's signature was not present. The facility was not able to provide documentation from the Quality Assessment and Assurance meeting notes that the Administrator had attended.

The facility administration was informed of the

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finding during a briefing on 05/01/19 at approximately 4:45 p.m. The facility did not present any further information about the findings.

The facility's policy titled QAPI - Committee (Last revision date: 02/21/19).
-Purpose: The QAPI Committee is responsible for the monitoring, identification, trending and evaluating of data to determine a problem or opportunity for improvement is present, and if identified, a determination of the cause and implementation of corrective actions; assessment of the effectiveness or corrective actions.

Committee Members included but not limited to:
-Medial Director
-Administrator
-Director of Nursing

1. The Medical Director and/or Administrator will serve as Chairperson of the committee.
2. The QAPI Committee will meet quarterly or more often if deemed necessary.

The facility's Quality assurance and Performance Improvement Plan (QAPI) (2018).
-Responsibility and Accountability:

The Administrator has responsibility and is accountable to senior leadership and the corporation for ensuring that a QAPI program is implement. QAPI will be at a minimum a quarterly standing agenda item. The administrator is responsible for assuring that all QAPI activities and required documentation at the facility and available to provide to senior leadership or the Board of Directors, as necessary.

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F 868	Continued From page 105 a. Facility Leaders may include, but not limited to: -Administrator -Director of Nursing -Medical Director	F 868		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;	F 880	1. Resident #229 was discharged from facility on 5/5/19. Resident #71 was discharged from facility on 5/3/19. As soon as issue was identifed, the oxygen equipment for resident # 58 was dated and stored in a sanitary manner. The situations regarding cleaning of the glucose monitoring machines before and after use could not be remedied due to the date of the citations reported on the CMS - 2567 form from survey ending 5/1/19. 2. All residents utilizing oxygen and/or glucose monitoring are at risk for not having an effective infection control program. 3. DON, Staff Educator, Infection Control Preventionist or designee will educate licensed nursing staff on appropriate cleaning of glucose monitoring units, infection control practices when performing glucose testing and appropriate hand hygiene. DON/ICP/Educator or designee will educate staff on appropriate infection control practices for residents on isolation to include hand hygiene and/or use of alcohol based solutions (hand sanitizers). DON/ICP/Educator or designee will educate on sanitary storage and dating of oxygen equipment. 4. CM, Staff Educator or designee will complete 2 observations of glucose monitoring 3 times weekly x 4 weeks. The ICP/Educator or designee will complete 2 observations for infection control practices for residents on isolation 3x per week x 4 weeks and 2 observations for appropriate oxygen equipment storage. Variances will be reviewed for patterns and/or trends, staff re-educated when deficient practice is identied and results reported to QAPI for input and guidance. 5. Compliance Date: June 10, 2019	

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(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.
(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and
(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.

§483.80(a)(4) A system for recording incidents 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, clinical record review and facility document review, it was determined that facility staff failed to follow infection control practices for three of 42

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residents in the survey sample, Resident # 229, #71, and #58; and the facility staff failed to ensure they followed infection control practices to prevent the possible transmission of infection and disease on 2 of 2 facility nursing units.

1. For Resident #229, facility staff failed to wear the appropriate PPE (Personal Protective Equipment) while she was on contact precautions on 4/28/19 and had the wrong precaution sign on the resident's door.

2. For Resident #71, facility staff failed to wear the appropriate PPE while she was on droplet precautions on 4/29/19 and had the wrong precaution sign on the resident's door.

3. For Resident #58, facility staff failed to maintain oxygen equipment in a sanitary manner.

4. On Unit I, the facility staff facility staff failed to disinfect the glucose monitoring machine before and after use.

5. On Unit II, the facility staff facility staff failed to disinfect the glucose monitoring machine before and after use.

The findings include:

1. Resident #229 was admitted to the facility 4/9/19 with diagnoses that included but were not limited to MRSA (1) in sputum, type two diabetes, congestive heart failure and chronic pain. Resident #229 did not have a completed MDS (minimum data set) assessment but was documented, in a nursing note dated 4/13/19, as being alert and oriented to person, place and time.

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On 4/28/19 at 1:28 p.m., a tour of the facility was conducted. Resident #229 was observed to have PPE (personal protective equipment) hanging from her door.

On 4/28/19 at 2:20 p.m., a staff member (CNA (Certified Nursing Assistant) #8) was observed walking into Resident #229's room with no personal protective equipment on. CNA #8 was observed to lower the resident's bed and then take the red hazard bag out of the resident's room. CNA #8 then walked into the soiled utility room and dropped off the red bag. CNA #8 was not observed to wash her hands. On 4/28/19 at 2:34 p.m., CNA #8 was observed to walk into Resident #229's room for the second time. She did not have PPE on. She walked out of Resident #229's room at 2:26 p.m.

On 4/29/19 at 9:42 a.m., a sign was posted on Resident #229's door for Enteric (intestinal) precautions.

Review of Resident #229's April 2019 POS (physician order summary) revealed that Resident #229 was not currently on any antibiotics. Further review of Resident #229's clinical record revealed the following order: "Contact Precautions; Resident placed on contact precautions for MRSA in SPUTUM." This order was dated 4/10/19.

Review of Resident #229's hospital discharge instructions revealed that she received intravenous antibiotics for MRSA in the sputum while at the hospital. The following discharge summary was written on 4/9/19: " ...She was recently admitted with MRSA pneumonia, and

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was discharged to the rehabilitation afterwards. Yesterday she went home with her daughter. This morning her daughter stated that she was feeling tired, she was confused and not acting Herself (sic) and she was staying in bed and not answering her when she talks to her ...she received IV (intravenous)vancomycin (antibiotic) (2) and doxycycline (antibiotic) (3) in the ER (emergency room) ...patient was admitted for AMS (altered mental status) and fevers. She was started on broad spectrum antibiotics however cultures were negative ...AMS (altered mental status) worsened and she was eventually intubated and transferred to IC (intensive care unit) ...She completed antibiotics for presumed aspiration pneumonia ..."

Review of Resident #229's comprehensive care plan dated 4/29/19 documented the following: "Isolation: Precautions for MRSA on Sputum. Goals: No complications from within the next 90 days. Interventions: Report results of cultures and treat as ordered, Lab tests as ordered by the physician, explain the need for isolation precautions to resident and family, Staff education in isolation procedures as needed."

On 4/30/19 at 9:13 a.m., an interview was conducted with RN (registered nurse) #1, the unit manager. When asked if Resident #229 was on isolation, RN #1 stated that Resident #229 was on enteric contact precautions for MRSA in her sputum. When asked if Resident #229 should be on enteric precautions for MRSA in the sputum, RN #1 stated that she was not sure. When asked what type of PPE should be worn for a resident on contact precautions, RN #1 stated that staff should be wearing a mask, gown and gloves. When asked how isolation status is

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communicated to other staff, RN #1 stated that isolation is usually communicated in the morning report and the signs and PPE on the door should alert staff to ask a nurse. When asked if Resident #229 was receiving antibiotics for her MRSA, RN #1 stated that Resident #229 received antibiotics in the hospital and that the PA (physician assistant) did not want to lift isolation precautions until her primary care physician evaluated Resident #229 on 5/1/19. RN #1 stated that she would try to find a note from the PA documenting this. RN #1 stated that she was made aware verbally by the PA.

Further review of Resident #229's clinical record revealed that her primary physician had followed up with her infection on 5/1/19. The following order was written: "Nasal Swab." A physician note was written on 5/1/19 with instructions to continue precautions until swab results were cleared.

On 5/1/19 at 12:11 p.m., an interview was conducted with CNA #8. When asked if a resident is on contact precautions what she should wear, CNA #8 stated that she should wear a gown, gloves and mask. When asked why she would wear these things, CNA #8 stated, "Because germs can go a distance if they cough or sneeze." When asked if Resident #229 was on isolation, CNA #8 stated that she was. When asked what type of precautions Resident #229 was on, CNA #8 stated that she was on Enteric precautions. When asked what enteric precautions meant, CNA #8 stated that she was not sure. When asked what infection Resident #229 had, CNA #8 stated she had MRSA but thought that it was in her urine. When asked if she wore PPE gear on 4/28/19 when going into Resident #229's room, CNA #8 stated that she

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did not and that there was no reason why she did not wear PPE. CNA #8 stated that wearing PPE equipment was something staff cannot be careless about because illness can spread. CNA #8 stated it was very wrong.

On 5/1/19 at 2:20 p.m., ASM (administrative staff member) #1, the interim administrator and ASM #2, the interim DON (Director of Nursing) were made aware of the above concerns.

Facility policy titled, "Isolation Policy," documented in part, the following: "Transmission based precautions are designed for patients documented or suspected to be infected with highly transmissible or epidemiologically important pathogens for which additional precautions beyond Standard Precautions are needed to interrupt transmission within hospitals.

Contact precautions: designed to reduce the risk of transmission of epidemiologically important microorganisms by direct or indirect contact. (i.e. Antibiotic -resistant infections, which are spread by close or direct contact, RSV (Respiratory syncytial virus), MRSA (Methicillin-resistant Staphylococcus aureus), VRE (Vancomycin Resistant Enterococcus), ESBL (Extended Spectrum B-Lactamase Mediated Resistance) and CRE.

Contact Enteric Precautions: designed to reduce the risk of transmission of epidemiologically important microorganisms by direct or indirect contact. (i.e. Clostridium difficile, Norovirus, Rotavirus, Diarrhea of unknown or infectious etiology)."

(1) MRSA (Methicillin-resistant Staphylococcus

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aureus) - "a staph infection that is resistant to several common antibiotics. There are two types of infection. Hospital-associated MRSA happens to people in health care settings. Community-associated MRSA happens to people who have close skin-to-skin contact with others, such as athletes involved in football and wrestling. Infection control is key to stopping MRSA in hospitals." This information was obtained from The National Institutes of Health. https://medlineplus.gov/mrsa.html.

(2) The National Institutes of Health. https://livertox.nlm.nih.gov/Vancomycin.htm.

(3) The National Institutes of Health. https://pubchem.ncbi.nlm.nih.gov/compound/doxycycline.

2. For Resident #71, facility staff failed to wear the appropriate PPE while she was on droplet precautions on 4/29/19 and had the wrong precaution sign on the resident's door.

Resident #71 was admitted to the facility on 3/28/19 with diagnoses that included but were not limited to MRSA (1) in sputum, anxiety disorder, heart failure, and bipolar disorder. Residents #71's most recent MDS (Minimum data set) was an admission assessment with an ARD (assessment reference date) of 4/5/19. Resident #71 was coded as being cognitively intact in the ability to make daily decisions scoring 14 out of 15 on the BIMS (Brief Interview for mental status) exam.

On 4/28/19 at 1:28 p.m., a tour of the facility was conducted. Resident #71 was observed to have personal protective equipment hanging on her

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door.

On 4/29/19 at 9:42 a.m., a sign was posted on Resident #229's door for Enteric (intestinal) precautions.

On 4/29/19 at 4:00 p.m., a staff member (CNA (certified nursing assistant) #12 was observed sitting on Resident #71's bed without the appropriate PPE. Resident #71 was wearing a mask and sitting in her chair.

Review of Resident #71's clinical record revealed the following orders:

1) "Bactrim DS (2) 800 mg- 160 mg tablet (one tablet) TABLET Oral- Pneumonia." This antibiotic was originally started on 4/12/19, and re-started on 4/26/19.

2) "Droplet precautions." This order was initiated on 4/11/19.

Further review of her clinical record revealed the following note from PACE (Program of All Inclusive Care for the Elderly) dated 4/24/19; that documented in part, the following: " ...Sputum culture still positive for MRSA, but she is colonized. Recent Cxr (chest x-ray) still positive for pneumonia. Will give second course of Bactrim DS and repeat Cxr. Would not repeat respiratory culture ...There was no repeat x-ray only a repeat sputum cx (culture). That's what prompted the extension of the ABX (antibiotic)."

Review of Resident #71's care plan dated 4/10/19, failed to reflect her diagnosis of MRSA in her sputum.

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On 4/29/19 at 4:14 p.m., an interview was conducted with CNA (certified nursing assistant) #12. When asked if Resident #71 had an infection, CNA #12 stated, "Not that I know of. I would have to ask. When asked if there was anything on her door to alert staff regarding precautions, CNA #12 stated that he would have to go look. This writer and CNA #12 looked at Resident #71's door and he confirmed that Resident #71 was on isolation. CNA #12 stated, "But I wasn't touching anything." When asked if he was on her bed, CNA #12 stated, "I know." When asked if the enteric precaution sign and PPE hanging on her door should have alerted him to ask a nurse about her diagnosis, CNA #12 stated that it should have.

On 5/1/19 at 2:20 p.m., ASM #1, the interim administrator and ASM #2, the interim DON (Director of Nursing) were made aware of the above concerns.

Facility policy titled, ""Isolation Policy," documented in part, the following: "Transmission based precautions are designed for patients documented or suspected to be infected with highly transmissible or epidemiologically important pathogens for which additional precautions beyond Standard Precautions are needed to interrupt transmission within hospitals.

Droplet precautions: designed to reduce the risk of droplet transmission of infectious agents (i.e. Influenza, Meningitis...

Contact Enteric Precautions: designed to reduce the risk of transmission of epidemiologically important microorganisms by direct or indirect contact. (i.e. Clostridium difficile, Norovirus,

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Rotavirus, Diarrhea of unknown or infectious etiology)."

(1) MRSA (Methicillin-resistant Staphylococcus aureus) - "a staph infection that is resistant to several common antibiotics. There are two types of infection. Hospital-associated MRSA happens to people in health care settings. Community-associated MRSA happens to people who have close skin-to-skin contact with others, such as athletes involved in football and wrestling. Infection control is key to stopping MRSA in hospitals." This information was obtained from The National Institutes of Health. https://medlineplus.gov/mrsa.html.

(2) Bactrim DS- is a synthetic antibacterial combination product available in DS (double strength) tablets. This information was obtained from The National Institutes of Health. https://aidsinfo.nih.gov/drugs/401/sulfamethoxazole---trimethoprim/43/professional.

3. For Resident #58, facility staff failed to maintain oxygen equipment in a sanitary manner.

Resident #58 was admitted to the facility on 11/5/18 with diagnoses that included but were not limited to dementia without behavioral disturbances, muscle weakness, major depressive disorder, psychosis and paranoid schizophrenia. Resident #58's most recent MDS (minimum data set) assessment was a quarterly assessment with an ARD (assessment reference date) of 3/27/19. Resident #58 was coded as being severely impaired in cognitive function scoring 99 on the BIMS (Brief Interview for Mental Status) exam.

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Review of Resident #58's clinical record revealed the following orders: "albuterol sulfate (1) 2.5 mg /3 ml solution for viral pneumonia. As needed four times a day daily starting 4/22/19."

On 4/28/19 at 1:28 p.m., 2:17 p.m., and 3:00 p.m., observations were made of Resident #58's room. Her nebulizer tubing was in a basket filled with stuffed animals and Easter shredded filling paper. There was no date on the nebulizer mask.

On 4/29/19 at 9:43 a.m., an observation was made of Resident #58's nebulizer mask. Her mask now dated 4/29/19, was on her bedside table, not stored in a bag.

On 4/29/19 at 11:16 a.m., 12:00 p.m., and 4:31 p.m., observations were made of Resident #58's nebulizer mask. Her mask was observed uncovered on the floor.

On 4/30/19 at approximately 9:15 a.m., an observation was made of Resident #58's nebulizer mask. Her nebulizer mask dated 4/29/19 was sitting upright on her bedside table left uncovered and not stored in a bag.

Review of Resident #58's April MAR (Medication Administration Record) revealed that Resident #58 had not received albuterol treatments since 4/25/19.

On 4/30/19 at 9:13 a.m., an interview was conducted with RN (registered nurse) #1, the unit manager. When asked how nebulizer masks should be stored when not in use by the resident, RN #1 stated that nebulizer tubing should be stored in a plastic bag to prevent dust, dirt etc. from getting on the mask. RN #1 then stated

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storing nebulizer masks in a bag was to prevent infections. When told RN #1 about the above observations, RN #1 stated that was not their common practice.

On 5/1/19 at 2:20 p.m., ASM (administrative staff member) #1, the interim administrator and ASM #2, the interim DON (Director of Nursing) were made aware of the above concerns.

Facility staff could not provide a policy regarding the above concerns.

(1) Albuterol Sulfate is used to treat or prevent bronchospasm in patients with asthma, bronchitis, emphysema, and other lung diseases. This information was obtained from The National Institutes of Health. https://search.nih.gov/search?utf8=%E2%9C%93&affiliate=nih&query=albuterol+sulfate

4. During the medication pass observation on 4/28/19 at 4:00 p.m., a Unit I Licensed Practical Nurse (LPN) #4 performed a finger stick blood glucose check using no gloves followed by hand sanitizer. Afterwards, the LPN proceeded to administer insulin using one glove on the left hand and injected the insulin with the un-gloved right hand. The LPN removed the one glove and deposited it into the trash followed by hand sanitizer.

On 5/1/19 at 1:15 p.m., an interview was conducted with LPN #4. Three other surveyors were present in the conference room where the interview took place. She confirmed she did use hand sanitizer after the finger stick blood glucose check, as well as using one glove because she

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felt there would be no contamination back and forth with the right hand. The glucose monitoring machine was not disinfected before or after use. LPN #4 took the machine back to the nurse's station and placed it on the charger.

5. During the medication pass observation 4/28/19 at 4:00 p.m., a Unit II Licensed Practical Nurse (LPN) #6 performed a finger stick blood glucose check using gloves followed by hand sanitizer. Afterwards, the LPN proceeded to administer insulin using gloves, deposited them it into the trash followed by hand sanitizer. The glucose monitoring machine was not disinfected before or after use. LPN #6 took the machine back to the nurse's station and placed it on the charger.

On 5/1/19 at 1:30 p.m., the Administrator and the Director of Nursing (DON) stated the glucose monitoring machine should have been disinfected before and after use.

The facility's policy titled "Glucose Monitoring" dated 8/15/18 indicated the glucose monitor was to be cleaned with disposable bleach wipes or germicidal disposable wipes before and after use. Gloves are used during the finger stick, removed afterwards followed by washing hands.